HMO: Cigna HealthCare of California, Inc.

Coverage Period: 01/01/2013 - 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Individual + Family | Plan Type: HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myCigna.com or by calling 1-800-Cigna24

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For in-network providers **$1,000** person / **$2,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.myCigna.com or call 1-800-Cigna24	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. Approval from primary care physician is required to see a **specialist**.	This plan will pay some or all of the costs to see a **specialist** for covered services, but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** of the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 co-pay/visit	Not Covered	----------none----------
	Specialist visit	$15 co-pay/visit	Not Covered	----------none----------
	Other practitioner office visit	$15 co-pay/visit for chiropractor	Not Covered	Coverage for Chiropractic services is limited to 30 days annual max.
	Preventive care/screening/immunization	$15 co-pay/visit	Not Covered	Coverage for children through age 16 is at $0 co-pay/visit
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not Covered	
	Imaging (CT/PET scans, MRIs)	No charge	Not Covered	----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myCigna.com	Generic drugs	$10 co-pay/prescription (retail), $20 co-pay/prescription (home delivery)	Not Covered	Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery)
	Preferred brand drugs	$20 co-pay/prescription (retail), $40 co-pay/prescription (home delivery)	Not Covered	Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery)
	Non-preferred brand drugs	$40 co-pay/prescription (retail), $80 co-pay/prescription (home delivery)	Not Covered	Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery)

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not Covered	----------none----------
	Physician/surgeon fees	No charge	Not Covered	----------none----------
If you need immediate medical attention	Emergency room services	$50 co-pay/visit	$50 co-pay/visit	Per visit co-pay is waived if admitted
	Emergency medical transportation	No charge	No charge	----------none----------
	Urgent care	$25 co-pay/visit	$25 co-pay/visit	Per visit co-pay is waived if admitted
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 co-pay/admission	Not Covered	----------none----------
	Physician/surgeon fees	No charge	Not Covered	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 co-pay/visit	Not Covered	----------none----------
	Mental/Behavioral health inpatient services	$100 co-pay/admission	Not Covered	----------none----------
	Substance use disorder outpatient services	$15 co-pay/visit	Not Covered	----------none----------
	Substance use disorder inpatient services	$100 co-pay/admission	Not Covered	----------none----------
If you are pregnant	Prenatal and postnatal care	No charge	Not Covered	----------none----------
	Delivery and all inpatient services	$100 co-pay/admission	Not Covered	----------none----------

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Home health care	No charge	Not Covered	----------none----------
	Rehabilitation services	$15 co-pay/visit	Not Covered	Unllimited days
	Habilitation services	Not Covered	Not Covered	----------none----------
	Skilled nursing care	No charge	Not Covered	Coverage is limited to 100 days annual max
	Durable medical equipment	No charge	Not Covered	----------none----------
	Hospice services	No charge/inpatient services and No charge/outpatient services	Not Covered	----------none----------
If you or your child needs dental or eye care	Eye Exam	$5 co-pay/exam.	Not Covered	Limited to 1 exam every 12 months
	Glasses	$10 copay for 1 pair of approved glasses	Not Covered	Limited to 1 pair per contract year
	Dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Bariatric Surgery, unless medically necessary. • Cosmetic Surgery • Dental Care (Adult and Children)	• Habilitation services • Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine foot care • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic care Infertility Treatment Routine Eye Care (Adult)		

Your Rights to Continue Coverage

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-Cigna24. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can 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 or the California Department of Insurance at 1-800-927-4357 . Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan's situs state: California Department of Managed Health Care Help Center at 888-466-2219. However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

----------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------

Coverage Examples

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These numbers assume enrollment in individual-only coverage.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,480
- **Plan pays:** $7,260
- **Patient pays:** $210

Sample care costs:	
Prescriptions	$180
Laboratory tests	$520
Routine Obstetric Care	$2,090
Radiology	$180
Vaccines, other preventive	$40
Anesthesia	$910
Hospital charges (baby)	$850
Hospital charges (mother)	$2,710
Total	**$7,480**

Patient pays:	
Deductible	$0
Co-pays	$180
Co-insurance	$0
Limits or exclusions	$30
Total	**$210**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,500
- **Plan pays:** $4,390
- **Patient pays:** $1,110

Sample care costs:	
Prescriptions	$2,890
Medical equipment and supplies	$1,310
Office visits & procedures	$730
Laboratory tests	$140
Education	$290
Vaccines, other preventive	$140
Total	**$5,500**

Patient pays:	
Deductible	$0
Co-pays	$790
Co-insurance	$0
Limits or exclusions	$320
Total	**$1,110**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium** , the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Plan ID: 1060
Plan Name: HMO Copay