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 see JMH.lucenthealth.com or call 1-877-214-2106. 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 1-877-214-2106 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers **$0** individual / **$0** family Out-of-network providers **Not covered**	N/A
Are there services covered before you meet your deductible?	N/A	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?	Network providers **$750** individual / **$1,500** family Out-of-network providers **Not covered**	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?	Premiums, balance-billing charges, penalties, 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. See John Muir Health Proprietary Network for a list of participating providers or call 1-877-214-2106.	This plan uses a provider network. You will pay less if you use a provider in the plan's 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?	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
		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	$15 copay	Not covered	Teladoc services available. See ID Card.
	Specialist visit	$15 copay	Not covered	None
	Preventive care/screening/ immunization	No charge	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	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Preauthorization may be required. Failure to obtain preauthorization could result in benefit being reduced by 50%.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** see your ID card	Generic drugs	31-day Supply: $7 copay/prescription 90-day Supply: $14 copay/prescription	Use of a Non-participating pharmacy requires payment for the prescription up front. The participant may then submit a claim reimbursement form with a receipt to Optum Rx for reimbursement. Reimbursement for covered prescription drugs will be based on the lowest contracted amount of a participating pharmacy minus any applicable deductible and/or retail copay shown in this schedule.	Covers up to a 31-day supply (retail prescription); up to 90-day supply (mail order prescription). Prescription Drugs recommended by the HRSA or USPSTF will be covered at 100% as required by ACA. Specialty drugs are limited to a 30-day supply, retail only.
	Preferred brand drugs	31-day Supply: $15 copay/prescription 90-day Supply: $30 copay/prescription		
	Non-preferred brand drugs	31-day Supply: $25 copay/prescription 90-day Supply: $50 copay/prescription		
	Specialty drugs	30-day Supply: Applicable Tier Copay as listed above		

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay; per admission	Not covered	Preauthorization may be required. Failure to obtain preauthorization could result in benefit being reduced by 50%.
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	$65 copay		Copay waived if admitted.
	Emergency medical transportation	No charge		None
	Urgent care	$40 copay	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay; per admission	Not covered	Preauthorization may be required. Failure to obtain preauthorization could result in benefit being reduced by 50%.
	Physician/surgeon fees	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $15 copay All other Outpatient: No charge	Not covered	None
	Inpatient services	$100 copay; per admission	Not covered	Preauthorization may be required. Failure to obtain preauthorization could result in benefit being reduced by 50%.
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, cost-sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay to avoid a 50% penalty.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$100 copay; per admission	Not covered	

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

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	Home health care	No charge	Not covered	Preauthorization may be required. Failure to obtain preauthorization could result in benefit being reduced by 50%. Limited to 100 visits per calendar year.
	Rehabilitation services	$15 copay	Not covered	None
	Habilitation services	$15 copay	Not covered	
	Skilled nursing care	$100 copay; per admission	Not covered	Preauthorization may be required. Failure to obtain preauthorization could result in benefit being reduced by 50%. Limited to 100 days per calendar year.
	Durable medical equipment	No charge	Not covered	Preauthorization may be required. Failure to obtain preauthorization could result in benefit being reduced by 50%.
	Hospice services	No charge	Not covered	Preauthorization may be required. Failure to obtain preauthorization could result in benefit being reduced by 50%.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Routine screenings covered as defined under the Patient Protection and Affordable Care Act of 2010.
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Routine screenings covered as defined under the Patient Protection and Affordable Care Act of 2010.

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)
- 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 $15 copay(limited to 45 visits per calendar year combined with Chiropractic Care)
- Bariatric Surgery
- Chiropractic Care $15 copay(limited to 45 visits per calendar year combined with Acupuncture)
- Hearing Aids (limited to $5,000 per calendar year)
- Infertility Treatment (limited to three treatments per lifetime

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

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. 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: the plan at John Muir Health Health Plan c/o Lucent Health Solutions, LLC at 10860 Gold Center Drive, Suite 225, Rancho Cordova, CA 95670-6068 or call 1-800-331-5301. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and http://www.cms.gov/CCIO/Resources/Consumer-Assistance-Grants.

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 1-877-214-2106

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-877-214-2106

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-214-2106

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-877-214-2106 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-214-2106

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-877-214-2106

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-877-214-2106

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-877-214-2106

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 copay	**$15**
Hospital (facility) copay	**$100**
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	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$160**

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 copay	**$15**
Hospital (facility) copay	**$100**
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	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$520**

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

The plan's overall deductible	**$0**
Specialist copay	**$15**
Hospital (facility) copay	**$100**
Other coinsurance	**0%**

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	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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