



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 : \$1,500/individual or \$3,000/family For out-of-network providers : \$2,000/individual or \$4,000/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, in-network prescription drugs , in-network 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?	Yes, \$1,000 for out-of-network outpatient hospital visit and \$1,500 per admission for out-of-network hospital stay 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 out-of-pocket limit for this plan?	For in-network providers : \$3,000/individual or \$6,000/family For out-of-network providers : \$6,000/individual or \$12,000/family 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 <u>network provider</u> ?	Yes. See www.cigna.com or call 1-800-Cigna24 for a list of <u>network providers</u> .	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's 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 <u>specialist</u> you choose without a <u>referral</u> .



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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit <u>Deductible</u> does not apply	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit <u>Deductible</u> does not apply	40% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge <u>Deductible</u> does not apply	40% <u>coinsurance</u>	You may have to pay for services that 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	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% penalty for no out-of-network precertification.
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	\$25 <u>copay</u> /prescription (retail 30 days), \$50 <u>copay</u> /prescription (retail & home delivery 90 days) <u>Deductible</u> does not apply	Not covered	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> . Certain limitations may apply.
More information about prescription drug coverage				

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)	
is available at www.cigna.com	Preferred brand drugs (Tier 2)	\$40 <u>copay</u> /prescription (retail 30 days), \$80 <u>copay</u> /prescription (retail & home delivery 90 days) <u>Deductible</u> does not apply	Not covered	including, for example: prior authorization, step therapy, quantity limits. For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts. In-network Federally required preventive drugs will be provided at no charge.
	Non-preferred brand drugs (Tier 3)	\$60 <u>copay</u> /prescription (retail 30 days), \$120 <u>copay</u> /prescription (retail & home delivery 90 days) <u>Deductible</u> does not apply	Not covered	
	<u>Specialty drugs</u> (Tier 4)	\$100 <u>copay</u> /prescription (retail & home delivery 30 days) <u>Deductible</u> does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500 <u>copay</u> /visit, plus 20% <u>coinsurance</u>	\$1,000 <u>deductible</u> /visit, plus 40% <u>coinsurance</u>	50% penalty for no out-of-network precertification. Per visit <u>copay</u> / <u>deductible</u> is waived for non-surgical procedures.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% penalty for no out-of-network precertification.
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of-network services are paid at the in-network cost share and <u>deductible</u> .
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of-network air ambulance services are paid at the in-network cost share and <u>deductible</u> .
	<u>Urgent care</u>	\$25 <u>copay</u> /visit <u>Deductible</u> does not apply	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750 <u>copay</u> /admission, plus 20% <u>coinsurance</u>	\$1,500 <u>deductible</u> /admission, plus 40% <u>coinsurance</u>	50% penalty for no out-of-network precertification.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% 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 mental health, behavioral health, or substance abuse services	Outpatient services	\$50 copay /office visit** 20% coinsurance /all other services ** Deductible does not apply	40% coinsurance /office visit 40% coinsurance /all other services	50% penalty if no precert of out-of-network non-routine services. Includes medical services for MH/SA diagnoses.
	Inpatient services	\$750 copay /admission, plus 20% coinsurance	\$1,500 deductible /admission, plus 40% coinsurance	50% penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services . 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	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	\$750 copay /admission, plus 20% coinsurance	\$1,500 deductible /admission, plus 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	50% penalty for no out-of-network precertification. Coverage is limited to 100 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	\$30 copay /PCP visit** \$50 copay Specialist visit** ** Deductible does not apply	40% coinsurance /PCP visit 40% coinsurance Specialist visit	Coverage is limited to annual max of: 40 days for Rehabilitation services ; 36 days for Cardiac rehab services; 12 days for Chiropractic care services. 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)	
	<u>Habilitation services</u>	<p>\$30 copay/PCP visit**</p> <p>\$50 copay / Specialist visit**</p> <p>**Deductible does not apply</p>	<p>40% coinsurance/PCP visit</p> <p>40% coinsurance/ Specialist visit</p>	<p>Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality.</p> <p>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.</p>
	<u>Skilled nursing care</u>	20% coinsurance	40% coinsurance	<p>50% penalty for no out-of-network precertification.</p> <p>Coverage is limited to 100 days annual max.</p>
	<u>Durable medical equipment</u>	20% coinsurance	40% coinsurance	50% penalty for no out-of-network precertification.
	<u>Hospice services</u>	<p>20% coinsurance/inpatient services</p> <p>20% coinsurance/outpatient services</p>	<p>40% coinsurance/inpatient services</p> <p>40% coinsurance/outpatient services</p>	50% penalty for failure to precertify out-of-network inpatient hospice services .
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](#).)

<ul style="list-style-type: none">• Bariatric surgery• Cosmetic surgery• Dental care (Adult)• Dental care (Children)	<ul style="list-style-type: none">• Eye care (Children)• Long-term care• Non-emergency care when traveling outside the U.S.• Private-duty nursing	<ul style="list-style-type: none">• Routine eye care (Adult)• Routine foot care• Weight loss programs
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

<ul style="list-style-type: none">• Acupuncture (12 days)• Chiropractic care (12 days)	<ul style="list-style-type: none">• Hearing aids (in-network only/2 devices per Lifetime)	<ul style="list-style-type: none">• Infertility treatment
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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: Cigna at 1-800-Cigna24, California Department of Insurance at 1-800-927-4357 and 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 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 California Department of Insurance at 1-800-927-4357. 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, kwijjigo 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](#) \$1,500
- [Specialist copayment](#) \$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 **\$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$800
Coinsurance	\$700
What isn't covered	
Limits or exclusions	\$20
The total Peg would pay is	\$3,020

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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 **\$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$120
Copayments	\$1,100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$40
The total Joe would pay is	\$1,260

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 **\$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$300
Coinsurance	\$90
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,890

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