



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, call 1-877-789-8488. 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 1-877-789-8488 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$125/individual or \$250/family per <u>plan</u> year.	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> , office visits, and outpatient <u>prescription drugs</u> 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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Medical <u>Plan</u> : <u>Network Provider</u> : \$1,000/individual or \$2,500/family per <u>plan</u> year; <u>Out-of-Network Provider</u> : No <u>out-of-pocket limit</u> . <u>Prescription Drugs</u> : \$1,000/individual or \$2,500/family per <u>plan</u> year	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> ?	Medical <u>Plan</u> <u>Out-of-Pocket Limit</u> : <u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> , acupuncture, chiropractic care, infertility services, outpatient <u>prescription drugs</u> (which have a separate <u>out-of-pocket limit</u>), dental and vision expenses through separate <u>plans</u> , and health care this <u>plan</u> doesn't cover. <u>Prescription drug</u> <u>Out-of-Pocket Limit</u> : <u>Premiums</u> ; <u>balance-billing</u> charges; medical <u>plan</u> , dental <u>plan</u> or vision <u>plan</u> expenses; the difference in price between generic and brand drug costs if a brand drug is filled when a generic is available; penalties for failure to obtain <u>preauthorization</u> ; drugs and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u>?	Call 1-877-789-8488 for a list of <u>network providers</u> . See www.anthem.com or call 1-866-837-4595 for a list of <u>Network Providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay the full cost if you use an <u>out-of-network provider</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>?	Yes. You do not need a <u>referral</u> from the <u>Plan</u> , a <u>Primary Care Provider</u> , or any other person in order to visit a <u>network provider</u> for obstetrical or gynecological care.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (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	\$5 <u>copayment</u> /visit, <u>deductible</u> does not apply	Not covered	None
	<u>Specialist</u> visit	\$5 <u>copayment</u> /visit, <u>deductible</u> does not apply	Not covered	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply.	Not covered	<u>Plan</u> covers required <u>preventive services</u> and supplies described at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/ . Age and frequency guidelines apply to covered <u>preventive care</u> . You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	<u>Referral</u> from <u>primary care physician</u> is required to avoid non-payment. Physician/ <u>provider's</u> professional fees may be billed separately.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	<u>Referral</u> from <u>primary care physician</u> is required to avoid non-payment. Physician/ <u>provider's</u> professional fees may be billed separately. <u>Preauthorization</u> of advanced imaging is required to avoid non-payment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic drugs	Retail (30-day supply): \$5 <u>copayment</u> per prescription; Mail Order (90-day supply): \$10 <u>copayment</u> per prescription. No charge for ACA required generic preventive drugs.	Not covered	• <u>Deductible</u> does not apply. • Some <u>prescription drugs</u> are subject to <u>preauthorization</u> (to avoid non-payment), quantity limits or step therapy requirements. • Certain over-the-counter (OTC) and <u>prescription drugs</u> are payable at no charge with a prescription. • Your <u>cost sharing</u> counts toward the <u>prescription drug out-of-pocket limit</u>, not the medical <u>plan out-of-pocket limit</u>.
	Preferred brand drugs	Retail (30-day supply): \$10 <u>copayment</u> per prescription; Mail Order (90-day supply): \$20 <u>copayment</u> per prescription. No charge for ACA required brand name preventive drugs if a generic is medically inappropriate.	Not covered	
	Non-preferred brand drugs	Retail (30-day supply): \$30 <u>copayment</u> per prescription; Mail Order (90-day supply): \$60 <u>copayment</u> per prescription.	Not covered	
	<u>Specialty drugs</u>	Same <u>copayments</u> as above depending on generic, preferred or non-preferred.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	<u>Referral</u> from <u>primary care physician</u> is required to avoid non-payment.
	Physician/surgeon fees	Surgeon: No charge Physician: \$5 <u>copayment</u> /visit	Not covered	

