
 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 1-559-274-4700 ext. 63103 or www.centralunified.org. 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 1-559-274-4700 ext. 63103 or www.centralunified.org to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Medical Benefits: \$4,000 / person \$8,000 / family	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 services ; outpatient surgery; prescription drugs; co-pays, diagnostic tests, hearing exams & aids, physician visits.	This plan covers items and services without meeting a deductible . But a copayment or coinsurance may apply. For example, this plan 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?	Yes. Pharmacy Benefits: \$1,000 / person \$2,000 / family	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical Benefits: \$5,000 / person \$10,000 / family Pharmacy Benefits: \$1,600 / person \$3,200 / family	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, and health care this plan doesn't cover. Rx copays , expenses in excess of non-Network UCR, non-Essential Health Benefits, and penalties for non-compliance with Utilization Management.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.netbyd.com for a list of In-Network Providers.</p>	<p>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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without permission from this plan.</p>

 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
		Preferred 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	\$60 copay / visit for first three visits, then 30% coinsurance	Not covered	Exam only
	Specialist visit	\$60 copay / visit for first three visits, then 30% coinsurance	Not covered	Exam only
	Preventive care/screening/immunization	No charge		Recommended frequency based on nationally required guidelines
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	Pre-authorization required for any single procedure exceeding \$350 or benefits reduced by 50%.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	Pre-authorization required or benefits reduced by 50%.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred 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.optumrx.com	Generic drugs	Retail: \$11 copay / prescription. Mail Order: \$22 copay / prescription.	Not covered	Retail: 34-day supply Mail order drugs are available in up to a 90-day supply with 1 Copay. The Plan requires that maintenance medications be obtained only through the Caremark mail order option or the Maintenance Choice Option at CVS Pharmacies after 2 fills at a retail pharmacy. If you are taking a brand-name drug, have not tried a generic form in the last 24 months and your doctor has not received prior approval for the brand-name drug, then your drug may not be covered by this Plan.
	Preferred brand drugs	Retail: \$35 copay / prescription. Mail Order: \$70 copay / prescription.	Not covered	
	Non-preferred brand drugs	Retail: \$55 copay / prescription. Mail Order: \$90 copay / prescription.	Not covered	
	Non-Formulary Drug	\$100 copay / prescription (retail/mail order)	Not covered	
	Specialty drugs	\$100 copay / prescription (retail/mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	None
	Physician/surgeon fees	30% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	\$100 copay , then 30% coinsurance		Copay waived if admitted.
	Emergency medical transportation	30% coinsurance	Not covered	None
	Urgent care	30% coinsurance	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	Pre-authorization required or additional \$250 copay /admission
	Physician/surgeon fees	30% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, substance abuse or behavioral health	Outpatient services	\$60 copay / visit for first three visits, then 30% coinsurance	Not covered	Exam only
	Inpatient services	30% coinsurance	Not covered	Pre-authorization required or additional \$250 copay /admission
If you are pregnant	Office visits	\$60 copay / visit for first three visits, then 30% coinsurance	Not covered	Cost sharing does not apply to certain preventive services .
	Childbirth/delivery professional services	30% coinsurance	Not covered	No pre-authorization is required for 48 hours following a vaginal delivery and 96 hours following a cesarean delivery. If exceeds those hours, then pre-authorization required for mother and newborn or no benefits payable for noncompliance.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	Limited to 100 visits calendar year. Visit equals 4 hours or less. Pre-authorization required. No benefits payable for noncompliance.
	Rehabilitation services	30% coinsurance	Not covered	Proof of Medical Necessity required following 30 days of therapy without surgery and following 90 days of therapy with surgery
	Habilitation services	30% coinsurance	Not covered	
	Skilled nursing care	30% coinsurance	Not covered	Limited to 60 days / calendar year.
	Durable medical equipment	30% coinsurance	Not covered	Requires pre-authorization for DME rentals and DME purchases over \$500 or no additional benefit.
	Hospice services	30% coinsurance	Not covered	Limited to \$10,000 / lifetime
If your child needs dental or eye care	Children's eye exam	\$15 copay / visit	Not covered	Not covered
	Children's glasses	No cost for standard lenses w/ eye size < 61 mm	Not covered	Not covered
	Children's dental check-up	1 st year: 30% coinsurance 2 nd year: 20% coinsurance 3 rd year: 10% coinsurance 4 th year: No charge		Maximum \$1,250 / calendar year

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](#).)

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| <ul style="list-style-type: none">• Bariatric surgery• Cosmetic surgery• Glasses• Infertility treatment | <ul style="list-style-type: none">• Long term care• Non-emergency care when traveling outside the U.S.• Private duty nursing | <ul style="list-style-type: none">• Routine eye care• Routine foot care• Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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| <ul style="list-style-type: none">• Acupuncture (pain management only)• Chiropractic care | <ul style="list-style-type: none">• Hearing aids (\$1,000 in any 5-year period)• Routine dental care |
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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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. 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 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: Advantek Benefit Administrators, 1180 E. Shaw, Suite 225, Fresno, CA 93710, 1-866-566-7655 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-888-997-7717

—————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	\$4,000
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	\$12,840
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,410
Copayments	\$0
Coinsurance	\$2,590
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,060

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$4,000
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	\$7,460
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,700
Copayments	\$1,400
Coinsurance	\$560
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$4,720

Mia's Simple Fracture

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

■ The plan's overall deductible	\$4,000
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	\$2,010
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,520
Copayments	\$180
Coinsurance	\$490
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,510