



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 1-888-312-2221 (TTY 711) or visit us at www.caloptima.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 healthcare.gov/sbc-glossary or call 1-888-312-2221 (TTY 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$200 individual / \$400 family Per calendar 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. Family, physician, and specialist office visits, preventive care , and other services not subject to 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 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 ?	\$3,000 individual / \$6,000 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.	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 www.caloptima.org or call 1-888-312-2221 (TTY 711) for a list of network providers .	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 ?	Yes. Prior Authorization is Required.*	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
		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	Not covered	None
	Specialist visit	\$8 copayment /visit; deductible does not apply	Not covered	Referral is required.
	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 you need are preventive. Then check what your plan will pay for.*
If you have a test	Diagnostic test (x-ray, blood work)	\$10 copayment /visit (blood work); deductible does not apply \$10 copayment /visit (x-ray); deductible does not apply	Not covered	Physician order is Required. Prior Authorization is Required.*
	Imaging (CT/PET scans, MRIs)	\$50 copayment /visit; deductible does not apply	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caloptima.org .	Tier 1 - Most Generics	\$3 copayment up to 30-day supply per prescription/ \$9 copayment up to 90-day supply per prescription (retail/mail order); deductible does not apply	Not covered	Up to 90-day supply for Retail Pharmacy and Mail Order except where quantity limits apply. Prior authorization is required for select drugs.
	Tier 2 -Preferred brand drugs	\$10 copayment up to 30-day supply per prescription/ \$30 copayment up to 90-day supply per prescription (retail/mail order); deductible does not apply	Not covered	
	Tier 3 - Non-preferred brand drugs	\$15 copayment up to 30-day supply per	Not covered	

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.caloptima.org.

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)	
		prescription/ \$45 copayment up to 90-day supply per prescription (retail/mail order); deductible does not apply		
	Tier 4 - Specialty drugs	10% coinsurance up to \$150 per prescription (retail/mail order); deductible does not apply	Not covered	Up to 30-day supply for Retail Pharmacy and Mail Order except where quantity limits apply. Prior authorization is required for select drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance /visit; deductible does not apply	Not covered	Prior Authorization is Required.*
	Physician/surgeon fees	10% coinsurance /visit; deductible does not apply	Not covered	None
If you need immediate medical attention	Emergency room care	\$50 copayment /visit; deductible does not apply No charge (ER Physician); deductible does not apply	\$50 copayment /visit; deductible does not apply No charge (ER Physician); deductible does not apply	Copayment waived if admitted into the hospital. Out-of-network services must meet the criteria for emergency care.
	Emergency medical transportation	\$30 copayment /transport; deductible does not apply	\$30 copayment /transport; deductible does not apply	Out-of-network services must meet the criteria for emergency care.
	Urgent care	\$5 copayment /visit; deductible does not apply	\$5 copayment /visit; deductible does not apply	Out-of-network Urgent care services are covered while you are out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance /visit; deductible applies	Not covered	Prior Authorization is Required.
	Physician/surgeon fees	10% coinsurance /visit; deductible does not apply	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$5 copayment /visit (office visit); deductible does not apply \$5 copayment /visit (other than office visit); deductible does not apply	Not covered	Depending on the type of services Prior Authorization may be required.*
	Inpatient services	10% coinsurance /visit; deductible applies	Not covered	Prior Authorization is Required.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.caloptima.org.

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	No charge (Prenatal); deductible does not apply \$5 copayment /visit (Postnatal); deductible does not apply	Not covered	Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% coinsurance /visit; deductible does not apply	Not covered	Coverage includes abortion services. Cost sharing does not apply for abortion services.
	Childbirth/delivery facility services	10% coinsurance /visit; deductible applies	Not covered	Coverage includes abortion services. Cost sharing does not apply for abortion services.
If you need help recovering or have other special health needs	Home health care	\$3 copayment /visit; deductible does not apply	Not covered	Up to a maximum of 100 visits per Calendar Year per Member by home health care agency providers. Prior Authorization is Required.*
	Rehabilitation services	\$5 copayment /visit; deductible does not apply	Not covered	Prior Authorization is Required.* Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	\$5 copayment /visit; deductible does not apply	Not covered	Prior Authorization is Required.*
	Skilled nursing care	10% coinsurance /visit; deductible applies	Not covered	Up to a maximum of 100 days per Calendar Year per Member. Prior Authorization is Required.*
	Durable medical equipment	10% coinsurance /visit; deductible does not apply	Not covered	Prior Authorization is Required.* Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No charge	Not covered	Prior Authorization is Required.*
If your child needs dental or eye care	Children's Eye exam	No charge	Not covered	1 visit per calendar year*
	Children's Glasses	No charge	Not covered	1 pair of glasses per year (or contact lenses in lieu of glasses).*
	Children's Dental check-up	No charge	Not covered	Oral exam and preventive cleaning limited to 1 every 6 months. See your plan document for additional information about services.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.caloptima.org.

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](#).)

- | | | |
|---------------------------------|--|---|
| • Adult Routine Dental Services | • Long-term care/Custodial Nursing Care | • Routine foot care |
| • Adult Vision Services | • Non-emergency care when traveling outside the U.S. | • Surrogate Pregnancy |
| • Chiropractic care | • Nutritional Counseling | • Travel and Lodging |
| • Hearing aids | • Private-duty nursing | • Weight loss programs (exclusion does not apply to preventive care behavioral interventions) |

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

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|---------------------|---------------------|--------------------|
| • Abortion Services | • Bariatric surgery | • Cosmetic surgery |
| • Acupuncture | | |

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 <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>.
- **California Department of Managed Health Care (DMHC)** at **1(888) HMO-2219 (1-888-466-2219)** or www.dmhc.ca.gov; U.S. Department of Health and Human Services at **1-877-267-2323** x61565 or www.cciio.cms.gov
- Covered California at **1-800-300-1506** or www.coveredca.com
- CalOptima at **1-888-312-2221 (TTY 711)**. We are available Monday–Friday, from 8 a.m. to 6 p.m.
- 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 Healthcare.gov or call **1-800-318-2596** or state health insurance marketplace or SHOP.

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 contact your rights, this notice, or assistance, contact:

- CalOptima Member Services at **1-888-312-2221 (TTY 711)**. We are available Monday–Friday, from 8 a.m. to 6 p.m.
- DMHC at **1-888-466-2219 (TDD 1-877-688-9891)** or visit www.dmhc.ca.gov.
- Mail to CalOptima Health **Grievance and Appeals Department**
505 City Parkway West
Orange, CA 92868
- Fill out a grievance form at your doctor's office
- Online: Visit the CalOptima website at www.caloptima.org

Does this plan provide Minimum Essential Coverage? Yes.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.caloptima.org.

[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:

If you need help in your language call **1-888-312-2221 (TTY 711)**. Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1-888-312-2221 (TTY 711)**. These services are free of charge.

Spanish (Español): Para obtener asistencia en Español, llame al **1-888-312-2221 (TTY 711)**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-888-312-2221 (TTY 711)**.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1-888-312-2221 (TTY 711)**.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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	\$200
■ Specialist copayment	\$8
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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:

Cost Sharing	
Deductibles	\$200
Copayments	\$200
Coinsurance	\$1,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,560

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$200
■ Specialist copayment	\$8
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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:

Cost Sharing	
Deductibles *	\$0
Copayments	\$400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$420

Mia's Simple Fracture

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

■ The plan's overall deductible	\$200
■ Specialist copayment	\$8
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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:

Cost Sharing	
Deductibles *	\$0
Copayments	\$200
Coinsurance	\$30
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$230

*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.