




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 ? | \$7,050 Individual / \$14,100 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 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 a specific service. |
| What is the out-of-pocket limit for this plan ? | \$7,050 Individual / \$14,100 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. |

| Important Questions | Answers | Why This Matters: |
|--|---------|--|
| 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 | 0% coinsurance | Not covered | None |
| | Specialist visit | 0% coinsurance | 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, deductible does not apply | 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) | 0% coinsurance | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance | Not covered | None |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at | Generic drugs | 0% coinsurance | Not covered | Up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Subject to formulary guidelines. |
| | Preferred brand drugs | 0% coinsurance | 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 | 0% coinsurance | Not covered | Up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Subject to formulary guidelines. |
| | Specialty drugs | 0% coinsurance | 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) | 0% coinsurance | Not covered | Preauthorization is required. |
| | Physician/surgeon fees | 0% coinsurance | Not covered | None |
| If you need immediate medical attention | Emergency room care | 0% coinsurance | 0% coinsurance | None |
| | Emergency medical transportation | 0% coinsurance | 0% coinsurance | None |
| | Urgent care | 0% coinsurance | 0% coinsurance | Non- Plan Providers covered when temporarily outside the service area. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 0% coinsurance | Not covered | Preauthorization is required. |
| | Physician/surgeon fees | 0% coinsurance | Not covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 0% coinsurance / individual visit; 0% coinsurance / individual visit for other outpatient services visit | Not covered | <u>Mental / Behavioral Health/ Substance Abuse</u> 0% coinsurance / group visit |
| | Inpatient services | 0% coinsurance | Not covered | None |
| If you are pregnant | Office visits | No Charge, deductible does not apply. | 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). |
| | Childbirth/delivery professional services | 0% coinsurance | Not covered | None |
| | Childbirth/delivery facility services | 0% coinsurance | Not covered | None |

| 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 | 0% coinsurance | Not covered | Up to 2 hours / visit, up to 3 visits per day / up to 100 visits per benefit year. |
| | Rehabilitation services | Outpatient: 0% coinsurance | Not covered | None |
| | Habilitation services | Outpatient: 0% coinsurance | Not covered | None |
| | Skilled nursing care | 0% coinsurance | Not covered | Up to 100 days / benefit period |
| | Durable medical equipment | 0% coinsurance | Not covered | Preauthorization is required. |
| | Hospice services | 0% coinsurance | Not covered | Preauthorization is required. |
| If your child needs dental or eye care | Children's eye exam | No Charge, deductible does not apply | Not covered | Coverage limited to one exam/year. |
| | Children's glasses | No Charge, deductible does not apply | Not covered | Limited to one pair of glasses / year from select frames and lenses. |
| | Children's dental check-up | No Charge, deductible does not apply | 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 • Chiropractic Care • Dental Care (Adults) • Hearing Aids | <ul style="list-style-type: none"> • Long Term Care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • 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.)

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> • Abortion • Infertility Treatment | <ul style="list-style-type: none"> • Acupuncture (plan provider preferred) | <ul style="list-style-type: none"> • Bariatric Surgery |
|---|---|---|

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): Dinek'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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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](#) \$7,050
- [Specialist copayment](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- 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 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$7,050 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$7,110 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$7,050
- [Specialist copayment](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- 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 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$5,400 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$5,420 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$7,050
- [Specialist copayment](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other (X-ray) [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 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$2,800 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,800 |

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