## Summary of Benefits and Coverage

**The School Board of Orange County, Florida: Open Access Plus IN**

**Coverage Period:** Beginning 10/01/2019

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

### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>For <strong>in-network providers</strong>: $100/individual or $200/family</td>
<td>Generally, you must pay all of the costs from <strong>providers</strong> up to the deductable amount before this <strong>plan</strong> begins to pay. If you have other family members on the <strong>plan</strong>, each family member must meet their own individual deductable until the total amount of deductable expenses paid by all family members meets the overall family deductable.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. In-network <strong>preventive care</strong> &amp; immunizations, office visits, <strong>diagnostic test</strong>, emergency room visits, <strong>urgent care</strong> facility visits, mental health services, substance abuse services and prescription drugs are covered before you meet your deductible.</td>
<td>This <strong>plan</strong> covers some items and services even if you haven’t yet met the deductable amount. But a <strong>copayment</strong> or <strong>coinsurance</strong> may apply. For example, this <strong>plan</strong> covers certain <strong>preventive services</strong> without cost-sharing and before you meet your deductable. See a list of covered <strong>preventive services</strong> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet <strong>deductibles</strong> for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>For <strong>in-network providers</strong> $5,000/individual or $10,000/family</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay in a year for covered services. If you have other family members in this <strong>plan</strong>, they have to meet their own <strong>out-of-pocket limits</strong> until the overall family <strong>out-of-pocket limit</strong> has been met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td><strong>Premiums</strong>, <strong>balance-billing</strong> charges, and health care this <strong>plan</strong> doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
</tbody>
</table>

---

**Note:**
- **Coverage Period:** Beginning 10/01/2019
- **Coverage for:** Individual/Individual + Family
- **Plan Type:** OAP
- **Premiums** are not included in the out-of-pocket limit.

---

**Details:**
- **Plan Name:** Open Access Plus IN
- **Provider Network:** In-network
- **Out-of-Pocket Limit:**
  - In-network: $5,000/individual or $10,000/family
  - Out-of-network: $1,000 person/ $2,000 family
Important Questions | Answers | Why This Matters:
---|---|---
**Will you pay less if you use a network provider?** | Yes. See [www.myCigna.com](http://www.myCigna.com) or call 1-800-Cigna24 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. |

---

**Warning:** All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 copay/visit Deductible does not apply</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$45 copay/visit Deductible does not apply</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No charge/visit** No charge/screening** No charge/immunizations** **Deductible does not apply</td>
<td>Not covered</td>
<td>None None None You may have to pay for services that aren’t preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.</td>
</tr>
</tbody>
</table>
## Common Medical Event Services You May Need

### If you have a test
- **Diagnostic test** (x-ray, blood work)
  - **In-Network Provider** (You will pay the least): 20% coinsurance/x-ray, 20% coinsurance/blood work, No charge/independent lab/physicians office** **Deductible does not apply**
  - **Out-of-Network Provider** (You will pay the most): Not covered
  - **Limitations, Exceptions, & Other Important Information**: None

- Imaging (CT/PET scans, MRIs)
  - **In-Network Provider** (You will pay the least): $100 copay per type of scan/day, Deductible does not apply
  - **Out-of-Network Provider** (You will pay the most): Not covered
  - **Limitations, Exceptions, & Other Important Information**: None

### If you need drugs to treat your illness or condition

**More information about prescription drug coverage is available at [www.caremark.com](http://www.caremark.com)**

- **Generic drugs (Tier 1)**
  - **In-Network Provider** (You will pay the least): $7 co-pay: retail 30-day prescription, $14 co-pay: CVS/Caremark mail order or CVS Retail 90-day prescription, $21 co-pay: retail 90-day prescription
  - **Out-of-Network Provider** (You will pay the most): Not covered
  - **Limitations, Exceptions, & Other Important Information**: None

- **Preferred brand drugs (Tier 2)**
  - **In-Network Provider** (You will pay the least): $40 co-pay: retail 30-day prescription, $80 co-pay: CVS/Caremark mail order or CVS Retail 90-day prescription, $120 co-pay: retail 90-day prescription
  - **Out-of-Network Provider** (You will pay the most): Not covered
  - **Limitations, Exceptions, & Other Important Information**: None

- **Non-preferred brand drugs (Tier 3)**
  - **In-Network Provider** (You will pay the least): Not covered
  - **Out-of-Network Provider** (You will pay the most): Not covered
  - **Limitations, Exceptions, & Other Important Information**: See Insurance Benefits Handbook for a full list of Exclusions/Limitations.

- **Covered Medications more than $1,500 for a 30 day supply.**
  - **In-Network Provider** (You will pay the least): $75 co-pay: retail 30-day prescription, $150 co-pay: CVS/Caremark mail order or CVS Retail 90-day prescription, $225 co-pay: retail 90-day prescription
  - **Out-of-Network Provider** (You will pay the most): Not covered
  - **Limitations, Exceptions, & Other Important Information**: None
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$300 copay/visit Deductible does not apply</td>
<td>$300 copay/visit Deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$35 copay/visit Deductible does not apply</td>
<td>$35 copay/visit Deductible does not apply</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services.</td>
<td>Mental/Behavioral Health Outpatient services</td>
<td>No charge (visits 1-5) $10 co-pay/visit (visits 6-10) $20 copay/visit (11-20) Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Substance Use Disorder Outpatient services</td>
<td>No charge (visits 1-5) $10 co-pay/visit (visits 6-10) $20 copay/visit (11-44) Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral Health Inpatient Services</td>
<td>10% co-insurance - Inpatient Psychiatric</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Substance Use Disorder Inpatient Services</td>
<td>10% co-insurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>$150 copay, plus 20% coinsuranceDeductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. 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).</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$25 copay/visit** **Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$25 copay/visit** **Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance/inpatient; No charge/outpatient services** **Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
### 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)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 (combined with Rehabilitation Services)
- Habilitation services
- Hearing aids ($3,000 maximum per 36 months)
- Private-duty nursing
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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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 www.dol.gov/ebsa/healthreform.

CVS/caremark - 1-800-378-9264

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'ohwo shinka, 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** is $100.
- **Specialist copayment** is $45.
- **Hospital (facility) coinsurance** is 20%.
- **Other coinsurance** is 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$190</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,500</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td>$10</td>
</tr>
</tbody>
</table>

**The total Peg would pay is** $2,800

---

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

- The **plan’s overall deductible** is $100.
- **Specialist copayment** is $45.
- **Hospital (facility) coinsurance** is 20%.
- **Other coinsurance** is 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$900</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$100</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td>$200</td>
</tr>
</tbody>
</table>

**The total Joe would pay is** $1,300

---

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

- The **plan’s overall deductible** is $100.
- **Specialist copayment** is $45.
- **Hospital (facility) coinsurance** is 20%.
- **Other coinsurance** is 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td>$0</td>
</tr>
</tbody>
</table>

**The total Mia would pay is** $800

---

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

**Plan Name:** OAPIN Ben Ver: 15  **Plan ID:** 7945521
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)

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）。


Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주시십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: Quay số 711)으로 전화해주세요.


French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou ki linyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 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).


Persian (Farsi) – توجه: خدمات کمک زبانی به سویی رایگان به شما ارائه می‌شود. برای اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).