Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
PIH Health: PIH HEALTH (PIH HEALTH EMPLOYEE BENEFIT PLAN) MEDICAL EPO PLAN

Coverage Period: 01/01/2025-12/31/2025
Coverage for: Individual, Family | Plan Type: EPO

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, www.myluminarehealth.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 https://www.healthcare.gov/sbc-glossary or call 1-833-944-1713 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 PIH Health preferred provider: $0 / individual or $0 / family per benefit period. Tier 2 Anthem preferred provider: $1,000 / individual or $2,000 / family per benefit period. Tier 3 nonpreferred provider: Not applicable.	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. Prescription drugs, and the following services by a Tier 1 PIH Health preferred provider and/or Tier 2 Anthem preferred provider: Preventive care, emergency room care, urgent care, hospice services, rehabilitative services, habilitative services, specialist, and primary care physician 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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	Tier 1 PIH Health preferred provider: $3,000 / individual or $6,000 / family per benefit period. Tier 2 Anthem preferred provider: $6,000 / individual or $12,000 / family per benefit period. Tier 3 nonpreferred provider: Not applicable.	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?	Penalties for failure to obtain pre-certification for 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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.anthem.com/ca or call 1-833-944-1713 for a list of preferred providers.	You pay the least if you use a Tier 1 PIH Health preferred provider. You pay more if you use a Tier 2 Anthem preferred provider . You will pay the most if you use a Tier 3 nonpreferred 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 Tier 1 PIH Health preferred provider or provider might use a Tier 3 nonpreferred 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
		Tier 1 PIH Health Provider (You will pay the least)	Tier 2 Anthem Preferred Provider (You will pay more)	Tier 3 Nonpreferred 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 copayment	$30 copayment (deductible does not apply)	Not covered	None.
	Specialist visit	$35 copayment	$45 copayment (deductible does not apply)	Not covered	Chiropractic care limited to 30 visits per benefit period.
	Preventive care / screening / immunization	No charge	No charge (deductible does not apply)	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)	No charge	40% coinsurance	Not covered	None.
	Imaging (CT/PET scans, MRIs)	$100 copayment	40% coinsurance	Not covered	Pre-certification is required for some services. Pre-certification is not required for MRIs, MRAs, and CT scans performed at a Tier 1 PIH Health facility.

* For more information about limitations and exceptions, see the plan or policy document at www.myluminarehealth.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 PIH Health Provider (You will pay the least)	Tier 2 Anthem Preferred Provider (You will pay more)	Tier 3 Nonpreferred 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 www.carelonrx.com or call 1-833-419-0530.	Generic drugs	PIH Health retail: $6 copayment (30 day supply) $12 copayment (31-90 day supply)	CarelonRx retail: $20 copayment (30 day supply) CarelonRx mail order: $40 copayment (90 day supply	Retail: Not covered Mail order: Not covered	Deductible does not apply. Copay applies to a 30 day supply Retail and Specialty drugs or 31-90 day supply Mail-Order prescription. Copay does not apply to preventive drugs required by the Affordable Care Act. The Prescription Drug Plan will pay up to the Tier 1 PIH Health price, less the Tier 1 PIH Health copay, whenever a generic drug is dispensed. If a Tier 2 Anthem or Tier 3 drug is dispensed, and a Tier 1 PIH Health equivalent is available, the covered person must pay the difference between the cost of the Tier 2 Anthem or Tier 3 drug and the Tier 1 PIH Health equivalent, plus the Tier 1 PIH Health copay unless the *physician* specifies "Dispense as Written".
	Preferred drugs	PIH Health retail: $30 copayment (30 day supply) $60 copayment (31-90 day supply)	CarelonRx retail: $45 copayment (30 day supply) CarelonRx mail order: $90 copayment (90 day supply	Retail: Not covered Mail order: Not covered	
	Non-preferred drugs	PIH Health retail: $60 copayment (30 day supply) $120 copayment (31-90 day supply)	CarelonRx retail: $100 copayment (30 day supply) CarelonRx mail order: $200 copayment (90 day supply	Retail: Not covered Mail order: Not covered	
	Specialty drugs	PIH Health retail: 25% coinsurance ($250 max) PIH Health mail order: Not covered	CarelonRx retail: 25% coinsurance ($250 max) CarelonRx mail order: Not covered	Retail: Not covered Mail order: Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copayment	40% coinsurance	Not covered	None.
	Physician/surgeon fees	No charge	40% coinsurance (deductible does not apply)	Not covered	None.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 PIH Health Provider (You will pay the least)	Tier 2 Anthem Preferred Provider (You will pay more)	Tier 3 Nonpreferred Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$150 copayment	Tier 1 PIH Health preferred provider benefit applies (deductible does not apply)	Tier 1 PIH Health preferred provider benefit applies (deductible does not apply)	Copay waived if admitted.
	Emergency medical transportation	No charge	Tier 1 PIH Health preferred provider benefit applies	Tier 1 PIH Health preferred provider benefit applies	None.
	Urgent care	$20 copayment	$30 copayment (deductible does not apply)	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copayment / admission	40% coinsurance	Not covered	Pre-certification is required.
	Physician/surgeon fees	No charge	40% coinsurance (deductible does not apply)	Not covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment Other outpatient services: 0% coinsurance	$20 copayment (deductible does not apply) Other outpatient services: No charge (deductible does not apply)	Office visit: Not covered Other outpatient services: Not covered	None.
	Inpatient services	$250 copayment / admission	40% coinsurance (deductible does not apply)	Not covered	Pre-certification is required.

