

Cigna Health & Life Insurance Company: myCigna Health Flex 1000 Coverage Period: 1/1/15-12/31/15
Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual & Family | Plan Type: LCP



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.cigna.com/individuals-families/california or by calling **1-800-Cigna24**.

| Important Questions | Answers | Why this Matters: | This plan is currently pending regulatory approval. |
|--|--|---|---|
| What is the overall <u>deductible</u>? | \$1,000 person /\$2,000 family for participating providers. \$12,500 person/\$25,000 family for non-participating providers Doesn't apply to: services with co-pay benefits, preventive care, child dental care and eye exam | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible . | |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet deductibles for specific services, but use the chart starting on page 2 for other costs for services this plan covers. | |
| Is there an <u>out-of-pocket limit</u> on my expenses? | Yes, \$5,000 person/\$10,000 family for participating providers. \$25,000 person/\$50,000 family for non-participating providers. | 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 <u>out-of-pocket limit</u>? | Premium, balance-billed charges, penalties for failure to obtain pre-authorization for services, 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 <i>specific</i> covered services, such as office visits | |
| Does this plan use a <u>network of providers</u>? | Yes. For a list of participating providers, see www.myCigna.com/ifp-providers 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 | |

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V1_2015_CA_IND_GOLD_Health Flex 1000_SBC

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual & Family | Plan Type: LCP

| | | |
|---|---|--|
| | | plan pays different kinds of providers . |
| Do I need a referral to see a <u>specialist</u>? | No. You don't need a referral to see a specialist | You can see the specialist you choose without permission from this plan |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 5 See your policy or plan document for additional information about excluded services . |



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** 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 a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|--|--|---|---|---|
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$20 co-pay | 50% co-insurance | -----None----- |
| | Specialist visit | \$40 co-pay | 50% co-insurance | -----None----- |
| | Other practitioner office visit | \$20 co-pay | 50% co-insurance | -----None----- |
| | Preventive care/screening/immunization | No charge | 50% co-insurance | -----None----- |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% co-insurance | 50% co-insurance | -----None----- |
| | Imaging (CT/PET scans, MRIs) | 20% co-insurance | 50% co-insurance | \$60 penalty for no pre-authorization |
| If you need drugs to treat your illness or | Preferred Generic drugs | Retail: \$4 co-pay Mail: \$10 co-pay | Retail: 50% co-ins Mail: not covered | Coverage limited up to a 30-day supply (retail) and to a 90-day supply (mail) |

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| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|--|
| | Non-preferred Generic drugs | Retail: \$10 co-pay Mail: \$25 co-pay | Retail: 50% co-ins Mail: not covered | Coverage limited up to a 30-day supply (retail) and to a 90-day supply (mail) |
| | Preferred brand drugs | Retail: \$30 copay Mail: \$75 copay | Retail: 50% co-ins Mail: not covered | Coverage limited to a 30-day supply (retail) and to a 90-day supply (mail) |
| | Non-preferred brand drugs | Retail/Mail: 50% co-ins | Retail: 50% co-ins Mail: not covered | Coverage limited to a 30-day supply (retail) and to a 90-day supply (mail) |
| | Specialty drugs | Retail: 40% co-ins Mail: 30% co-ins | Retail: 50% co-ins Mail: not covered | Coverage limited to a 30-day supply (retail) and to a 90-day supply (mail). Prior auth required for select drugs. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% co-insurance | 50% co-insurance | -----None----- |
| | Physician/surgeon fees | 20% co-insurance | 50% co-insurance | \$60 penalty for no pre-authorization. |
| If you need immediate medical attention | Emergency room services | 20% co-insurance | 20% co-insurance | -----None----- |
| | Emergency medical transportation | 20% co-insurance | 20% co-insurance | -----None----- |
| | Urgent care | \$75 copay | 50% co-insurance | -----None----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% co-insurance | 50% co-insurance | \$500 penalty for no pre-authorization. |
| | Physician/surgeon fee | 20% co-insurance | 50% co-insurance | -----None----- |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | 20% co-insurance | 50% co-insurance | -----None----- |
| | Mental/Behavioral health inpatient services | 20% co-insurance | 50% co-insurance | \$500 penalty for no pre-authorization. |
| | Substance use disorder outpatient services | 20% co-insurance | 50% co-insurance | -----None----- |
| | Substance use disorder inpatient services | 20% co-insurance | 50% co-insurance | \$500 penalty for no pre-authorization. |
| If you are pregnant | Prenatal care in any trimester, and first post-partum visit | No charge Deductible waived | 50% co-insurance | -----None----- |

