




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 the Benefits Department at 1-866-755-6974. 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 [brmsonline.com/dignityhealth](http://brmsonline.com/dignityhealth) or call 1-866-755-6974 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	Dignity Health Central Coast Network: \$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
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> ?	<p>The Medical <a href="#">Out-of-Pocket</a> Limit is separate from the Prescription Drug <a href="#">Out-of-Pocket</a> Limit.</p> <p>Dignity Health Central Coast Network: Individual \$5,000 / Family \$10,000</p> <p>Prescription: Individual \$1,350 / Family \$2,700</p>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> for certain services and <a href="#">premiums</a> .	Even though you pay these expenses they do not count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://brmsonline.com/dignityhealth">brmsonline.com/dignityhealth</a> or call 1-866-755-6974 for a list of <a href="#">network providers</a> .	The <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> . There is no coverage 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 provider</a> 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> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		Dignity Health Preferred Network (You will pay the least)	Out-of-Network (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> /office visit	Not Covered	None
	<a href="#">Specialist</a> visit	\$10 <a href="#">copay</a> /office visit	Not Covered	Okay to self-refer to OBGYN and for well-woman exam.
	<a href="#">Preventive care/screening</a> /immunization	No Charge	Not Covered	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> (Lab)	No Charge	Not Covered	Except in emergency, all tests must be ordered and performed in-network, otherwise not covered. <a href="#">Preauthorization</a> may be required.
	Imaging/X-Ray (CT/PET scans, MRIs)	No Charge	Not Covered	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.optumrx.com</a>	Generic drugs (Tier 1)	\$7 <a href="#">copay</a> / retail \$10 <a href="#">copay</a> / mail order		No coverage for use of out of network pharmacies.
	Preferred brand drugs (Tier 2)	\$15 <a href="#">copay</a> / retail \$10 <a href="#">copay</a> / mail order		No charge for all diabetic supplies.
	Non-preferred brand drugs (Tier 3)	\$25 <a href="#">copay</a> / retail \$25 <a href="#">copay</a> / mail order		During the year, your prescription may change Tiers. Some prescription drugs require prior authorization, compliance with step therapy and/or may be subject to quantity limits.  Covers up to a 30-day supply (retail prescription); 31 to 90-day supply (mail order prescription).  Members can receive up to a 90-day supply of most maintenance medications at an OptumRx national network pharmacy.
	<a href="#">Specialty drugs</a>	\$7 <a href="#">copay</a> / Generic \$15 <a href="#">copay</a> / Preferred brand \$25 <a href="#">copay</a> / Non-Preferred brand		Covers up to a 30-day supply.  Participating Specialty Pharmacies: <ul style="list-style-type: none"> <li>CommonSpirit Specialty Pharmacy</li> </ul>

For more information about limitations and exceptions, see the [plan](#) or policy document at [brmsonline.com/dignityhealth](#).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Dignity Health Preferred Network (You will pay the least)	Out-of-Network (You will pay the most)	
				<ul style="list-style-type: none"> <li>Optum Specialty Pharmacy</li> </ul> NOTE: Specialty Medications may also be filled at any CommonSpirit Health owned pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 <a href="#">copay</a> / visit	Not Covered	<a href="#">Preauthorization</a> is required.
	Surgeon/Surgical Assistant fees	No Charge	Not Covered	<a href="#">Preauthorization</a> is required.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$50 <a href="#">copay</a> / visit	\$50 <a href="#">copay</a> / visit	Copay waived if admitted to the Hospital.
	<a href="#">Emergency medical transportation</a>	\$10 <a href="#">copay</a>	\$10 <a href="#">copay</a>	Limited to emergent, medically necessary transportation. For emergencies only. <a href="#">Preauthorization</a> is required for air ambulance.
	<a href="#">Urgent care</a>	\$25 <a href="#">copay</a> / visit	\$25 <a href="#">copay</a> / visit	Tier 1 benefits will apply if members seek services from an Anthem contracted Urgent Care provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <a href="#">copay</a> / admit	Not Covered	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	\$10 <a href="#">copay</a> / visit	Not Covered	None
	Surgical Assistant & Anesthesiologist Fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Office Visit & Outpatient services	\$10 <a href="#">copay</a> / visit	Not Covered	None
	Inpatient services	\$100 <a href="#">copay</a> / visit	Not Covered	<a href="#">Preauthorization</a> is required.
If you are pregnant	Office visits	\$10 <a href="#">copay</a> / initial visit	Not Covered	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> .
	Childbirth/delivery professional services	No Charge	Not Covered	Depending on the type of services, <a href="#">copay</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	\$100 <a href="#">copay</a> / admit	Not Covered	<a href="#">Preauthorization</a> is required if the stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Dignity Health Preferred Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge	Not Covered	<a href="#">Preauthorization</a> is required. Limited to 250 visits/calendar year.
	<a href="#">Rehabilitation services</a>	Chiropractor - \$10 <a href="#">copay</a> / visit All other – No Charge	Not Covered	Chiropractor maximum of 12 visits per calendar year. All other therapies combined limited to 24 visits per calendar year. <a href="#">Preauthorization</a> required for Inpatient.
	<a href="#">Habilitation services</a>	\$10 <a href="#">copay</a> / visit	Not Covered	Limited to 24 visits per calendar year (all therapies combined). <a href="#">Preauthorization</a> required for inpatient.
	<a href="#">Skilled nursing care</a>	\$100 <a href="#">copay</a> / admit	Not Covered	Limited to 60 visits per calendar year. <a href="#">Preauthorization</a> is required.
	<a href="#">Durable medical equipment</a>	\$10 <a href="#">copay</a> / item per month	Not Covered	<a href="#">Preauthorization</a> is required.
	<a href="#">Hospice services</a>	No Charge	Not Covered	<a href="#">Preauthorization</a> is required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)			
<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental Care (Child, Adult)</li> <li>• Hearing Aids</li> <li>• Weight Loss Programs</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care</li> <li>• Non-emergency care when traveling outside of the U.S.</li> <li>• Private-Duty Nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Eye Care</li> <li>• Routine Foot Care</li> <li>• Acupuncture</li> </ul>	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
• Chiropractic Care	• Infertility Services	• Bariatric Surgery

**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/agencies/ebsa](http://www.dol.gov/agencies/ebsa). 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](#). Your [plan](#) documents also provide complete information on how 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:

BRMS & Risk Management Services  
P.O. Box 2140  
Folsom, CA 95673

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**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 1-866-755-6974

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-755-6974.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-755-6974.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-755-6974.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$10
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

Total Example Cost	\$12,840
--------------------	----------

In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$148
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$208

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$10
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">copayment</a>	\$15

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	\$7,460
--------------------	---------

In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$852
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$907

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$10
■ Emergency Room (facility) <a href="#">copayment</a>	\$50
■ Other (ambulance) <a href="#">copayment</a>	\$10

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	\$2,010
--------------------	---------

In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$70
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$70

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.