

 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 1-888-773-7218. 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 <http://www.healthcare.gov/sbc-glossary/> or call 1-888-773-7218 to request a copy.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| What is the overall <a href="#">deductible</a> ?                                | \$0 Tier 1 / \$1,500 Tier 2  | Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. In-Network preventive care, In-Network office services where copay applies.   | This plan covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .   |
| Are there other <a href="#">deductibles</a> for specific services?              | No.  | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$1,350 Tier 1 / \$6,800 Tier 2 & Rx OOP Max are combined.   | The <a href="#">out of pocket limit</a> is the most you could pay in a year for covered services.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover and <a href="#">penalties</a> for failure to obtain pre-authorization. | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. For Prime Providers: <a href="https://app.strivebenefits.com/PHS">https://app.strivebenefits.com/PHS</a><br>User ID = PHS PW = Benefits   | This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network</a> provider for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | Yes. Contact Prime Healthcare Utilization Management Department at 1-877-234-5227 or fax 909-235-4414  | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .  |



All [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   |
|--|--|---|---|--|
|  |  | Tier 1 Prime Healthcare<br>(You will pay the least)   | Tier 2 Blue Shield of CA<br>(You will pay the most) |  |
| If you visit a health care <a href="#">provider's</a> office or clinic   | Primary care visit to treat an injury or illness       | \$10 <a href="#">copay</a>  | \$40 <a href="#">copay</a>                          | Tier 2 Pediatrician \$10 <a href="#">copay</a>   |
|  | <a href="#">Specialist</a> visit                       | \$10 <a href="#">copay</a>  | \$60 <a href="#">copay</a>                          | None   |
|  | <a href="#">Preventive care/screening/immunization</a> | No Charge   | No Charge   | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for. |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | No Charge   | 20%   | None   |
|  | Imaging (CT/PET scans, MRIs)                           | No Charge   | 20%   | None   |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> | Generic drugs  | <b>Express Scripts:</b> Retail \$10 <a href="#">copay</a> or \$20 <a href="#">copay</a> mail order            |   | Retail up to a 30 day supply. Mail order up to a 90 day supply.  |
|  | Formulary brand drugs                                  | <b>Express Scripts:</b> \$30 <a href="#">copay</a> or \$60 <a href="#">copay</a> mail order                   |   | Maintenance drugs filled at a retail pharmacy up to 30-day supply.   |
|  | Non-formulary brand drugs                              | Not Covered   |   | Non-formulary brand drugs are not covered unless prior authorization is obtained through Express Scripts.  |
|  | <a href="#">Specialty drugs</a>                        | <b>Express Scripts (Accredo):</b><br>Generic \$200 <a href="#">copay</a> or Brand \$300 <a href="#">copay</a> |   | None   |
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center)         | No Charge   | \$250 <a href="#">copay</a> plus 20%                | None   |
|  | Physician/surgeon fees                                 | No Charge   | 20%   | None   |
| If you need immediate medical attention  | <a href="#">Emergency room care</a>                    | \$25 <a href="#">copay</a>  | \$200 <a href="#">copay</a> plus 20%                | <a href="#">Copay</a> waived if admitted. Deductible waived.   |
|  | <a href="#">Emergency medical transportation</a>       | \$250 <a href="#">copay</a> / trip  | \$250 <a href="#">copay</a> / trip                  | Deductible waived  |
|  | <a href="#">Urgent care</a>                            | \$10 <a href="#">copay</a>  | \$40 <a href="#">copay</a>                          | None   |
| If you have a hospital   | Facility fee (e.g., hospital room)                     | No Charge   | \$500 <a href="#">copay</a> plus 20%                | <a href="#">Pre-cert</a> required. Unapproved days are not covered.  |

