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, Benefit & Risk Management Services at (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 or call (866) 755-6974 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Dignity Health Central Coast/SCICN Network: Individual: $250 / Family: $750	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. Well-child care, preventive drug list medications and preventive care 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 specific services.
What is the out-of-pocket limit for this plan?	The Medical Out-of-Pocket Limit is separate from the Prescription Drug Out-of-Pocket Limit. Dignity Health Central Coast/SCICN Network: Individual $1,000 / Family $3,000 Prescription: Individual $500 / Family $1,000	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?	Copayments for certain services, premiums, balance-billing charges, 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. See brmsonline.com/dignityhealth or call (866) 755-6974 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. There is no coverage 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
		Dignity Health Preferred Network (You will pay the least)	Out-of- Network 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 copay/visit after deductible	Not covered	None
	Specialist visit	$25 copay/visit after deductible	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	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)	$10 copay/visit after deductible	Not covered	Except in an emergency, all tests must be performed in-network, otherwise not covered. Preauthorization may be required
	Imaging (CT/PET scans, MRIs)	$10 copay/visit after deductible	Not covered	

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 Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **welcome.optumrx.com/Dignity**	Generic drugs (Tier 1)	$10 copay / retail 1 -30 day supply $25 copay / home delivery 1 – 90 day supply		No coverage for use of out of network pharmacies. No charge for all diabetic supplies. 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. Members can receive up to a 90-day supply of most maintenance medications at an Optum Rx/CommonSpirit Health pharmacy.. (DAW: member pays preferred or non-preferred brand copayment for brand name plus cost difference between generic and brand name when brand name is requested by member). Optum Rx Member Services: (800) 241-1657 Optum Rx Specialty Pharmacy: (877) 838-2907
	Preferred brand drugs (Tier 2)	$20 copay / retail 1 - 30 day supply $50 copay / home delivery 1 – 90 day supply		
	Non-preferred brand drugs (Tier 3)	$40 copay / retail 1 - 30 day supply $100 copay / home delivery 1 – 90 day supply		
	Specialty drugs	$10 copay / Generic $20 copay / Preferred brand $40 copay / Non-Preferred brand		Covers up to a 30-day supply. (DAW: member pays preferred or non-preferred brand copayment for brand name plus cost difference between generic and brand name when brand name is requested by member. Specialty medications must be filled at the CommonSpirit Specialty Pharmacy or CommonSpirit Health owned pharmacy. Optum Rx Member Services: (800) 241-1657 Optum Rx Specialty Pharmacy: (877) 838-2907
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/visit after deductible	Not Covered	Preauthorization is required.

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 Provider (You will pay the most)	
	Physician/surgeon fees	No Charge	Not Covered	Preauthorization is required.
If you need immediate medical attention	Emergency room care	$75 copay/visit after deductible	$75 copay/visit after deductible	Copay waived if admitted to the Hospital.
	Emergency medical transportation	$25 copay/visit after deductible	$25 copay/visit after deductible	Limited to emergent, medically necessary transportation. For emergencies only. Preauthorization is required for air ambulances.
	Urgent care	$25 copay/visit after deductible	$25 copay/visit after deductible	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)	$250 copay/visit after deductible	Not Covered	Preauthorization is required.
	Physician/surgeon fees	$25 copay/visit after deductible.	Not Covered	None
	Surgical Assistant & Anesthesiologist Fees	Surgical Assistant -No Charge Anesthesiologist – No Charge after deductible	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit after deductible	Not Covered	None
	Inpatient services	$250 copay/visit after deductible	Not Covered	Preauthorization is required.

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 Provider (You will pay the most)	
If you are pregnant	Office visits	$25 copay / visit after deductible	Not Covered	Cost sharing does not apply to certain preventive services.
	Childbirth/delivery professional services	$25 copay / visit after deductible	Not Covered	Depending on the type of services, copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	$250 copay / visit after deductible	Not Covered	Preauthorization is required if the stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean.
If you need help recovering or have other special health needs	Home health care	$10 copay / visit after deductible.	Not Covered	Preauthorization is required. Limited to 250 visits/calendar year.
	Rehabilitation services	$10 copay / visit after deductible.	Not Covered	Limited to 24 visits per calendar year (all therapies combined). Preauthorization required for Inpatient.
	Habilitation services	$10 copay / visit after deductible	Not Covered	Limited to 24 visits per calendar year (all therapies combined). Preauthorization required for inpatient.
	Skilled nursing care	$250 copay / admit after deductible	Not Covered	Limited to 60 visits per calendar year. Preauthorization is required.
	Durable medical equipment	$25 copay / item per month (up to purchase price)	Not Covered	Preauthorization is required.
	Hospice services	$10 copay / visit after deductible.	Not Covered	Preauthorization 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic Surgery	• Long Term Care	• Routine Eye Care
• Dental Care (Child, Adult)	• Non-emergency care when traveling outside of the U.S.	• Routine Foot Care
• Hearing Aids	• Private-Duty Nursing	• Acupuncture
• 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	• 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: (866) 444-EBSA (3272) or 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 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:

Benefit & 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 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, kwiijigo 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 plan's overall deductible**	**$250**
■ **Specialist copayment**	**$25**
■ **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)*

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$910**

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

■ **The plan's overall deductible**	**$250**
■ **Specialist copayment**	**30%**
■ **Hospital (facility) copayment**	**30%**
■ **Other (Tier 2 prescription drug) copay**	**30%**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$250
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,070**

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

■ **The plan's overall deductible**	**$250**
■ **Specialist copayment**	**$25**
■ **Hospital (facility) copayment**	**$75**
■ **Other copayment**	**$25**

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	
Deductibles*	$250
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$650**

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