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		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copayment</u> /visit	\$100 <u>copayment</u> /visit	<u>Copayment</u> waived if admitted to hospital directly from emergency room within 12 hours. You pay 100% for non-emergency medical condition services, even in-network. Professional/physician charges may be billed separately.
	<u>Emergency medical transportation</u>	No charge	Not covered	Non-emergency transportation requires <u>preauthorization</u> to avoid a financial penalty.
	<u>Urgent care</u>	\$40 <u>copayment</u> /visit	Not covered	One combined <u>copayment</u> per date of service applies to all services billed by the facility and physician.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <u>copayment</u> /admission	Not covered	Referral from <u>primary care physician</u> is required to avoid non-payment. <u>Copayment</u> waived if admitted to San Joaquin General Hospital (SJGH). Additional <u>copayment</u> required upon transfer when admitted to a different inpatient facility. Elective inpatient admission requires <u>preauthorization</u> to avoid a financial penalty. Room and board charge is limited to the rate of a semi-private or ICU room. The charge for a private room is based on the hospital's private room or 80% of its lowest daily rate if it does not have semi-private accommodations. Private room payable only if <u>medically necessary</u> .
	Physician/surgeon fees	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: \$5 <u>copayment</u> /visit, <u>deductible</u> does not apply Other Outpatient Services: No charge	Not covered	Partial day care/partial <u>hospitalization copayment</u> waived if admitted to San Joaquin General Hospital.
	Inpatient services	\$100 <u>copayment</u> /admission	Not covered	<u>Copayment</u> waived if admitted to San Joaquin General Hospital (SJGH). Additional <u>copayment</u> required upon transfer when admitted to a different inpatient facility. <u>Preauthorization</u> of elective hospital admission and residential treatment program admission is required to avoid a financial penalty. Room and board charge is limited to the rate of a semi-private or ICU room. The charge for a private room is based on the hospital's private room or 80% of its lowest daily rate if it does not have semi-private accommodations. Private room payable only if <u>medically necessary</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you are pregnant	Office visits	\$5 <u>copayment</u> /visit, <u>deductible</u> does not apply	Not covered	• <u>Cost sharing</u> does not apply for <u>network preventive services</u>. • Depending on the type of services, a <u>copayment</u> or <u>deductible</u> may apply. • Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$100 <u>copayment</u> /admission	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	<u>Plan</u> covers part-time or intermittent <u>skilled nursing care</u> . <u>Referral</u> from <u>primary care physician</u> is required to avoid non-payment. Limited to 60 days per <u>plan</u> year per condition combined with inpatient <u>rehabilitation/ habilitation</u> and <u>skilled nursing care</u> . Services must be in lieu of inpatient <u>hospitalization</u> or inpatient <u>skilled nursing care</u> .
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	Outpatient: \$5 <u>copayment</u> /visit Inpatient: No charge	Not covered	<u>Referral</u> from <u>primary care physician</u> is required to avoid non-payment. Outpatient visits limited to 60 visits per <u>plan</u> year combined for physical, speech and occupational therapies. Elective inpatient admission requires <u>preauthorization</u> to avoid a financial penalty. Inpatient admission is limited to 60 days per <u>plan</u> year per condition combined with <u>home health care</u> and <u>skilled nursing care</u> . Room and board charge is limited to the rate of a semi-private room. The charge for a private room is limited to the facility's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations. Private room payable only if <u>medically necessary</u> .
	<u>Habilitation services</u>	Outpatient: \$5 <u>copayment</u> /visit Inpatient: No charge	Not covered	
	<u>Skilled nursing care</u>	No charge	Not covered	<u>Referral</u> from <u>primary care physician</u> is required to avoid non-payment. Elective inpatient admission requires <u>preauthorization</u> to avoid a financial penalty. Limited to 60 days per <u>plan</u> year per condition combined with <u>home health care</u>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
				and inpatient rehabilitation/habilitation. Room and board charge is limited to the rate of a semi-private room. The charge for a private room is limited to the facility's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations. Private room payable only if <u>medically necessary</u> .
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	Not covered	<u>Referral from primary care physician</u> is required to avoid non-payment. <u>Durable medical equipment</u> of over \$500 requires <u>preauthorization</u> to avoid a financial penalty. No charge from <u>network providers</u> for breastfeeding pump and supplies needed to operate pump.
	<u>Hospice services</u>	No charge	Not covered	Covered if terminally ill only. Requires re-evaluation every 6 months.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	If elected, vision coverage will be available under a separate vision <u>plan</u> .
	Children's glasses	Not covered.	Not covered.	If elected, vision coverage will be available under a separate vision <u>plan</u> .
	Children's dental check-up	Not covered	Not covered	If elected, dental coverage will be available under a separate dental <u>plan</u> .

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)			
- Abortion (except in cases of rape, incest, or when the life of the mother is endangered, if the fetus has a known condition incompatible with life, or when medical complications arise from an abortion) - Bariatric surgery - Cosmetic surgery	- Dental Care (Adult and Child) (available under separate dental <u>plan</u> if elected) - Hearing aids - Long-term care - Non-emergency care when traveling outside the U.S. - Private-duty nursing	- Routine eye care (Adult and Child) (available under separate vision <u>plan</u> if elected) - Weight loss programs (except as required by health reform law, see www.healthcare.gov/coverage/preventive-care-benefits/)	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
- Acupuncture (referral required, limited to 20 visits per <u>plan</u> year combined with chiropractic care, does not count toward <u>Out-of-Pocket Limit</u>) - Chiropractic care (referral required, limited to 20 visits per <u>plan</u> year combined with acupuncture, does not count toward <u>Out-of-Pocket Limit</u>)	Infertility treatment (<u>preauthorization</u> required, limited to 12 cycles of artificial insemination per person per lifetime, does not count toward <u>Out-of-Pocket Limit</u>)	Routine foot care (covered for treating diabetic (metabolic) or peripheral vascular insufficiency only)	

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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight 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: Lucent Health at 1-877-789-8488, or the San Joaquin County Human Resources Division at 1-209-468-9987.

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 1-877-789-8488.

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>	\$125
■ <u>Specialist copayment</u>	\$5
■ Hospital (SJGH facility) <u>copayment</u>	\$0
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$125
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$195

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>	\$125
■ <u>Specialist copayment</u>	\$5
■ Hospital (SJGH facility) <u>copayment</u>	\$0
■ Other <u>coinsurance</u>	50%

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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$120
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$640

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$125
■ <u>Specialist copayment</u>	\$5
■ Hospital (facility) ER <u>copayment</u>	\$100
■ Other <u>coinsurance</u>	50%

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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$125
<u>Copayments</u>	\$150
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$275