



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, call 1-855-672-2789 or visit <https://www.hioscar.com/forms/2024/ca>. 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 www.healthcare.gov/sbc-glossary/ or call 1-855-672-2789 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$2,600 individual / \$5,200 family	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 deductible?	Yes. <u>Preventive care</u> , PCP/ <u>Specialist</u> visits, Ind Lab, <u>Urgent Care</u> , Outpatient mental health/substance use office visits, Pre- and post-natal <u>preventive care</u> , Home Health Care, T1 <u>Prescription Drugs</u> , Child Vision and Dental Check-up	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$300 individual / \$600 family for <u>prescription drug coverage</u> . No other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	\$9,400 individual / \$18,800 family	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?	<u>Premiums</u> , <u>balance billing</u> charges, healthcare this <u>plan</u> does not cover and manufacturer drug coupons.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.hioscar.com or call 1-855-672-2789 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's</u> 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 referral to see a specialist?	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*
		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	\$75 <u>copayment</u> /visit <u>Deductible</u> does not apply	Not Covered	<u>Cost share</u> applies to both in-person and virtual visits. Virtual PCP visits from Oscar-designated <u>Virtual Providers</u> are covered in full; <u>deductible</u> does not apply.
	<u>Specialist</u> visit	\$100 <u>copayment</u> /visit <u>Deductible</u> does not apply	Not Covered	<u>Cost share</u> applies to both in-person and virtual visits.
	<u>Preventive care</u> / <u>screening</u> / immunization	No charge	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	40% <u>coinsurance</u> subject to <u>deductible</u> (X-rays), No charge (OV/Independent labs), 40% <u>coinsurance</u> subject to <u>deductible</u> (All other outpatient labs)	Not Covered	<u>Preauthorization</u> required for certain services.
	Imaging (CT/PET scans, MRIs)	40% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	<u>Preauthorization</u> required. <u>Preauthorization</u> is not required in an emergency.
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	\$25 <u>copayment</u> /prescription <u>Deductible</u> does not apply (retail), \$75 <u>copayment</u> /prescription <u>Deductible</u> does not apply (mail order)	Not Covered	Retail is limited to a 30-day supply. Mail Order is limited to a 90-day supply and is subject to 3x retail <u>cost share</u> amount. <u>Preauthorization</u> /step therapy may be required.
	Preferred brand drugs (Tier 2)	\$85 <u>copayment</u> /prescription subject to <u>prescription drug deductible</u> (retail), \$255 <u>copayment</u> /prescription subject to <u>prescription drug deductible</u> (mail order)	Not Covered	Retail is limited to a 30-day supply. Mail Order is limited to a 90-day supply and is subject to 3x retail <u>cost share</u> amount. <u>Preauthorization</u> /step therapy may be required.

*For more information about limitations and exceptions, see the plan or policy document at <https://www.hioscar.com/forms/2024/ca>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		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 https://hioscar.com/drug-formularies	Non-preferred brand drugs (Tier 3)	\$125 <u>copayment</u> /prescription subject to <u>prescription drug deductible</u> (retail), \$375 <u>copayment</u> /prescription subject to <u>prescription drug deductible</u> (mail order)	Not Covered	Retail is limited to a 30-day supply. Mail Order is limited to a 90-day supply and is subject to 3x retail <u>cost share</u> amount. <u>Preauthorization</u> /step therapy may be required.
	<u>Specialty drugs</u> (Tier 4)	30% <u>coinsurance</u> subject to <u>prescription drug deductible</u> (retail/mail order)	Not Covered	Limited to a 30-day supply up to \$250 per script. <u>Preauthorization</u> /step therapy may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <u>coinsurance</u> subject to <u>deductible</u> (surgical and non-surgical services)	Not Covered	<u>Preauthorization</u> may be required.
	Physician/surgeon fees	40% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	<u>Preauthorization</u> may be required.
If you need immediate medical attention	<u>Emergency room care</u>	40% <u>coinsurance</u> subject to <u>deductible</u> (ER Facility Fee/ER Physician Fee)	40% <u>coinsurance</u> subject to <u>deductible</u> (ER Facility Fee/ER Physician Fee)	<u>Cost share</u> waived if admitted. See Medical Inpatient Services or Mental Health Services for details on emergency admissions. <u>Emergency Room care</u> by an out of <u>network provider</u> is covered if the services are for an emergency condition.
	<u>Emergency medical transportation</u>	40% <u>coinsurance</u> subject to <u>deductible</u>	40% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> is required for non-emergency transportation. Emergency Transportation services by an out of <u>network provider</u> , including air ambulance, are covered if the services are for an emergency condition. Non-emergency ambulance transportation by a licensed ambulance service is covered when the vehicle transports the member to or from covered services, and the use of other means of transportation may endanger the insured's life. The <u>cost share</u> also applies to covered non-emergency transportation.

