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 Scripps Health Plan Customer Service at **1-844-337-3700 or TTY 1-888-515-4065**. 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.healthcare.gov/sbc-glossary/ or call **1-844-337-3700** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** for Individual or Family	This plan does not have an overall individual or family deductible. See the Common Medical Events Chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	This plan does not have an overall individual or family deductible. See the Common Medical Events Chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes. **$250** for Durable Medical Equipment (DME). **$150** for Hearing Aids. There are no other specific deductibles.	Generally, you must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For Medical **$1,500** individual / **$3,000** family; for Pharmacy **$2,500** individual / **$5,000** 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?	Copayments for certain services, premiums, 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. For a list of plan providers, see https://www.scrippshealthplan.com/physicians/find or call 1-844-337-3700 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. 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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	$20 copay/visit	Not Covered	For other services received during the office visit, additional member cost-share may apply.
	Specialist visit	$35 copay/visit	Not Covered	Preauthorization may be required. If you don't get preauthorization, you may be responsible for the total cost of the service.
	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 needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$0 copay/test	Not Covered	Preauthorization may be required. If you don't get preauthorization, you may be responsible for the total cost of the service.
	Imaging (CT/PET scans, MRIs)	$150 copay/test	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.scrippshealthplan.com or by calling 1-844-337-3700	Generic drugs (Tier 1)	$20 copay/$40 copay prescription (retail & mail order)	Not Covered	Retail: Covers up to a 30-day supply Mail Order: 31-90-day supply Select formulary and non-formulary drugs require preauthorization or step-therapy. Specialty drugs $75 minimum copay/prescription; $250 maximum copay /prescription.
	Preferred brand drugs/High Cost Generic (Tier 2)	$40 copay/$100 copay prescription (retail & mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3)	$80 copay/$225 copay prescription (retail & mail order)	Not Covered	
	Specialty drugs (Tier 4)	30% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay/surgery	Not Covered	SHP network providers only. Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service.
	Physician/surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Emergency Room copay waived if admitted.
	Emergency medical transportation	$150 copay	$150 copay	

[* For more information about limitations and exceptions, see the plan or policy document at http://www.scrippshealthplan.com/.]

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)	
	Urgent care	$40 copay/visit	$40 copay/visit	Preauthorization is required for Urgent Care services provided outside of your assigned medical group. Out- of-network providers are covered only for urgent and emergent services.
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay/admission	Not Covered	Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service. Out- of-network providers are covered only for urgent and emergent services.
	Physician/surgeon fees	No Charge	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit $0 copay/partial hospitalization	Not Covered	Preauthorization for some behavioral health & substance abuse services is required from Evernorth Behavioral Health of California, Inc. If you don't get preauthorization, you may be responsible for the total cost of the service. Visit www.ScrippsHealthPlan.com or call Evernorth Behavioral Health of California, Inc. at 1-888-736-7009.
	Inpatient services	$300 copay/admission	Not Covered	
If you are pregnant	Office visits	No Charge	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). SHP HMO Network Hospitals Only. Out-of-network providers are covered only for emergent labor and delivery.
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	$300 copay/admission	Not Covered	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service.
	Rehabilitation services	$30 copay/visit	Not Covered	Includes physical therapy, speech therapy, and occupational therapy. Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service
	Habilitation services	$30 copay/visit	Not Covered	
	Skilled nursing care	No Charge	Not covered	100 visits/calendar year. Preauthorization is required. If you don't get preauthorization, you

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)	
				may be responsible for the total cost of the service.
	Durable medical equipment	$250 deductible	Not Covered	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service.
	Hospice services	No Charge	Not Covered	Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service.
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
- Dental care
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- 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
- 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: the California Department of Managed Care at **1-888-466-2219** or **http://www.dmhc.ca.gov/**, the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or 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. 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 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: Customer Service at **1-844-337-3700 or TTY 1-888-515-4065**. Additionally, a consumer assistance program can help you file your appeal. The California

[* For more information about limitations and exceptions, see the plan or policy document at http://www.scrippshealthplan.com/.]

Department of Managed Health Care can be reached at **1-888-466-2219** or visit **http://www.healthhelp.ca.gov**.

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 1-844-337-3700]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-337-3700]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-337-3700]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-337-3700]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[* For more information about limitations and exceptions, see the plan or policy document at http://www.scrippshealthplan.com/.]

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	$25
Hospital (facility) copayment	$250
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$320**

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

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) copayment	$250
Other coinsurance	0%

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*	$60
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,120**

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

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) copayment	$250
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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$200
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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.

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