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| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|-------------------------------------|---|---|---|
| | Delivery and all inpatient services | 20% co-insurance | 50% co-insurance | \$500 penalty for no pre-authorization. |
| If you need help recovering or have other special health needs | Home health care | 20% co-insurance | 50% co-insurance | Coverage limited to 100 visits/year. \$60 penalty for no pre-authorization. |
| | Rehabilitation services | 20% co-insurance | 50% co-insurance | -----None----- |
| | Habilitation services | 20% co-insurance | 50% co-insurance | -----None----- |
| | Skilled nursing care | 20% co-insurance | 50% co-insurance | \$500 penalty for no pre-authorization. |
| | Durable medical equipment | 20% co-insurance | 50% co-insurance | -----None----- |
| | Hospice service | 20% co-insurance | 50% co-insurance | \$500 penalty for no pre-authorization. |
| If your child needs dental or eye care | Eye exam | No charge Deductible waived | 50% co-insurance | Coverage is limited to 1 exam/year |
| | Glasses | No charge Deductible waived | Not covered | Coverage is limited to 1 pair of glasses/year |
| | Dental check-up | No charge Deductible waived | No charge | -----None----- |

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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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Weight loss programs

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-Cigna24.

You may also contact your state insurance department at 1-800-927-HELP (4357) or at www.insurance.ca.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: California Department of Insurance, Consumer Communications Bureau Health Unit, 300 South Spring Street, South Tower, Los Angeles, CA 90013 or 1-800-927-HELP (4357) or 1-800-482-4833 TDD or www.insurance.ca.gov

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Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care Help Center at 1-888-466-2219.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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, kwijigo holne' 1-800-244-6224.

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

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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.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,070
- Patient pays \$2,470

Sample care costs:

| | |
|----------------------------|----------------|
| Hospital charges (mother) | \$2,700 |
| Routine obstetric care | \$2,100 |
| Hospital charges (baby) | \$900 |
| Anesthesia | \$900 |
| Laboratory tests | \$500 |
| Prescriptions | \$200 |
| Radiology | \$200 |
| Vaccines, other preventive | \$40 |
| Total | \$7,540 |

Patient pays:

| | |
|----------------------|----------------|
| Deductibles | \$1,200 |
| Copays | \$40 |
| Coinsurance | \$1,200 |
| Limits or exclusions | \$30 |
| Total | \$2,470 |

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

- Amount owed to providers: \$5,400
- Plan pays \$4,600
- Patient pays \$800

Sample care costs:

| | |
|--------------------------------|----------------|
| Prescriptions | \$2,900 |
| Medical Equipment and Supplies | \$1,300 |
| Office Visits and Procedures | \$700 |
| Education | \$300 |
| Laboratory tests | \$100 |
| Vaccines, other preventive | \$100 |
| Total | \$5,400 |

Patient pays:

| | |
|----------------------|--------------|
| Deductibles | \$100 |
| Copays | \$400 |
| Coinsurance | \$0 |
| Limits or exclusions | \$300 |
| Total | \$800 |

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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 by 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 preexisting 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, copayments, and coinsurance 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 copayments, deductibles, and coinsurance. You should also 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.

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