




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, www.communitycarehealth.org or by calling 1-855-343-2247. 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.healthcare.gov/sbc-glossary/ or call 1-855-343-2247 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Medical: \$0/Individual or \$0/Family Prescription Drugs:\$0	See the common Medical Events Chart below for your costs for services this plan covers. 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 and the other services listed in the “What you will pay” column of the chart starting on page 2, indicates services 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: For network providers \$2,000 Individual or \$4,000 Family; for out-of-network providers Not Applicable Prescription Drugs: \$3,600 / Individual or \$7,200 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?	Copayment for certain services, premiums , balancing-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.communitycarehealth.org or call 1-855-343-2247 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 .

 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	\$20 / visit, and for other outpatient services	Not covered	None
	Specialist visit	\$20 / visit	Not covered	Referral 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 . Preauthorization may be required for some procedures and services provided by specialists, but is not required for the specialist visit itself.
	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)	X-ray: No Charge Lab test: No Charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at	Generic drugs	Retail: \$5 / prescription Mail order: \$10 / prescription ,	Not covered	Up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Subject to formulary guidelines.
	Preferred brand drugs	Retail: \$10 / prescription Mail order: \$20 / prescription .	Not covered	Up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Subject to formulary guidelines.

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)	
www.communitycarehealth.org	Non-preferred brand drugs	Retail: \$25 / prescription Mail order: \$50 / prescription ,	Not covered	Up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Subject to formulary guidelines.
	Specialty drugs	Specialty generic: \$5 Specialty brand: (10% coinsurance with \$25 min. & \$75 max.) Specialty non-brand: (20% coinsurance with a \$50 min – \$100 max)	Not covered	Up to a 30-day supply (retail prescription). Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 / visit	Not covered	Preauthorization is required.
	Physician/surgeon fees	No Charge	Not covered	Physician/Surgeon Fee is included in the Facility Fee.
If you need immediate medical attention	Emergency room care	\$400 / visit	\$400 / visit	Copayment waived if admitted to hospital as inpatient.
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	\$20 / visit	\$20 / visit	Non- Plan Providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 / admission	Not covered	Preauthorization is required.
	Physician/surgeon fees	No Charge	Not covered	Professional services are included in the Facility Fee.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 / visit	Not covered	<u>Mental / Behavioral health/ Substance Abuse</u> \$25 / group visit
	Inpatient services	\$500 / admission	Not covered	None
If you are pregnant	Office visits	\$20 / visit	Not covered	Depending on the type of services, a copayment , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).

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)	
	Childbirth/delivery professional services	No Charge	Not covered	Professional services are included in the Facility Fee.
	Childbirth/delivery facility services	\$500 / admission	Not covered	None
If you need help recovering or have other special health needs	Home health care	No Charge	Not covered	Up to 2 hours / visit, up to 3 visits per day / up to 100 visits per benefit year.
	Rehabilitation services	Outpatient: \$20 / visit Inpatient: \$500 / visit	Not covered	None
	Habilitation services	Outpatient: \$20 / visit Inpatient: \$500 / visit	Not covered	None
	Skilled nursing care	No Charge	Not covered	Up to 100 days' limit / benefit period. Excludes take home drugs.
	Durable medical equipment	10% coinsurance	Not covered	Preauthorization is required.
	Hospice services	No Charge	Not covered	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	Coverage limited to one exam/year.
	Children's glasses	Not Covered	Not covered	None
	Children's dental check-up	No Charge	Not covered	Limited to two check-ups / 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 .)		
<ul style="list-style-type: none"> • Cosmetic Surgery • Dental Care (Adults) • 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 (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.)	
<ul style="list-style-type: none"> • Abortion • Acupuncture • Bariatric Surgery 	<ul style="list-style-type: none"> • Chiropractic care • Hearing Aids • Weight Loss Programs

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

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services 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:

Community Care Health Plan	1-855-343-2247 or www.communitycarehealth.org
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3273) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance oversight	1-877-267-2323 X61565 or www.cciio.cms.gov
California Department of Insurance	1-850-927-HELP (4357) or www.insurance.ca.gov
California Department of Managed Health Care	1-888-466-2219 or www.healthhelp.ca.gov/

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 1-855-343-2247.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-343-2247.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-343-2247.

[Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-343-2247.

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

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1850.

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	\$20
■ Hospital (facility) copayment	\$500
■ Other (blood work) copayment	\$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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$2,000
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,060

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	\$20
■ Hospital (facility) copayment	\$500
■ Other (blood work) copayment	\$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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$545
Coinsurance	\$173
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$773

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$20
■ Hospital (facility) copayment	\$500
■ Other (blood work) copayment	\$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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,700
Coinsurance	\$4
<i>What isn't covered</i>	
Limits or exclusions	\$
The total Mia would pay is	\$1,704

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