**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, visit www.jhmbhealthconnect.com. 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.jhmbhealthconnect.com or call 1-559-457-3520 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network Providers: **$250** Individual/**$500** Family. Out-of-Network Providers: **$750** Individual/**$1,500** Family. | 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. Preventive care, hospice, prescription drugs, chiropractic care, acupuncture, ambulance, inpatient mental health or substance abuse care, and services covered under the planned surgery benefit. | 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?** | Network Providers: Medical and Mental Health / Substance Abuse Combined - $2,100 Individual/$4,200 Family; Prescription $400 Individual/$800 Family. Out-of-Network Providers: Medical only - $10,000 Individual/ $20,000 Family. | 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?** | Premiums, health care this plan doesn't cover, balance-billing charges, penalties for failure to obtain pre-authorization for services. | 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 a list of network providers, see/call: Medical - www.anthem.com/ca or 1-800-807-0820; Mental Health / Substance Abuse - www.fusdmentalhealth.com or 1-800-498-9055. | 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?** | 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 |
|---|---|---|---|---|
| | | Network Provider (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 | $15 copay/office visit, and 10% coinsurance for other outpatient services | 40% coinsurance | None |
| | Specialist visit | $15 copay/office visit, and 10% coinsurance for other outpatient services | 40% coinsurance | 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% coinsurance | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 40% coinsurance | None |
| **If you need drugs to treat your illness or condition; for those enrolled in the standard prescription plan.**<br><br>(If you are enrolled in the Medicare approved plan, EnvisionRx*Plus*, see following page.)<br><br>More information about **prescription drug** | Tier 1 - Generic drugs used for treating high cholesterol, high blood pressure, diabetes, and depression | No charge | Not covered | All maintenance medications must be filled with a 90-day supply through EnvisionMail, Rite Aid, Walgreens, or Costco retail pharmacy.<br><br>90-day supply: Requires two 30-day copays.<br>30-day and 90-day supplies at retail; 90-day supplies at mail order.<br><br>The prescription plan uses EnvisionRx's Select Formulary. The formulary list is available at www.EnvisionRx.com. |
| | Tier 2 - Generic drugs | $10 copay/30-day supply Deductible does not apply | Not covered | |
| | Tier 3 - Preferred brand drugs | $35 copay/30-day supply Deductible does not apply | Not covered | |
| | Tier 4 - Non-preferred brand drugs | $50 copay/30-day supply Deductible does not apply | Not covered | |

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) | |
| **coverage** is available at www.envisionrx.com | | | | Patient pays cost difference for brand with generic alternative. Cost difference does not apply to out-of-pocket maximum. |
| **For those enrolled in the Medicare approved plan, EnvisionRx Plus.**<br><br>More information about **prescription drug coverage** is available at www.envisionrxplus.com | Generic drugs | $10 copay/prescription Retail and Mail Order | Not Covered | Retail: Covers up to 30-day supply; Up to 90-day supply for maintenance and non-maintenance drugs.<br><br>Mail Order: Covers up to 90-day supply for non-maintenance drugs; Up to 180-days for maintenance drugs.<br><br>Patient pays cost difference for brand with generic equivalent. |
| | Brand drugs with generic equivalent | $35 copay/prescription Retail and Mail Order. | Not Covered | |
| | Brand drugs with no generic equivalent | $35 copay/prescription Retail and Mail Order | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $100 copay plus 10% coinsurance | Not Covered | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250. No charge for covered services under the planned surgery benefit. |
| | Physician/surgeon fees | 10% coinsurance | 40% coinsurance | No charge for covered services under the planned surgery benefit. |
| **If you need immediate medical attention** | Emergency room care | $100 copay plus 10% coinsurance | $100 copay plus 10% coinsurance | None |
| | Emergency medical transportation | $100 copay plus 10% coinsurance for Ground; No Charge for Air Deductible does not apply | $100 copay plus 10% coinsurance for Ground; No Charge for Air Deductible does not apply | None |
| | Urgent care | $35 copay plus 10% coinsurance | $35 copay plus 40% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 40% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250. No charge for covered services under the planned surgery benefit. |

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) | |
| | Physician/surgeon fees | 10% coinsurance | 40% coinsurance | No charge for covered services under the planned surgery benefit. |
| **If you need mental health, behavioral health, or substance abuse services** | Mental/Behavioral Health Outpatient services | $10 copay/visit. Deductible does not apply | Not Covered | Preauthorization is required. Maximum 60 visits per calendar year. |
| | Mental/Behavioral Health Inpatient services | No Charge | Not Covered | Preauthorization is required. Maximum 45 days per calendar year. |
| | Substance Abuse Outpatient services | No Charge | Not Covered | Preauthorization is required. |
| | Substance Abuse Inpatient services | No Charge | Not Covered | Preauthorization is required. |
| **If you are pregnant** | Office visits | $15 copay/office visit, and 10% coinsurance for other outpatient services | 40% coinsurance | Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC.<br><br>Dependent Children are only covered for preventive services as defined under the Affordable Care Act. |
| | Childbirth/delivery professional services | 10% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 10% coinsurance | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 40% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250. |
| | Rehabilitation services | 10% coinsurance | 40% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250. |
| | Habilitation services | 10% coinsurance | 40% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250. |
| | Skilled nursing care | 10% coinsurance | 40% coinsurance | Maximum 120 days per calendar year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250. |

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) | |
| | Durable medical equipment | 10% coinsurance | 40% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250. |
| | Hospice services | No Charge | No Charge | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered under Medical Plan | Not Covered under Medical Plan | |
| | Children's glasses | | | |
| | Children's dental check-up | | | |

## 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 (Adult)
- Genetic Testing
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Acupuncture (through PhysMetrics)
- Bariatric Surgery
- Chiropractic Care (through PhysMetrics)
- Non-emergency care when traveling outside United States
- Private-duty Nursing

**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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x 61565 or www.cciio.cms.gov. 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: Delta Health Systems at 1-800-807-0820.

**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.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-559-457-3596. Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-559-457-3596.

Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-559-457-3596.

*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* | $15 |
| Hospital (facility) *coinsurance* | 10% |
| Other *coinsurance* | 10% |

**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** | **$12,731** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $63 |
| Coinsurance | $1,431 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,804** |

### 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* | $15 |
| Hospital (facility) *coinsurance* | 10% |
| Other *coinsurance* | 10% |

**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** | **$7,389** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $490 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$795** |

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

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist *copayment* | $15 |
| Hospital (facility) *coinsurance* | 10% |
| Other *coinsurance* | 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** | **$1,925** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $230 |
| Coinsurance | $124 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$604** |

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