



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:
<p>What is the overall deductible?</p>	<p>For in-network providers: \$750/individual or \$1,500/family For out-of-network providers: \$1,500/individual or \$3,000/family</p>	<p>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.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. preventive care & immunizations, office visits, prescription drugs are covered before you meet your deductible.</p>	<p>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/.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For in-network providers: \$3,000/individual or \$6,000/family For out-of-network providers: \$5,000/individual or \$10,000/family</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See www.cigna.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 .



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	\$20 copay /visit Deductible does not apply	30% coinsurance	None	
	Specialist visit	\$50 copay /visit Deductible does not apply	30% coinsurance	None	
	Preventive care/ screening/ immunization	No charge/visit No charge/ screening ** No charge/immunizations**	No charge/visit No charge/ screening ** No charge/immunizations**	None None None	Covers immunizations related to travel. 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.
		** Deductible does not apply	** Deductible does not apply		
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	\$250 penalty for no out-of-network precertification.	

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 need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic drugs	\$10 co-pay / prescription (retail), \$20 co-pay / prescription (home delivery)	30% co-insurance, after the deductible	Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery)
	Preferred brand drugs	\$40 co-pay / prescription (retail), \$80 co-pay / prescription (home delivery)	30% co-insurance, after the deductible	
	Non-preferred brand drugs	\$80 co-pay / prescription (retail), \$160 co-pay / prescription (home delivery)	30% co-insurance, after the deductible	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	\$250 penalty for no out-of-network precertification.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	\$250 penalty for no out-of-network precertification.
If you need immediate medical attention	Emergency room care	\$150 copay /visit	\$150 copay /visit	Per visit copay is waived if admitted
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	\$20 copay /visit	\$20 copay /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	\$250 penalty for no out-of-network precertification.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	\$250 penalty for no out-of-network precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copay /office visit 10% coinsurance /other outpatient services	Professional fees: 10% coinsurance All other services: 30% coinsurance	None
	Inpatient services	10% coinsurance	30% coinsurance	None

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 are pregnant	Office visits	10% coinsurance	30% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. \$250 penalty for no precertification. 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 professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	

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 need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	16 hour maximum per day
	Rehabilitation services	\$20 copay /PCP visit** \$50 copay / Specialist visit** ** Deductible does not apply	30% coinsurance	Coverage for Rehabilitation services is limited to 100 days annual max per therapy, not combined. Cardiac Rehabilitation services are limited to 100 days annual max. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	\$20 copay /PCP visit** \$50 copay / Specialist visit** ** Deductible does not apply	30% coinsurance	\$250 penalty for failure to precertify speech therapy services. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism). Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies
	Skilled nursing care	10% coinsurance	30% coinsurance	Coverage is limited to 120 days annual max.
	Durable medical equipment	10% coinsurance	30% coinsurance	None
	Hospice services	10% coinsurance /inpatient; 10% coinsurance /outpatient services	30% coinsurance /inpatient; 30% coinsurance /outpatient services	None
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](#).)

- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Long-term care
- 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
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment

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: California Department of Managed Health Care Help Center at (888) 466-2219.

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, kwijigo 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](#) \$750
- [Specialist copayment](#) \$50
- 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$30
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Peg would pay is	\$2,000

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

- The [plan's](#) overall [deductible](#) \$750
- [Specialist copayment](#) \$50
- 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$120
Copayments	\$700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$840

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

- The [plan's](#) overall [deductible](#) \$750
- [Specialist copayment](#) \$50
- 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$400
Coinsurance	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,180

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.