

 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.ihmbhealthconnect.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 <u>deductible</u> ?	<u>Network Providers</u> : \$250 Individual/\$500 Family. <u>Out-of-Network Providers</u> : \$750 Individual/\$1,500 Family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> , <u>hospice</u> , <u>prescription drugs</u> , chiropractic care, acupuncture, ambulance, mental health, and substance abuse care are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. <u>Out-of-network</u> chiropractic care has a separate \$100 calendar year <u>deductible</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<u>Network Providers</u> : Medical and Mental Health / Substance Abuse Combined - \$2,100 Individual/\$4,200 Family; Prescription \$400 Individual/\$800 Family. <u>Out-of-Network Providers</u> : Medical only - \$10,000 Individual/\$20,000 Family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , health care this <u>plan</u> doesn't cover, <u>balance-billing</u> charges, penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. For a list of <u>network providers</u> , see/call: Medical - www.anthem.com/ca or 1-800-807-0820; Mental Health / Substance Abuse - www.fusdmhsa.com or 1-888-425-4800.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an


		<u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /office visit, and 10% <u>coinsurance</u> for other outpatient services	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$15 <u>copay</u> /office visit, and 10% <u>coinsurance</u> for other outpatient services	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition; for those enrolled in the <u>standard</u> prescription plan. (If you are enrolled in the Medicare approved plan, <u>Elixir Plus</u> , see following page.) More information about <u>prescription drug coverage</u> is available at www.envisionrx.com	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 Elixir Mail, Rite Aid, Walgreens, or Costco retail pharmacy.
	Tier 2 - Generic drugs	\$10 <u>copay</u> /30-day supply <u>Deductible</u> does not apply	Not covered	30-day and 90-day supplies at retail; 90-day supplies at mail order. 90-day supply: Requires two 30-day copays.
	Tier 3 - Preferred brand drugs	\$35 <u>copay</u> /30-day supply <u>Deductible</u> does not apply	Not covered	The prescription plan uses Elixir's Select Formulary. The formulary list is available at www.EnvisionRx.com .
	Tier 4 - Non-preferred brand drugs	\$50 <u>copay</u> /30-day supply <u>Deductible</u> does not apply	Not covered	Patient pays cost difference for brand with generic alternative. Cost difference does not apply to <u>out-</u>

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

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

 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)	
				<u>preauthorization</u> , 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

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 1-559-457-3596.

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 <u>deductible</u>	\$250
■ <u>Specialist copayment</u>	\$15
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,520

Managing Joe's type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$250
■ <u>Specialist copayment</u>	\$15
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$135
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$795

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$250
■ <u>Specialist copayment</u>	\$15
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$255
<u>Coinsurance</u>	\$220
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$725