**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 plan covers. |
| **Are there services covered before you meet your deductible?** | Not applicable. | This plan does not have a deductible. |
| **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?** | Medical Plan: Network Provider: **$1,000**/individual per plan year; Out-of-Network Provider: No out-of-pocket limit.<br>Prescription drugs: No out-of-pocket limit. | 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?** | Medical Plan Out-of-Pocket Limit: Premiums, balance-billing charges, penalties for failure to obtain preauthorization, infertility services, outpatient prescription drugs, dental and vision expenses through separate plans, 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. Call 1-877-789-8488 for a list of network providers. | This plan uses a provider network. You will pay the full cost if you use an out-of-network provider. 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. You do not need a referral from the Plan, a Primary Care Provider, or any other person in order to visit a network provider for obstetrical or gynecological care. | 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. |

| 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 | $5 copayment/visit. | Not covered. | None. |
| | Specialist visit | $5 copayment/visit. | Not covered. | 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. |
| | Preventive care/screening/ immunization | Immunization: $25 copayment/visit<br>Physical exam office visit: $5 copayment/visit. | Not covered. | Not all services that are considered preventive services by the health reform law are covered by this Plan. Age and frequency guidelines apply to covered preventive care. May include tests and services described elsewhere in the SBC (i.e., diagnostic tests). |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge. | Not covered. | Referral from primary care physician is required to avoid non-payment. Physician/provider's professional fees for interpretations of covered diagnostic tests may be billed separately. |
| | Imaging (CT/PET scans, MRIs) | No charge. | Not covered. | Preauthorization 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 |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network 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.caremark.com or 1-866-475-0056. | Generic drugs | Retail (30-day supply): $7 copayment per prescription; Mail Order (90-day supply): $14 copayment per prescription. No charge for FDA-approved generic contraceptives. | Not covered. | • Some prescription drugs are subject to preauthorization (to avoid non-payment), quantity limits or step therapy requirements.<br>• Certain over-the-counter (OTC) and prescription drugs are payable at no charge with a prescription.<br>• 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-network.<br>• Your cost sharing does not count toward the medical plan out-of-pocket limit. |
| | Preferred brand drugs | Retail (30-day supply): $15 copayment per prescription; Mail Order (90-day supply): $30 copayment 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 copayment per prescription; Mail Order (90-day supply): $70 copayment per prescription. | Not covered. | |
| | Specialty drugs | You pay the same cost sharing as noted above for generic, preferred brand, and non-preferred brand drugs. | Not covered. | Specialty Drugs are only available from the CVS Caremark Specialty Pharmacy. Specialty drugs require preauthorization (to avoid non-payment) by calling CVS Caremark at 1-800-626-3046. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge. | Not covered. | Referral from a primary care physician is required to avoid non-payment. Preauthorization 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** | Emergency room care | $40 copayment/visit. | $40 copayment/visit. | Copayment waived if admitted within 12 hours as an inpatient into the treating hospital directly from the emergency room. |
| | Emergency medical transportation | No charge. | Not covered. | Non-emergency transportation requires preauthorization to avoid a financial penalty. |
| | Urgent care | $20 copayment/visit. | Not covered. | One combined copayment 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 copayment/admission. | Not covered. | Copayment waived if admitted within 12 hours as an inpatient into the treating hospital directly from the emergency room, or in cases of emergency. Preauthorization 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 medically necessary. |
| | Physician/ surgeon fees | No charge. | Not covered. | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office visits: $5 copayment/visit. Other outpatient services: No charge. | Not covered. | None. |
| | Inpatient services | $100 copayment/admission | Not covered. | Copayment waived if admitted within 12 hours as an inpatient directly from the emergency room or in cases of emergency. Preauthorization 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 medically necessary. |

| 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 copayment/visit. | Not covered. | • Depending on the type of services, a copayment may apply.<br>• Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth delivery professional services | No charge. | Not covered. | Preauthorization 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 medically necessary or the hospital only has private rooms. |
| | Childbirth delivery facility services | $100 copayment/admission. | Not covered. | |
| **If you need help recovering or have other special health needs** | Home health care | No charge | Not covered. | Preauthorization required to avoid non-payment. Plan covers part-time or intermittent skilled nursing care.<br>Limited to 60 days per plan year per condition combined with skilled nursing care. Services must be in lieu of inpatient hospitalization or inpatient skilled nursing care. 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. |
| | Rehabilitation services | Outpatient:<br>$5 copayment/visit.<br>Inpatient:<br>No Charge. | Not covered. | Preauthorization required to avoid non-payment. Referral from primary care physician is required to avoid non-payment. Outpatient visits limited to 60 visits per plan year combined for physical, speech and occupational therapies. Inpatient admission is limited to 60 days per plan year per condition combined with home health care and skilled nursing care. 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 medically necessary. |
| | Habilitation services | Outpatient:<br>$5 copayment/visit.<br>Inpatient:<br>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 help recovering or have other special health needs** | Skilled nursing care | No charge. | Not covered. | Preauthorization of skilled nursing facility admission is required to avoid non-payment. Maximum benefit is 60 days per Plan year per condition. Benefit maximum is combined with the home health care 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 medically necessary. |
| | Durable medical equipment | 50% coinsurance. | Not covered. | Durable medical equipment of over $500 requires preauthorization to avoid a financial penalty. |
| | Hospice services | 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 plan. |
| | Children's glasses | Not covered. | Not covered. | If you elect vision coverage, it will be available under a separate vision plan. |
| | Children's dental check-up | Not covered. | Not covered. | If you elect dental coverage, it will be available under separate dental plan 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 in 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 plan's overall deductible** **$0**
- **Specialist copayment** **$5**
- **Hospital (facility) copayment** **$100**
- **Other copayment** **$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 | $160 |
| Coinsurance | $0 |
| *What isn't covered* | |
| 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 plan's overall deductible** **$0**
- **Specialist copayment** **$5**
- **Hospital (facility) copayment** **$100**
- **Other coinsurance** **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** |
|---|---|

**In this example, Joe would pay:**

| *Cost sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $740 |
| Coinsurance | $0 |
| *What isn't covered* | |
| 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 plan's overall deductible** **$0**
- **Specialist copayment** **$5**
- **Hospital (facility) copayment** **$40**
- **Other coinsurance** **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** |
|---|---|

**In this example, Mia would pay:**

| *Cost sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $90 |
| Coinsurance | $0 |
| *What isn't covered* | |
| 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.