



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](http://www.communitycarehealth.org) or by calling 1-559-724-4995. 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/](http://www.healthcare.gov/sbc-glossary/) or call 1-559-724-4995 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                           | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$2,150 Individual / \$4,300 Family                                                                                                                                                               | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> 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 <a href="#">plan</a> covers some items and services even if you haven’t yet met the <a href="#">deductible</a> amount, but a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                               | You don’t have to meet <a href="#">deductibles</a> for a specific service.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | Medical: \$7,550 Individual / \$15,100 Family<br>Pediatric Dental: \$350 Individual / \$700 Family                                                                                                | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Copayment</a> for certain services, <a href="#">premiums</a> , <a href="#">balancing-billing</a> charges, and health care this plan doesn’t cover.                                    | Even though you pay these expenses, they don’t count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.communitycarehealth.org">www.communitycarehealth.org</a> or call 1-559-724-4995 for a list of <a href="#">network providers</a> .                                    | This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |

| Important Questions                                                          | Answers | Why This Matters:                                                                                                                                                                                                    |
|------------------------------------------------------------------------------|---------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | Yes.    | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> . |

 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<br>(You will pay the least)                                                                                               | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                             |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                                                 | Primary care visit to treat an injury or illness       | \$35 / visit, <a href="#">deductible</a> does not apply                                                                                    | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                        | <a href="#">Specialist</a> visit                       | \$50 / visit, <a href="#">deductible</a> does not apply                                                                                    | Not covered                                        | <a href="#">Referral</a> is required. This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services, but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> . Preauthorization may be required for some procedures and services provided by specialists, but is not required for the specialist visit itself. |
|                                                                                                                                                                                                                        | <a href="#">Preventive care/screening/immunization</a> | No Charge, <a href="#">deductible</a> does not apply                                                                                       | Not covered                                        | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.                                                                                                                                                                                 |
| If you have a test                                                                                                                                                                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)    | X-ray: 25% <a href="#">coinsurance</a><br>Lab test: 25% <a href="#">coinsurance</a>                                                        | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                        | Imaging (CT/PET scans, MRIs)                           | 25% <a href="#">coinsurance</a>                                                                                                            | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                        |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.communitycarehealth.org">www.communitycarehealth.org</a> | Generic drugs                                          | Retail: \$15 / <a href="#">prescription</a><br>Mail order: \$30 / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply | Not covered                                        | Up to a 30-day supply (retail <a href="#">prescription</a> ); 90-day supply (mail order <a href="#">prescription</a> ). Subject to <a href="#">formulary</a> guidelines.                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                        | Preferred brand drugs                                  | Retail: \$30 / <a href="#">prescription</a><br>Mail order: \$60 / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply | Not covered                                        | Up to a 30-day supply (retail <a href="#">prescription</a> ); 90-day supply (mail order <a href="#">prescription</a> ). Subject to <a href="#">formulary</a> guidelines.                                                                                                                                                                                                                                    |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                                                                                                            |                                                         | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                  |
|---------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network Provider<br>(You will pay the least)                                                                                                                                 | Out-of-Network Provider<br>(You will pay the most)      |                                                                                                                                                                                                                                         |
|                                                                           | Non-preferred brand drugs                        | Retail: \$45 / <a href="#">prescription</a><br>Mail order: \$90 / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply                                   | Not covered                                             | Up to a 30-day supply (retail <a href="#">prescription</a> ); 90-day supply (mail order <a href="#">prescription</a> ). Subject to <a href="#">formulary</a> guidelines.                                                                |
|                                                                           | <a href="#">Specialty drugs</a>                  | 20% <a href="#">coinsurance</a> , up to \$250 per <a href="#">prescription</a> , <a href="#">deductible</a> does not apply                                                   | Not covered                                             | Up to a 30-day supply (retail <a href="#">prescription</a> ). Subject to <a href="#">formulary</a> guidelines.                                                                                                                          |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | 25% <a href="#">coinsurance</a>                                                                                                                                              | Not covered                                             | <a href="#">Preauthorization</a> is required.                                                                                                                                                                                           |
|                                                                           | Physician/surgeon fees                           | No Charge                                                                                                                                                                    | Not covered                                             | None                                                                                                                                                                                                                                    |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 25% <a href="#">coinsurance</a>                                                                                                                                              | 25% <a href="#">coinsurance</a>                         | <a href="#">Copayment</a> waived if admitted to hospital as inpatient.                                                                                                                                                                  |