\* For more information about limitations and exceptions, see the plan or policy document at <https://app.strivebenefits.com/PHS>

| Common Medical Event   | Services You May Need                     | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|--|---|--|--|--|
|  |   | Tier 1 Prime Healthcare (You will pay the least)           | Tier 2 Blue Shield of CA (You will pay the most) |  |
| <b>stay</b>  | Physician/surgeon fees                    | No Charge  | 20%  | None   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$10 <a href="#">copay</a>                                 | \$40 <a href="#">copay</a>                       | Per office visit.  |
|  | Inpatient services                        | No Charge  | \$500 <a href="#">copay</a> plus 20%             | <a href="#">Pre-cert</a> required. Unapproved days are not covered. Prime UM required.   |
| <b>If you are pregnant</b>   | Office visits                             | No Charge (pre-natal)                                      | No Charge (pre-natal)                            | <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|  | Childbirth/delivery professional services | No Charge  | 20%  |  |
|  | Childbirth/delivery facility services     | No Charge  | \$500 <a href="#">copay</a> plus 20%             |  |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | 20%  | 20%  | 100 visits max per cal year. <a href="#">Pre-cert</a> is required. Unapproved days are not covered.  |
|  | <a href="#">Rehabilitation services</a>   | \$10 <a href="#">copay</a> / No Charge at a Prime Facility | \$40 <a href="#">copay</a>                       | Limited to 30 visits per cal year.   |
|  | <a href="#">Habilitation services</a>     | Not Covered  | Not Covered                                      | None   |
|  | <a href="#">Skilled nursing care</a>      | No Charge  | 20%  | <a href="#">Per-cert</a> is required. Unapproved days are not covered.   |
|  | <a href="#">Durable medical equipment</a> | 20%  | 20%  | Deductible waived.   |
|  | <a href="#">Hospice services</a>          | No Charge  | Outpatient = No Charge<br>Inpatient = 20%        | <a href="#">Pre-cert</a> is required for inpatient. Unapproved days are not covered. Prime UM required.  |
| <b>If your child needs dental or eye care</b>                                    | Children's eye exam                       | No Charge  | No Charge  | Eye refraction is not covered (preventive exam only).  |
|  | Children's glasses                        | Not Covered  | Not Covered                                      | Refer to VSP   |
|  | Children's dental check-up                | Not Covered  | Not Covered                                      | Refer to Delta Dental  |

## 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](#).)

- Acupuncture
- All Blue Shield of CA Network services that were not reviewed and approved by Prime UM (except PCP office visit, pediatrics, well woman exam, urgent care and emergency visits).
- Cosmetic surgery
- Dental Care (adult & child)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (adult)
- Routine eye refractions (child)
- Routine foot care
- Services performed by an Out of Network provider, except ER care.
- Weight loss programs

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

- Bariatric surgery (Prime facilities only)
- Chiropractic 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](http://www.dol.gov/ebsa/healthreform). 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](http://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](#) which includes the following dedicated fax number 310-533-5755. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### 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](#).

The Plan and Plan Sponsor described in the Summary of Benefits and coverage comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan and Plan Sponsor does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

The Plan and Plan Sponsor:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters; and
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters; and
  - Information written in other languages.

If you need these services, contact the Civil Rights Coordinator named in your Benefits Guide.

If you believe that the Plan or Plan Sponsor has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator named in your Benefits Guide. Contact information of the Civil Rights Coordinator can be found in the Benefits Guide.

You can file a grievance by mail or in person or fax or email. If you need help filing a grievance contact the Civil Rights Coordinator named in the Benefits Guide.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

## Language Access Services:

### Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123)

### Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123)

### Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123)

### Tagalog - Filipino

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123)

### Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 번으로 전화해 주십시오. 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123)

**Armenian**

ՈՒՇԱԴԴՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123)

**Persian**

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123)

**Russian**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните. 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123)

**Japanese**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。まで、電話にてご連絡ください。1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123)

**Arabic**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم

**Punjabi**

ਧਿਆਨ ਦਿਓ :ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ ,ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। ਤੇ ਕਾਲ ਕਰੋ। 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123)

**Mon-Khmer Cambodian**

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123)

**Hmong**

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123)

**Hindi**

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। पर कॉल करें। 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123)

**Thai**

เรียน :ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123)

—————*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](#) \$0
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

**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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$0          |
| Copayments                        | \$200        |
| Coinsurance                       | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$50         |
| <b>The total Peg would pay is</b> | <b>\$250</b> |

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$0            |
| Copayments                        | \$1,000        |
| Coinsurance                       | \$10           |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$80           |
| <b>The total Joe would pay is</b> | <b>\$1,090</b> |

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- Hospital (facility) [copayment](#) \$25
- Other [coinsurance](#) 0%

**This EXAMPLE event includes services like:**  
 Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$0          |
| Copayments                        | \$140        |
| Coinsurance                       | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$140</b> |