* For more information about limitations and exceptions, see the plan or policy document at www.myluminarehealth.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 PIH Health Provider (You will pay the least)	Tier 2 Anthem Preferred Provider (You will pay more)	Tier 3 Nonpreferred Provider (You will pay the most)	
If you are pregnant	Office visits	$20 copayment	$30 copayment (deductible does not apply)	Not covered	Dependent daughters are covered for this benefit. Cost sharing does not apply for preventive services. Depending on the type of services, a copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	40% coinsurance (deductible does not apply)	Not covered	
	Childbirth/delivery facility services	$250 copayment / admission	40% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	$30 copayment	$30 copayment (deductible does not apply)	Not covered	Home health care visits limited to 100 visits (4 hours = 1 visit) per benefit period. Pre-certification is required.
	Rehabilitation services	$20 copayment	$30 copayment (deductible does not apply)	Not covered	None.
	Habilitation services	$20 copayment	$30 copayment (deductible does not apply)	Not covered	None.
	Skilled nursing care	No charge	No charge (deductible does not apply)	Not covered	Skilled nursing care limited to 100 days per benefit period. Pre-certification is required.
	Durable medical equipment	No charge	No charge (deductible does not apply)	Not covered	None.
	Hospice services	No charge	No charge (deductible does not apply)	Not covered	Pre-certification is required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None.
	Children's glasses	Not covered	Not covered	Not covered	None.
	Children's dental check-up	Not covered	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 (Adult)
- Infertility treatment
- 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 (Limited to 20 visits per benefit period)
- Bariatric surgery (Only covered at Tier 1 PIH Health facilities)
- Chiropractic care (Limited to 30 visits per benefit period)
- Hearing aids

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 Labor's Employee Benefits Security Administration at 1-866-444-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 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

* For more information about limitations and exceptions, see the plan or policy document at www.myluminarehealth.com.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-833-944-1713.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-833-944-1713.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-944-1713.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-833-944-1713 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-944-1713.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-833-944-1713.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-833-944-1713.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-833-944-1713.

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 (Tier 1 PIH Health preferred provider)**	**$0**
■ **Specialist copayment**	**$35**
■ **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$760**

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

■ **The plan's overall (Tier 1 PIH Health preferred provider)**	**$0**
■ **Specialist copayment**	**$35**
■ **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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
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 (Tier 1 PIH Health preferred provider)**	**$0**
■ **Specialist copayment**	**$35**
■ **Hospital (facility) copayment**	**$250**
■ **Other coinsurance**	**0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

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