*For more information about limitations and exceptions, see the plan or policy document at <https://www.hioscar.com/forms/2024/ca>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Urgent care	\$75 copayment/visit Deductible does not apply	Not Covered	Urgent Care is covered Out of network when a member is located outside the network's service area. Virtual Urgent Care visits from Oscar-Designated Virtual Providers are covered in full not subject to deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance subject to deductible	Not Covered	Preauthorization is required. However, Preauthorization is not required for emergency admissions.
	Physician/surgeon fees	40% coinsurance subject to deductible	Not Covered	Preauthorization is required. However, Preauthorization is not required for emergency admissions.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$75 copayment/visit Deductible does not apply (office visit), 40% coinsurance subject to deductible (other outpatient services)	Not Covered	Preauthorization may be required for Other Outpatient Services. Preauthorization is not required for Outpatient Office visits Includes covered virtual care visits. Includes medical services for MH/SA diagnoses.
	Inpatient services	40% coinsurance subject to deductible	Not Covered	Includes medical services for MH/SA diagnoses. Preauthorization is required. However, Preauthorization is not required for emergency admissions.
If you are pregnant	Office Visits	No charge	Not Covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	40% coinsurance subject to deductible	Not Covered	Preauthorization is required.
	Childbirth/delivery facility services	40% coinsurance subject to deductible	Not Covered	Preauthorization is required for a hospital stay that will exceed 48 hours following a vaginal birth or 96 hours following a cesarean section.

*For more information about limitations and exceptions, see the plan or policy document at <https://www.hioscar.com/forms/2024/ca>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		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	\$100 <u>copayment</u> /visit <u>Deductible</u> does not apply	Not Covered	100 visits per <u>plan</u> year. (The limit is not applicable to mental health and substance use disorder conditions.) <u>Preauthorization</u> is required.
	<u>Rehabilitation services</u>	40% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	None
	<u>Habilitation services</u>	40% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	None
	<u>Skilled nursing care</u>	40% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	Coverage limited to 100 days per benefit period. <u>Preauthorization</u> is required.
	<u>Durable medical equipment</u>	40% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	<u>Preauthorization</u> may be required.
	<u>Hospice services</u>	40% <u>coinsurance</u> subject to <u>deductible</u>	Not Covered	<u>Preauthorization</u> is required.
If your child needs dental or eye care	Children's eye exam	No charge	Not Covered	One (1) exam per <u>plan</u> year for children up to age 19.
	Children's glasses	No charge	Not Covered	One (1) prescribed lenses and frames per <u>plan</u> year for children up to age 19.
	Children's dental check-up	No charge	Not Covered	One (1) <u>preventive</u> visit per 6 months

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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs (does not apply to Preventive care related weight loss interventions)

*For more information about limitations and exceptions, see the plan or policy document at <https://www.hioscar.com/forms/2024/ca>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Private-duty nursing - 100 visits/year combined with home health care
- Routine foot care

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 \(3272\)](tel:1-866-444-EBSA) 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](#) Covered California. For more information about Covered California, visit www.coveredca.com or call 1-800-300-1506.

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 more information about your rights, this notice, or assistance, contact: Cigna c/o Oscar Insurance Company, 1-855-672-2789, P.O. Box 52146 Phoenix, AZ 85072-2146 California Department of Insurance Consumer Services, Division 300 South Spring Street, South Tower, Los Angeles, CA 90013 www.insurance.ca.gov Calling within California: 1-800-927-HELP (4357). TDD: 1-800-482-4TDD. Department of Labor's Employee Benefits Security Administration at [1-866-444-EBSA \(3272\)](tel:1-866-444-EBSA) or www.dol.gov/ebsa/healthreform.

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 1-855-672-2789.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-672-2789.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-672-2789.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-672-2789.

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 \$2,600
- Specialist copayment \$100
- Hospital (facility) coinsurance 40%
- Other coinsurance 40%

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>	
<u>Deductibles</u>	\$2,600
<u>Copayments</u>	\$20
<u>Coinsurance</u>	\$3,100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$5,720

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

- The plan's overall deductible \$2,600
- Specialist copayment \$100
- Hospital (facility) coinsurance 40%
- Other coinsurance 40%

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>	
<u>Deductibles</u> *	\$1,300
<u>Copayments</u>	\$1,600
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,900

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

- The plan's overall deductible \$2,600
- Specialist copayment \$100
- Hospital (facility) coinsurance 40%
- Other coinsurance 40%

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>	
<u>Deductibles</u>	\$2,600
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

*NOTE: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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