
 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, go to [www.MyScrippsHealthPlan.com](http://www.MyScrippsHealthPlan.com) or call 1-877-552-7247. 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.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-877-552-7247 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	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. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	N/A. There is no <a href="#">deductible</a> .	This <a href="#">plan</a> 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?	Yes. \$300 for Durable Medical Equipment and Prosthetics.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Medical: \$3,000 individual / \$6,000 family; <a href="#">Prescription Drugs</a> : \$4,150 individual / \$8,300 family:	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. There is a separate <a href="#">out-of-pocket limit</a> for <a href="#">Prescription Drugs</a> .
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 penalties for not obtaining prior 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> ?	You must use <a href="#">network providers</a> , except in the event of an emergency. See <a href="http://www.MyScrippsHealthPlan.com">www.MyScrippsHealthPlan.com</a> or call 1-877-552-7247 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . If you use an in- <a href="#">network</a> doctor or other health care <a href="#">provider</a> , this plan will pay some or all of the costs of covered services. 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 may self-refer to any <a href="#">provider</a> within the Scripps Custom <a href="#">Network</a> .	You can see the <a href="#">network specialist</a> you choose without permission from this <a href="#">plan</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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /visit if you designate a <a href="#">Primary Care Physician</a> (PCP); \$35 <a href="#">copay</a> /visit if you do not designate a PCP	Not Covered	Designation of a <a href="#">Primary Care Physician</a> is required for the lowest copay and you can see any <a href="#">Network Primary Care Physician</a> for a \$25 copay.
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit	Not Covered	None
	<a href="#">Preventive care/screening/immunization</a>	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	Not Covered	Outpatient radiology services must be performed at a Scripps Imaging Center facility except basic x-rays and OB ultra-sounds performed in a physician's office, and pediatric services. \$450 <a href="#">copay</a> maximum/calendar year.
	Imaging (CT/PET scans, MRIs)	\$150 <a href="#">copay</a> /test	Not Covered	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.[insert].com</a>	Generic drugs (Tier 1)	\$15 <a href="#">copay</a> /30 day Supply; \$30 <a href="#">copay</a> /90 day supply	Not Covered	Covers up to a 30-day supply (retail prescription) when using a MedImpact Retail Pharmacy (excluding Walgreens); 31-90 day supply (mail order prescription) when using the Scripps Direct Pharmacy. No charge for oral contraceptives.
	High cost generic drugs (high cost generics have relevant alternatives and cost more than \$50)	\$40 <a href="#">copay</a> /30 day Supply; \$100 <a href="#">copay</a> /90 day supply	Not Covered	
	Preferred brand drugs (Tier 2)	\$40 <a href="#">copay</a> /30 day supply; \$100 <a href="#">copay</a> /90 day supply	Not Covered	Specialty Drugs are subject to a minimum <a href="#">copay</a> of \$100 and a maximum <a href="#">copay</a> of \$200 for those living outside of San Diego County.
	Non-preferred brand drugs (Tier 3)	\$70 <a href="#">copay</a> /30 day supply; \$210 <a href="#">copay</a> /90 day supply	Not Covered	Specialty Drugs are subject to a minimum <a href="#">copay</a> of \$100 and a maximum <a href="#">copay</a> of \$300 for those living within San Diego County.
	<a href="#">Specialty drugs</a> (Tier 4)	30% <a href="#">coinsurance</a> /prescription	Not Covered	Prior Authorization is required for Specialty drugs.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200 <a href="#">copay</a>	Not Covered	Scripps Custom <a href="#">Network</a> Hospitals Only; Prior Authorization may be required – refer to the Summary Plan Document.
	Physician/surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a>	\$200 <a href="#">copay</a>	<a href="#">Emergency room care copay</a> waived if admitted. Non- <a href="#">emergency</a> use of <a href="#">emergency</a> services not covered.
	<a href="#">Emergency medical transportation</a>	\$150 <a href="#">copay</a>	\$150 <a href="#">copay</a>	
	<a href="#">Urgent care</a>	\$50 <a href="#">copay/visit</a>	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300 <a href="#">copay/admission</a>	Not Covered	Scripps Custom <a href="#">Network</a> Hospitals Only; Prior Authorization required or \$250 penalty.
	Physician/surgeon fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <a href="#">copay/office visit</a>	Not Covered	Outpatient Services: Anthem Blue Cross <a href="#">Network</a> services only. Prior Authorization may be required – refer to the Summary Plan Document. Inpatient services: Acute inpatient facility only, not residential facilities; Prior Authorization required or \$250 penalty.
	Inpatient services	\$300 <a href="#">copay/admission</a>	Not Covered	
If you are pregnant	Office visits	\$40 <a href="#">copay</a>	Not Covered	Office visits: copay applies to the first visit only. Facility: Scripps Custom <a href="#">Network</a> Hospitals Only; Prior Authorization required for stays exceeding those outlined in the Newborns' and Mothers' Health Protection Act – refer to the Summary Plan Document.
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	\$300 <a href="#">copay/admission</a>	Not Covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge	Not Covered	When ordered by a physician and subject to Prior Authorization or \$250 penalty.
	<a href="#">Rehabilitation services</a>	\$30 <a href="#">copay</a>	Not Covered	Pre-service review required after 24 combined therapy visits. Not all habilitation services are covered – refer to the Summary Plan Document.
	<a href="#">Habilitation services</a>	\$25 <a href="#">copay</a>	Not Covered	
	<a href="#">Skilled nursing care</a>	No Charge	Not Covered	When ordered by a physician and subject to Prior Authorization or \$250 penalty. Limited to 100 days/calendar year.
	<a href="#">Durable medical equipment</a>	No Charge	Not Covered	Separate \$300 <a href="#">calendar year deductible</a> applies to durable medical equipment and

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				prosthetics – refer to the Summary Plan Document.
	<a href="#">Hospice services</a>	No Charge	Not Covered	For a person who is terminally ill with a life expectancy of 6 months or less.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$10 <a href="#">copay</a> /visit	\$10 <a href="#">copay</a> /visit	Limited to one exam per 12 months. Maximum <a href="#">Plan</a> payment for non- <a href="#">network</a> providers is \$40.
	Children's glasses	No charge for standard lenses and frames.	Partial payment depending on lens type. See Summary Plan Document for details.	Limited to one set of lenses per 12 months; one set of frames per 24 months.
	Children's dental check-up	Not Covered	Not Covered	Must enroll in a separate dental plan for dental coverage.

#### 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
- Dental Care
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Weight Loss Programs
- Routine Foot Care

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

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). For more information on your rights to continue coverage, contact the plan at 1-877-552-7247. You may also contact your state insurance department, the California Department of Insurance. 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 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: 1-877-552-7247.

**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 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 1-877-552-7247.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-552-7247.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-877-552-7247.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-552-7247.

—————*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](#) \$40
- [Hospital \(facility\) copay](#) \$300
- 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>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$360
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$380</b>

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

- The [plan's overall deductible](#) \$500
- [Specialist copayment](#) \$50
- [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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$60
Copayments	\$1,200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,320</b>

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

- The [plan's overall deductible](#) \$0
- [Specialist copayment](#) \$40
- [Hospital \(facility\) copay](#) \$200
- 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>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$200
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$700</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert].

\*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.