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(800) 288-5555** or visit **sfhp.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(800) 288-5555** 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?	Yes.	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 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?	$5,000	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balance-billing is prohibited), 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 sfhp.org or call **1(800) 288-5555** 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.	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.

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* For more information about limitations and exceptions, see the plan or policy document at sfhp.org.

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	No Charge	Not Covered	None
	Specialist visit	No Charge	Not Covered	Preauthorization may be 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 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	Preauthorization may be required.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Preauthorization may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at sfhp.org	Generic drugs	$5 copay/prescription	Not Covered	Preauthorization may be required. Covers 90-day supply for most drugs; 30-day supply for opiate pain drugs; up to 12-month supply for FDA-approved contraceptives. No copay for FDA-approved contraceptives.
	Preferred brand drugs	$10 copay/prescription	Not Covered	Preauthorization may be required. Covers 30-day supply for most drugs; up to a 90-day supply for drugs used to treat chronic conditions; up to 12-month supply for FDA-approved contraceptives. No copay for FDA-approved contraceptives.
	Non-preferred brand drugs	$10 copay/prescription	Not Covered	Preauthorization may be required. Covers 30-day supply for most drugs; up to a 90-day supply for drugs used to treat chronic conditions; up to 12-month supply for FDA-approved contraceptives. No copay for FDA-approved contraceptives.
	Specialty drugs	$10 copay/prescription	Not Covered	Preauthorization may be required. Specialty drugs are available at a limited network of pharmacies. For a list of specialty pharmacies, see the provider directory at sfhp.org.

* For more information about limitations and exceptions, see the plan or policy document at sfhp.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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	**Preauthorization** may be required.
	Physician/surgeon fees	No Charge	Not Covered	**Preauthorization** may be required.
If you need immediate medical attention	**Emergency room care**	No Charge	No Charge	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	No Charge	No Charge	**Preauthorization** may be required for **out-of-network providers.**
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	**Preauthorization** may be required.
	Physician/surgeon fees	No Charge	Not Covered	**Preauthorization** may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	Not Covered	None
	Inpatient services	No Charge	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	None
	Childbirth/delivery professional services	No Charge	Not Covered	None
	Childbirth/delivery facility services	No Charge	Not Covered	None
If you need help recovering or have other special health needs	**Home health care**	No Charge	Not Covered	Up to 100 days per benefit year
	Rehabilitation services	No Charge	Not Covered	**Preauthorization** may be required.
	Habilitation services	No Charge	Not Covered	**Preauthorization** may be required.
	Skilled nursing care	No Charge	Not Covered	Up to 100 days per benefit year
	Durable medical equipment	No Charge	Not Covered	**Preauthorization** is required.
	Hospice services	No Charge	Not Covered	**Preauthorization** may be required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Dependents are not covered.
	Children's glasses	Not Covered	Not Covered	Dependents are not covered.
	Children's dental check-up	Not Covered	Not Covered	Dependents are not covered.

* For more information about limitations and exceptions, see the plan or policy document at **sfhp.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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic Surgery
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Dental care (Adult)
- Hearing aids
- Long-term care
- Routine eye care (Adult)

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 **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 **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 the California Department of Managed Health Care, at **1(888) 466-2219** or **dmhc.ca.gov.**

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(800) 288-5555.**

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1(800) 288-5555.**

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 **1(800) 288-5555.**

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1(800) 288-5555.**

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

* For more information about limitations and exceptions, see the plan or policy document at **sfhp.org.**

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	$0
Hospital (facility) copayment	$0
Other copayment	$5/$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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$25
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$25**

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	$0
Hospital (facility) copayment	$0
Other copayment	$5/$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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$160**

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

The plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) copayment	$0
Other copayment	$5/$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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$5
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$5**

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

* For more information about limitations and exceptions, see the plan or policy document at sfhp.org.