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 deductible?	San Joaquin General Hospital (SJGH) Network: **$125**/individual or **$250**/family per plan year. Select Network (including SJGH): **$250**/individual or **$500**/family per plan year.	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. Preventive care, office visits, and outpatient prescription drugs 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?	Medical Plan: Network Provider: **$1,000**/individual or **$2,500**/family per plan year; Out-of-Network Provider: No out-of-pocket limit. Prescription Drugs: **$1,000**/individual or **$2,500**/family per plan year	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, acupuncture, chiropractic care, infertility services, outpatient prescription drugs, dental and vision expenses through separate plans, and health care this plan doesn't cover. Prescription drug Out-of-Pocket Limit: Premiums; balance-billing charges; medical plan, dental plan or vision plan 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 preauthorization; drugs 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. Call 1-877-789-8488 for a list of network providers. Network Providers are available within the California counties of San Joaquin, Sacramento and Stanislaus only.	You pay the least if you use a provider in the San Joaquin General Hospital and Associated Physicians (SJGH) Network. You pay more if you use a provider in the Select 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. 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.

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
		SJGH Network Provider (You will pay the least)	Select 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, deductible does not apply	$10 copayment/visit, deductible does not apply	Not covered	Primary care visit will be covered at an out-of-network provider for an emergency medical condition will be covered, subject to the Select Network Provider cost sharing, plus you pay any balance billing amount charged by an out-of-network provider.
	Specialist visit	$5 copayment/visit, deductible does not apply	$10 copayment/visit, deductible does not apply	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	No charge, deductible does not apply.	No charge, deductible does not apply.	Not covered	Plan covers required preventive services and supplies described at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/. Age and frequency guidelines apply to covered preventive care. 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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SJGH Network Provider (You will pay the least)	Select Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	Not covered	Referral from primary care physician is required to avoid non-payment. Physician/provider's professional fees may be billed separately.
	Imaging (CT/PET scans, MRIs)	No charge	No charge	Not covered	Referral from primary care physician is required to avoid non-payment. Physician/provider's professional fees may be billed separately. Preauthorization of advanced imaging is required to avoid non-payment.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	Retail (30-day supply): $5 copayment per prescription; Mail Order (90-day supply): $10 copayment per prescription. No charge for ACA required generic preventive drugs.		Not covered	• Deductible does not apply. • Some prescription drugs are subject to preauthorization (to avoid non-payment), quantity limits or step therapy requirements. • Certain over-the-counter (OTC) and prescription drugs 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-network. • Your cost sharing counts toward the prescription drug out-of-pocket limit, not the medical plan out-of-pocket limit. • Specialty Drugs are only available from the CVS Caremark Specialty Pharmacy.
	Preferred brand drugs	Retail (30-day supply): $15 copayment per prescription; Mail Order (90-day supply): $30 copayment per prescription. No charge for ACA required brand name preventive drugs if a generic is medically inappropriate.		Not covered	
	Non-preferred brand drugs	Not covered		Not covered	
	Specialty drugs	Same copayments 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	No charge	Not covered	Referral from primary care physician is required to avoid non-payment.
	Physician/ surgeon fees	Surgeon: No charge Physician: $5 copayment/visit	Surgeon: No charge Physician: $10 copayment/visit	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SJGH Network Provider (You will pay the least)	Select 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	$100 copayment/visit	$100 copayment/ visit, plus you pay any balance billing amount charged by an out-of-network provider.	Copayment 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.
	Emergency medical transportation	No charge	No charge	Not covered	Non-emergency transportation requires preauthorization to avoid a financial penalty.
	Urgent care	$40 copayment/visit	$40 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)	No charge	$100 copayment/ admission	Not covered	Elective inpatient admission requires preauthorization, referral from primary care physician, to avoid a financial penalty. Additional copayment may be required upon transfer when admitted to a different inpatient facility. Room and board limited to the rate of a semi-private or ICU room. Medically necessary private room rate is hospital's private room or 80% of its lowest daily rate if no semi-private room.
