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, contact Claims Department at 1-888-233-7915. 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.cciio.cms.gov or call 1-888-233-7915 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	PPO Providers $300 Individual/ $900 family Non-PPO Providers $550 Individual/ $1,650 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 and primary care services are covered before you meet your deductible.	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 deductible for specific services
What is the out-of-pocket limit for this plan?	For PPO Providers $3,000 individual / $6,000 family; for Non-PPO providers $6,000 individual / $12,000 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-billed charges, chiropractic, acupuncture, prescription drugs and health care this plan doesn't cover	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, www.cigna.com for a listing of participating providers or call 1-888-233-7915 for help in locating a provider.	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
		PPO Provider (You will pay the least)	Non PPO 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	$25 co-pay per visit	40% co-insurance of UCR	Some of the services this plan doesn't cover are listed on page 4. See your Plan Document for additional information about excluded services
	Specialist visit	$25 co-pay per visit	40% co-insurance of UCR	
	Preventive care/screening/ immunization	No charge	40% co-insurance of UCR	Coverage is limited to preventive services as defined under the Health Care Reform Regulations as stated in Exhibit F of plan document.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance of UCR	Some of the services this plan doesn't cover are listed on page 4. See your Plan Document for additional information about excluded services
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance of UCR	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	$10 co-pay retail $20 co-pay mail order	Not Covered	Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail order prescription) Members taking maintenance medications must use the Express-Scripts Exclusive Home Delivery program or Members may fill up to a 90-day supply at Walgreens or CVS retail pharmacies.
	Preferred brand drugs	$25 co-pay retail $50 co-pay mail order	Not Covered	
	Non-preferred brand drugs	$40 co-pay retail $80 co-pay mail order	Not Covered	
	Specialty drugs	$25 co-pay	Not Covered	
	Prescription Plan out –of – pocket limit: $2,600 Individual/ $5,200 family PPO No limit Non-PPO			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance of UCR	Some of the services this plan doesn't cover are listed on page 4. See your Plan Document for additional information about excluded services
	Physician/surgeon fees	20% co-insurance	40% co-insurance of UCR	
If you need immediate medical attention	Use of Emergency room facility Emergency room physician services	$150 co-pay per visit 20% co-insurance		Co-pay is waived if patient is admitted.

[* For more information about limitations and exceptions, call Claims Department at 1-888-233-7915] – Option 1

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non PPO Provider (You will pay the most)	
	Emergency medical transportation	20% of UCR		Some of the services this plan doesn't cover are listed on page 4. See your Plan Document for additional information about excluded services.
	Urgent care	$50 co-pay		
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance of UCR	Preauthorization is required for hospital stays. Some of the services this plan doesn't cover are listed on page 4. See your Plan Document for additional information about excluded services
	Physician/surgeon fees	20% co-insurance	40% co-insurance of UCR	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	The Mental/Behavioral Health and Substance Abuse services are provided through a separate Plan Please refer to the separate summary for copays and services provided through your Behavioral Health Plan.		
	Inpatient services			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 co-pay	40% co-insurance of UCR	
	Inpatient services	20% co-insurance	40% co-insurance of UCR	
If you are pregnant	Office visits	$25 co-pay for initial office visit	40% co-insurance of UCR	Some of the services this plan doesn't cover are listed on page 4. See your Plan Document for additional information about excluded services
	Childbirth/delivery professional services	20% co-insurance	40% co-insurance of UCR	
	Childbirth/delivery facility services	20% co-insurance	40% co-insurance of UCR	
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance of UCR	Limited to 100 visits per calendar year. Member must be confined at home and under active supervision of a physician.
	Rehabilitation services	$25 co-pay per visit	40% co-insurance of UCR	Medically necessary physical and occupational therapy limited to 60 visits, per year combined Some of the services this plan doesn't cover are listed on page 4. See your Plan Document for additional information about excluded services
	Habilitation services	$25 co-pay per visit	40% co-insurance of UCR	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non PPO Provider (You will pay the most)	
If you need help recovering or have other special health needs	Skilled nursing care	20% co-insurance	40% co-insurance of UCR	Confinement for non-skilled or custodial care is not covered.
	Durable medical equipment	20% co-insurance	40% co-insurance of UCR	Some of the services this plan doesn't cover are listed on page 4. See your Plan Document for additional information about excluded services
	Hospice services	20% co-insurance	40% co-insurance of UCR	Inpatient and outpatient services (member life expectancy of 6 months or less and subject to utilization review every 60 days.
If your child needs dental or eye care	Children's eye exam	No Charge	40% co-insurance of UCR	Per Health Care Reform visual acuity screening to detect the presence of amblyopia or its risk factors ages 3 to 6 years. This does not cover services for Routine Eye exams and routine eye refractions.
	Children's glasses	20% co-insurance	40% co-insurance of UCR	The first pair of contact lenses or the first pair of eyeglasses when required as a result of Medically Necessary eye surgery.
	Children's dental check-up	Not Covered	Not Covered	

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
- Experimental or investigational treatments or drugs
- Dental Care
- Routine foot care (over-the-counter orthotics and pedicures)
- Routine eye care
- Private Duty Nurse
- Custodial Care
- Services not medically necessary for standard of care
- Long-term care
- Services provided by a non-licensed provider
- Infertility Treatment
- Surrogacy
- Any maintenance or comfort item or equipment regardless of medical necessity. Examples include: spa, hot tubs, pools steam rooms, therapeutic mattress, pillows, any type of home modifications, air purifiers, air conditioners, humidifiers, exercise equipment, and supplies for comfort, hygiene or beautification.

[* For more information about limitations and exceptions, call Claims Department at 1-888-233-7915] – Option 1

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

- Acupuncture
- Chiropractic
- Hearing Aids

- OptumHealth Care Solutions Managed Transplant Program
  1-888-321-0881

- Pharmacy Coverage through RxBenefits
  Member Services
  1-800-334-8134
  Rxhelp@rxbenefits.com
  www.express-scripts.com

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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: San Diego & Imperial County School Fringe Benefits Consortium at 1-888-233-7915.

Does this plan provide Minimum Essential Coverage? [Yes]
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-888-233-7915

———————————*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	$300
Specialist copayment	$25
Hospital (facility) co-insurance	20%
Other co-insurance	20%

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	$12,731

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$175
Coinsurance	$2,486
What isn't covered	
Limits or exclusions over count drugs	$60
The total Peg would pay is	$3,021

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

The plan's overall deductible	$300
Specialist co-payment	$25
Hospital (facility) *co-insurance*	20%
Other co-insurance	20%

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	$7,389

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$835
Coinsurance	$1,417
What isn't covered	
Limits or exclusions over counter drugs	$55
The total Joe would pay is	$2,607

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

The plan's overall deductible	$300
Specialist co-payment	$25
Hospital (facility) co-insurance	20%
Other co-insurance	20%

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	$1,925

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$140
Coinsurance	$325
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$765