



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 including your plan's Plan document, 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 www.cciio.cms.gov or call 1-844-344-8413 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	Not applicable.	This <u>plan</u> does not have a <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this <u>plan</u>?	Medical <u>Plan</u> : <u>Network Provider</u> : \$1,000 /individual per <u>plan</u> year; <u>Out-of-Network Provider</u> : No <u>out-of-pocket limit</u> . <u>Prescription drugs</u> : No <u>out-of-pocket limit</u> .	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 out-of-pocket limit?	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> , infertility services, outpatient <u>prescription drugs</u> , dental and vision expenses through separate <u>plans</u> , 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> .
Will you pay less if you use a <u>network provider</u>?	Yes. Call 1-877-789-8488 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> .

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 provider's office or clinic	Primary care visit to treat an injury or illness	\$5 <u>copayment</u> /visit.	Not covered.	None.
	<u>Specialist</u> visit	\$5 <u>copayment</u> /visit.	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>	Immunization: \$25 <u>copayment</u> /visit Physical exam office visit: \$5 <u>copayment</u> /visit.	Not covered.	Not all services that are considered <u>preventive services</u> by the health reform law are covered by this <u>Plan</u> . Age and frequency guidelines apply to covered <u>preventive care</u> . May include tests and services described elsewhere in the SBC (i.e., diagnostic tests).
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</u> 's professional fees for interpretations of covered <u>diagnostic tests</u> may be billed separately.
	Imaging (CT/PET scans, MRIs)	No charge.	Not covered.	<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 or 1-866-475-0056.	Generic drugs	Retail (30-day supply): \$7 <u>copayment</u> per prescription; Mail Order (90-day supply): \$14 <u>copayment</u> per prescription. No charge for FDA-approved generic contraceptives.	Not covered.	<ul style="list-style-type: none"> 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. If you purchase a brand drug when a generic drug is available you pay the 100% of the cost of the brand drug, even in-<u>network</u>. Your <u>cost sharing</u> does not count toward the medical <u>plan out-of-pocket limit</u>.
	Preferred brand drugs	Retail (30-day supply): \$15 <u>copayment</u> per prescription; Mail Order (90-day supply): \$30 <u>copayment</u> per prescription. No charge for FDA-approved brand name contraceptives if a generic is medically inappropriate.	Not covered.	
	Non-preferred brand drugs	Retail (30-day supply): \$35 <u>copayment</u> per prescription; Mail Order (90-day supply): \$70 <u>copayment</u> per prescription.	Not covered.	
	<u>Specialty drugs</u>	You pay the same <u>cost sharing</u> as noted above for generic, preferred brand, and non-preferred brand drugs.	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge.	Not covered.	<u>Referral</u> from a <u>primary care physician</u> is required to avoid non-payment. <u>Preauthorization</u> required to avoid non-payment.
	Physician/surgeon fees	No charge	Not covered.	

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 immediate medical attention	<u>Emergency room care</u>	\$40 <u>copayment</u> /visit.	\$40 <u>copayment</u> /visit.	<u>Copayment</u> waived if admitted within 12 hours as an inpatient into the treating hospital directly from the <u>emergency room</u> .
	<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>	\$20 <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.	<u>Copayment</u> waived if admitted within 12 hours as an inpatient into the treating hospital directly from the emergency room, or in cases of emergency. <u>Preauthorization</u> of hospital admission is required to avoid non-payment. 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. Other outpatient services: No charge.	Not covered.	None.
	Inpatient services	\$100 <u>copayment</u> /admission	Not covered.	<u>Copayment</u> waived if admitted within 12 hours as an inpatient directly from the emergency room or in cases of emergency. <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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	\$5 <u>copayment</u> /visit.	Not covered.	<ul style="list-style-type: none"> Depending on the type of services, a <u>copayment</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). <p><u>Preauthorization</u> is required to avoid a financial penalty only if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section. Private room payable only if <u>medically necessary</u> or the hospital only has private rooms.</p>
	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.	<p><u>Preauthorization</u> required to avoid non-payment. <u>Plan</u> covers part-time or intermittent <u>skilled nursing care</u>. Limited to 60 days per <u>plan</u> year per condition combined with <u>skilled nursing care</u>. Services must be in lieu of inpatient <u>hospitalization</u> or inpatient <u>skilled nursing care</u>. Includes medical supplies and related pharmaceutical and laboratory services to the extent that benefits would have been provided had the you remained in the Hospital.</p>
	<u>Rehabilitation services</u>	Outpatient: \$5 <u>copayment</u> /visit. Inpatient: No Charge.	Not covered.	<p><u>Preauthorization</u> required to avoid non-payment. <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. 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>.</p>
	<u>Habilitation services</u>	Outpatient: \$5 <u>copayment</u> /visit. Inpatient: No Charge.	Not covered.	<p>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>.</p>

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 help recovering or have other special health needs	<u>Skilled nursing care</u>	No charge.	Not covered.	<u>Preauthorization</u> of <u>skilled nursing</u> facility admission is required to avoid non-payment. Maximum benefit is 60 days per <u>Plan</u> year per condition. Benefit maximum is combined with the <u>home health care</u> benefit maximum. 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>Durable medical equipment</u> of over \$500 requires <u>preauthorization</u> to avoid a financial penalty.
	<u>Hospice services</u>	No charge.	Not covered.	Covered in 6 month increments if terminally ill.
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 you elect vision coverage, it will be available under a separate vision <u>plan</u> .
	Children's dental check-up	Not covered.	Not covered.	If you elect dental coverage, it will be available under separate dental <u>plan</u> options.

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.)

- 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)
- Acupuncture
- Bariatric Surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult and child) (payable under separate dental plan 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) (payable under separate vision plan if elected)
- Weight loss programs, except for weight control counseling and nutritional counseling with preauthorization

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

- Infertility treatment (preauthorization required, limited to 12 cycles of artificial insemination per person per lifetime, does not count toward Out-of-Pocket Limit)
- 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 <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$5
■ Hospital (facility) <u>copayment</u>	\$100
■ Other <u>copayment</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>	\$0
<u>Copayments</u>	\$160
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$220

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$5
■ Hospital (facility) <u>copayment</u>	\$100
■ 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>	\$0
<u>Copayments</u>	\$740
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$40
The total Joe would pay is	\$780

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$5
■ Hospital (facility) <u>copayment</u>	\$40
■ 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>	\$0
<u>Copayments</u>	\$90
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$90

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