

 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?	\$0 individual / \$0 family for <u>in-network</u> and \$1,000 individual / \$2,000 family for <u>out-of-network</u>	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	Yes. All <u>in-network</u> services.	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?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$5,000 individual / \$10,000 family for <u>in-network</u> and \$9,200 individual / \$18,400 family for <u>out-of-network</u>	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 <u>out-of-pocket limit</u> ?	Premiums, <u>balance billing</u> charges, healthcare this <u>plan</u> does not cover, manufacturer drug coupons, and infertility benefits.	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 <u>network provider</u> ?	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 <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*
		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	\$10 <u>copayment</u> /visit	50% <u>coinsurance</u> subject to <u>deductible</u>	<u>Cost share</u> applies to both in-person and virtual visits. Virtual PCP visits from Oscar-designated Virtual Providers are covered in full; <u>deductible</u> does not apply.
	<u>Specialist</u> visit	\$45 <u>copayment</u> /visit	50% <u>coinsurance</u> subject to <u>deductible</u>	<u>Cost share</u> applies to both in-person and virtual visits.
	<u>Preventive care/ screening/ immunization</u>	No charge	50% <u>coinsurance</u> subject to <u>deductible</u>	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)	10% <u>coinsurance</u> (X-rays), No charge (OV/Independent labs), 10% <u>coinsurance</u> (All other outpatient labs)	50% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> required for certain services.
	Imaging (CT/PET scans, MRIs)	40% <u>coinsurance</u>	50% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> required. <u>Preauthorization</u> is not required in an emergency.
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	Generic drugs (Tier 1)	\$5 <u>copayment</u> /prescription (retail), \$15 <u>copayment</u> /prescription (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)	\$30 <u>copayment</u> /prescription (retail), \$90 <u>copayment</u> /prescription (mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3)	\$50 <u>copayment</u> /prescription (retail), \$150 <u>copayment</u> /prescription (mail order)	Not Covered	
	<u>Specialty drugs</u> (Tier 4)	30% <u>coinsurance</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.

*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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 <u>copayment</u> /visit (surgical services), 10% <u>coinsurance</u> (non-surgical services)	50% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> may be required.
	Physician/surgeon fees	10% <u>coinsurance</u>	50% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> may be required.
If you need immediate medical attention	<u>Emergency room care</u>	1st visit \$250.00 <u>copayment</u> /visit; Additional visits \$500.00 <u>copayment</u> /visit (ER Facility Fee); Covered in full (ER Physician Fee)	1st visit \$250.00 <u>copayment</u> /visit; Additional visits \$500.00 <u>copayment</u> /visit (ER Facility Fee); Covered in full (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 medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</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.
	<u>Urgent care</u>	\$25 <u>copayment</u> /visit	50% <u>coinsurance</u> subject to <u>deductible</u>	Virtual <u>Urgent Care</u> visits from Oscar-designated Virtual <u>Providers</u> are covered in full not subject to the <u>deductible</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copayment</u> /day	50% <u>coinsurance</u> subject to <u>deductible</u>	Includes covered virtual care visits. Includes medical services for MH/SA diagnoses. The \$250 per day <u>copay</u> applies up to 5 days of an <u>in-network</u> admission. <u>Preauthorization</u> is required. However, <u>Preauthorization</u> is not required for emergency admissions.

*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 have a hospital stay	Physician/surgeon fees	10% <u>coinsurance</u>	50% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> is required. However, <u>Preauthorization</u> is not required for emergency admissions.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <u>copayment</u> /visit (office visit), No charge (other outpatient services)	50% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> may be required for Other Outpatient Services. <u>Preauthorization</u> is not required for Outpatient Office visits Includes covered virtual care visits. Includes medical services for MH/SA diagnoses.
	Inpatient services	\$250 <u>copayment</u> /day	50% <u>coinsurance</u> subject to <u>deductible</u>	Includes medical services for MH/SA diagnoses. The \$250 per day <u>copay</u> applies up to 5 days of an <u>in-network</u> admission. <u>Preauthorization</u> is required. However, <u>Preauthorization</u> is not required for emergency admissions.
If you are pregnant	Office Visits	No charge	50% <u>coinsurance</u> subject to <u>deductible</u>	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	10% <u>coinsurance</u>	50% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> is required.
	Childbirth/delivery facility services	\$250 <u>copayment</u> /day	50% <u>coinsurance</u> subject to <u>deductible</u>	The \$250 per day <u>copay</u> applies up to 5 days of an <u>in-network</u> admission. <u>Preauthorization</u> is required for a hospital stay that will exceed 48 hours following a vaginal birth or 96 hours following a cesarean section.
If you need help recovering or have other special health needs	<u>Home health care</u>	\$45 <u>copayment</u> /visit	50% <u>coinsurance</u> subject to <u>deductible</u>	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.

*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	Rehabilitation services	10% <u>coinsurance</u>	50% <u>coinsurance</u> subject to <u>deductible</u>	None
	Habilitation services	10% <u>coinsurance</u>	50% <u>coinsurance</u> subject to <u>deductible</u>	None
	Skilled nursing care	\$250 <u>copayment</u> /day	50% <u>coinsurance</u> subject to <u>deductible</u>	The \$250 per day <u>copayment</u> will apply for a maximum of 5 days per admission. Coverage limited to 100 days per benefit period. <u>Preauthorization</u> is required.
	Durable medical equipment	10% <u>coinsurance</u>	50% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> may be required.
	Hospice services	10% <u>coinsurance</u>	50% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> is required.
If your child needs dental or eye care	Children's eye exam	No charge	50% <u>coinsurance</u> subject to <u>deductible</u>	One (1) exam per <u>plan</u> year for children up to age 19.
	Children's glasses	No charge	50% <u>coinsurance</u> subject to <u>deductible</u>	One (1) prescribed lenses and frames per <u>plan</u> year for children up to age 19.
	Children's dental check-up	No charge	50% <u>coinsurance</u> subject to <u>deductible</u>	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
- 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)

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
- Infertility Treatment (\$5,000 Lifetime Limit)
- Private-duty nursing - 100 visits/year combined with home health care
- Routine foot care

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

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 <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$45
■ <u>Hospital (facility) copayment</u>	\$250
■ Other <u>coinsurance</u>	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:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$300
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$600

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

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$45
■ <u>Hospital (facility)</u>	
■ Other <u>coinsurance</u>	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:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$100
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$700

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

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$45
■ <u>Hospital (facility)</u>	
■ Other <u>coinsurance</u>	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:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$700

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