	Physician/ surgeon fees	No charge	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse service	Outpatient services	Office Visits: $5 copayment/ visit, deductible does not apply. Other outpatient services: No charge	Office Visits: $10 copayment/visit, deductible does not apply. Other outpatient services: No charge	Not covered	None
	Inpatient services	No charge	$100 copayment/ admission	Not covered	Preauthorization of elective hospital admission & residential treatment program admission is required to avoid a financial penalty. Additional copayment may be required upon transfer when admitted to a different inpatient facility. Room and board limited to the rate of a semi-private or ICU room. Medically necessary private room rate is hospital's private room or 80% of its lowest daily rate if no semi-private room.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SJGH Network Provider (You will pay the least)	Select 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, deductible does not apply	$10 copayment/visit, deductible does not apply	Not covered	• Cost sharing does not apply for preventive services. • Depending on the type of services, a copayment or deductible may apply. • Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	No charge	Not covered	
	Childbirth/ delivery facility services	No charge	$100 copayment/ admission	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. Additional copayment may be required upon transfer when admitted to a different inpatient facility. Private room payable only if medically necessary or the hospital only has private rooms.
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Not covered	Plan covers part-time or intermittent skilled nursing care. Referral from primary care physician is required to avoid non-payment. Limited to 60 days per plan year per condition combined with inpatient rehabilitation/ habilitation and skilled nursing care. Services must be in lieu of inpatient hospitalization or inpatient skilled nursing care.
	Rehabilitation services	Outpatient: $10 copayment/visit Inpatient: No charge	Outpatient: $10 copayment/visit Inpatient: No charge	Not covered	Elective inpatient admission requires preauthorization to avoid a financial penalty. 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 limited to the rate of a semi-private or ICU room. Medically necessary private room rate is hospital's private room or 80% of its lowest daily rate if no semi-private room.
	Habilitation services	Outpatient: $10 copayment/visit Inpatient: No charge	Outpatient: $10 copayment/visit Inpatient: No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SJGH Network Provider (You will pay the least)	Select 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	No charge	Not covered	Elective inpatient admission requires preauthorization to avoid a financial penalty. Referral from primary care physician is required to avoid non-payment. Limited to 60 days per plan year per condition combined with home health care and inpatient rehabilitation/habilitation. Room and board limited to the rate of a semi-private or ICU room. Medically necessary private room rate is hospital's private room or 80% of its lowest daily rate if no semi-private room.
	Durable medical equipment	50% coinsurance	50% coinsurance	Not covered	Referral from primary care physician is required to avoid non-payment. Durable medical equipment of over $500 requires preauthorization to avoid a financial penalty. No charge from network providers for breastfeeding pump and supplies needed to operate pump.
	Hospice services	No charge	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.	Not covered	If elected, vision coverage will be available under a separate vision plan.
	Children's glasses	Not covered.	Not covered.	Not covered.	If elected, vision coverage will be available under a separate vision plan.
	Children's dental check-up	Not covered	Not covered	Not covered	If elected, dental coverage will be available under a separate dental plan.

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)
- Bariatric surgery
- Cosmetic surgery
- Dental Care (Adult and Child) (available under separate dental plan if elected)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-preferred brand drugs
- Private-duty nursing
- Routine eye care (Adult and Child) (available under separate vision plan 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 plan document.)

- Acupuncture (referral required, limited to 20 visits per plan year combined with chiropractic care, does not count toward Out-of-Pocket Limit)
- Chiropractic care (referral required, limited to 20 visits per plan year combined with acupuncture, does not count toward Out-of-Pocket Limit)
- Infertility services (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** **$125**
- **Specialist (SJGH provider) copayment** **$5**
- **Hospital (SJGH facility) copayment** **$0**
- **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	$125
Copayments	$10
Coinsurance	$0
What isn't covered	
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 deductible** **$125**
- **Specialist (SJGH provider) copayment** **$5**
- **Hospital (SJGH facility) copayment** **$0**
- **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	$120
Copayments	$650
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$790**

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

- **The plan's overall deductible** **$125**
- **Specialist (SJGH provider) copayment** **$5**
- **Hospital (SJGH facility) ER 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	$125
Copayments	$110
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$235**

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