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 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 deductible?	$2,500 Tier 1 / $5,000 Tier 2	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-Network preventive care, Tier 1 OP Emergency Room, Office Visit, Urgent Care. Refer to plan document for full list.	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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,000 Tier 1 / $5,700 Tier 2, combined with RX	The out of pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization.	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. For Prime Providers: https://app.strivebenefits.com/PHSVALUE User ID = PHSVALUE PW=Benefits For Blue Shield of CA Providers: www.blueshieldca.com/networkppo or call 1-888-773-7218	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?	Yes. Contact Prime Healthcare Utilization Management Department at 1-877-234-5227 or fax 909-235-4414	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

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 (You will pay the least)	Tier 2 Blue Shield of CA (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	$20 copay	$60 copay	None
	Specialist visit	$40 copay	$100 copay plus 20%	None
	Preventive care/screening/ immunization	No Charge	No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% deductible waived	60%	None
	Imaging (CT/PET scans, MRIs)	20%	60%	None
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	**Express Scripts:** Retail $25 copay or $50 copay mail order		Retail up to a 30 day supply. Mail order up to a 90 day supply.
	Formulary brand drugs	**Express Scripts:** $100 copay or $200 copay mail order		Retail up to a 30 day supply. Mail order up to a 90 day supply.
	Non-formulary brand drugs	Not Covered		Non-formulary brand drugs are not covered unless prior authorization is obtained through Express Scripts.
	Specialty drugs	**Express Scripts (Accredo):** Generic $200 copay or Brand $300 copay		None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay plus 20%	$750 copay plus 60%	None
	Physician/surgeon fees	20%	60%	None
If you need immediate medical attention	Emergency room care	$300 copay	$300 copay plus 60%	Copay waived if admitted.
	Emergency medical transportation	$300 copay plus 30%	$300 copay plus 30%	None
	Urgent care	$40 copay	$100 copay plus 60%	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20%	$500 copay plus 60%	Pre-cert required. Unapproved days are not covered.
	Physician/surgeon fees	20%	60%	None

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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay	$60 copay	Per office visit.
	Inpatient services	20%	$500 copay plus 60%	Pre-cert required. Unapproved days are not covered.
If you are pregnant	Office visits	$20 copay	$60 copay	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20%	60%	
	Childbirth/delivery facility services	20%	$500 copay plus 20%	
If you need help recovering or have other special health needs	Home health care	20% deductible waived	60%	24 visits max per cal year. Pre-cert is required. Unapproved days are not covered.
	Rehabilitation services	20% deductible waived	60%	Limited to 24 visits per cal year.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	20%	60%	Per-cert is required. Unapproved days are not covered.
	Durable medical equipment	20% deductible waived	60%	None
	Hospice services	20%	60%	Pre-cert is required for inpatient. Unapproved days are not covered.
If your child needs dental or eye care	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
- Bariatric surgery
- Cosmetic surgery
- Dental Care (adult
- Dental care (child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- Routine eye refraction (child)
- Routine foot care (except for treatment of foot pain or cramps, including plantar fasciitis).
- Services performed by an Out of Network Provider, except emergency care.
- Weight loss programs

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

- Chiropractic Care (20 visits per calendar year)
- Dialysis

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/heathreform. 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 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.

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

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

- 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

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ 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. تماس بگیرید. 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៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល 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 rau1-1-844-203-2025, 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	$2500
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2500
Copayments	$100
Coinsurance	$700
What isn't covered	
Limits or exclusions	$200
The total Peg would pay is	**$3,500**

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

The plan's overall deductible	$2500
Specialist copayment	$40
Hospital (facility) coinsurance	20%
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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2400
Copayments	$2,000
Coinsurance	$60
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$4,540**

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

The plan's overall deductible	$2500
Specialist copayment	$40
Hospital (facility) copayment	$300
Other coinsurance	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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$80
The total Mia would pay is	**$1,980**

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