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?	$3,200 individual / $6,400 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. Preventive care, Pre- and post-natal preventive care, HSA Preventive Drugs T1/T2/T3, Child Vision and Dental Checkup	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7,500 individual / $15,000 family	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?	Premiums, balance billing charges, healthcare this plan does not cover and manufacturer drug coupons.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
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 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*
		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	30% coinsurance subject to deductible	Not Covered	Cost share applies to both in-person and virtual visits.
	Specialist visit	30% coinsurance subject to deductible	Not Covered	Cost share applies to both in-person and virtual visits.
	Preventive care/ screening/ immunization	No charge	Not Covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance subject to deductible (X-rays), 30% coinsurance subject to deductible (OV/Independent labs), 40% coinsurance subject to deductible (All other outpatient labs)	Not Covered	Preauthorization required for certain services.
	Imaging (CT/PET scans, MRIs)	40% coinsurance subject to deductible	Not Covered	Preauthorization required. Preauthorization is not required in an emergency.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://hioscar.com/drug-formularies	Generic drugs (Tier 1)	$15 copayment/prescription subject to deductible (retail), $45 copayment/prescription subject to deductible (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 cost share amount. Preauthorization/step therapy may be required. Deductible waived for HSA Preventive Drug List Tiers 1, 2 & 3.
	Preferred brand drugs (Tier 2)	$85 copayment/prescription subject to deductible (retail), $255 copayment/ prescription subject to deductible (mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3)	$115 copayment/prescription subject to deductible (retail), $345 copayment/ prescription subject to deductible (mail order)	Not Covered	

*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 prescription drug coverage is available at https://hioscar.com/drug-formularies	Specialty drugs (Tier 4)	30% coinsurance subject to deductible (retail/mail order)	Not Covered	Limited to a 30-day supply up to $250 per script. Preauthorization/step therapy may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance subject to deductible (surgical and non-surgical services)	Not Covered	Preauthorization may be required.
	Physician/surgeon fees	30% coinsurance subject to deductible	Not Covered	Preauthorization may be required.
If you need immediate medical attention	Emergency room care	1st visit 30% coinsurance subject to deductible; Additional visits 40% coinsurance subject to deductible (ER Facility Fee/ER Physician)	1st visit 30% coinsurance subject to deductible; Additional visits 40% coinsurance subject to deductible (ER Facility Fee/ER Physician)	Cost share waived if admitted. See Medical Inpatient Services or Mental Health Services for details on emergency admissions. Emergency Room care by an out of network provider is covered if the services are for an emergency condition.
	Emergency medical transportation	30% coinsurance subject to deductible	30% coinsurance subject to deductible	Preauthorization is required for non-emergency transportation. Emergency Transportation services by an out of network provider, 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 cost share 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	30% coinsurance subject to deductible	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 after the deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance subject to deductible	Not Covered	Preauthorization is required. However, Preauthorization is not required for emergency admissions.
	Physician/surgeon fees	30% 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	30% coinsurance subject to deductible (office visit/other outpatient services)	Not Covered	Includes covered virtual care visits. Includes medical services for MH/SA diagnoses. Preauthorization may be required for Other Outpatient Services. Preauthorization is not required for Outpatient Office visits
	Inpatient services	30% 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	30% coinsurance subject to deductible	Not Covered	Preauthorization is required.
	Childbirth/delivery facility services	30% 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	30% coinsurance subject to deductible	Not Covered	100 visits per plan year. (The limit is not applicable to mental health and substance use disorder conditions.) Preauthorization is required.
	Rehabilitation services	30% coinsurance subject to deductible	Not Covered	None
	Habilitation services	30% coinsurance subject to deductible	Not Covered	None
	Skilled nursing care	30% coinsurance subject to deductible	Not Covered	Coverage limited to 100 days per benefit period. Preauthorization is required.
	Durable medical equipment	30% coinsurance subject to deductible	Not Covered	Preauthorization may be required.
	Hospice services	30% coinsurance subject to deductible	Not Covered	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No charge	Not Covered	One (1) exam per plan year for children up to age 19.
	Children's glasses	No charge	Not Covered	One (1) prescribed lenses and frames per plan year for children up to age 19.
	Children's dental check-up	No charge	Not Covered	One (1) preventive 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) 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.govCalling 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) 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, kwiijigo 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	$3,200
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$3,200
Copayments	$20
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$5,620**

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

The plan's overall deductible	$3,200
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$3,200
Copayments	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$4,000**

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

The plan's overall deductible	$3,200
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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
Copayments	$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.