|                                                                           | <a href="#">Emergency medical transportation</a> | 25% <a href="#">coinsurance</a>                                                                                                                                              | 25% <a href="#">coinsurance</a>                         | None                                                                                                                                                                                                                                    |
|                                                                           | <a href="#">Urgent care</a>                      | \$35 / visit, <a href="#">deductible</a> does not apply                                                                                                                      | \$35 / visit, <a href="#">deductible</a> does not apply | Non- <a href="#">Plan Providers</a> covered when temporarily outside the service area.                                                                                                                                                  |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 25% <a href="#">coinsurance</a>                                                                                                                                              | Not covered                                             | <a href="#">Preauthorization</a> is required.                                                                                                                                                                                           |
|                                                                           | Physician/surgeon fees                           | No Charge                                                                                                                                                                    | Not covered                                             | None                                                                                                                                                                                                                                    |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$35 / individual visit; <a href="#">deductible</a> does not apply<br>\$35 / individual visit for other outpatient services visit, <a href="#">deductible</a> does not apply | Not covered                                             | <b><u>Mental / Behavioral Health/ Substance Abuse</u></b><br>\$17 / group visit, <a href="#">deductible</a> does not apply                                                                                                              |
|                                                                           | Inpatient services                               | 25% <a href="#">coinsurance</a>                                                                                                                                              | Not covered                                             | None                                                                                                                                                                                                                                    |
| If you are pregnant                                                       | Office visits                                    | No Charge, <a href="#">deductible</a> does not apply                                                                                                                         | Not covered                                             | Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                           | Childbirth/delivery professional                 | No Charge                                                                                                                                                                    | Not covered                                             | Professional services are included in                                                                                                                                                                                                   |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                                           |                                                    | Limitations, Exceptions, & Other Important Information                             |
|----------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------|
|                                                                |                                           | Network Provider<br>(You will pay the least)                                | Out-of-Network Provider<br>(You will pay the most) |                                                                                    |
|                                                                | services                                  |                                                                             |                                                    | the Facility Fee.                                                                  |
|                                                                | Childbirth/delivery facility services     | 25% <a href="#">coinsurance</a>                                             | Not covered                                        | None                                                                               |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | No Charge, <a href="#">deductible</a> does not apply                        | Not covered                                        | Up to 2 hours / visit, up to 3 visits per day / up to 100 visits per benefit year. |
|                                                                | <a href="#">Rehabilitation services</a>   | Outpatient: \$35 / visit                                                    | Not covered                                        | None                                                                               |
|                                                                | <a href="#">Habilitation services</a>     | Outpatient: \$35 / visit                                                    | Not covered                                        | None                                                                               |
|                                                                | <a href="#">Skilled nursing care</a>      | 25% <a href="#">coinsurance</a>                                             | Not covered                                        | Up to 100 days limit / benefit period                                              |
|                                                                | <a href="#">Durable medical equipment</a> | 50% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply | Not covered                                        | <a href="#">Preauthorization</a> is required.                                      |
|                                                                | <a href="#">Hospice services</a>          | No Charge, <a href="#">deductible</a> does not apply                        | Not covered                                        | <a href="#">Preauthorization</a> is required.                                      |
| If your child needs dental or eye care                         | Children's eye exam                       | No Charge, <a href="#">deductible</a> does not apply                        | Not covered                                        | Coverage limited to one exam/year.                                                 |
|                                                                | Children's glasses                        | No Charge, <a href="#">deductible</a> does not apply                        | Not covered                                        | Limited to one pair of glasses / year from select frames and lenses.               |
|                                                                | Children's dental check-up                | No Charge, <a href="#">deductible</a> does not apply                        | Not covered                                        | Limited to two check-ups / year.                                                   |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                                  |                                                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adults)</li> <li>• Hearing Aids</li> </ul>                                                                      | <ul style="list-style-type: none"> <li>• Long Term Care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private Duty Nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul> |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.) |                                                                                                                            |                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Abortion</li> <li>• Chiropractic Care</li> </ul>                                                    | <ul style="list-style-type: none"> <li>• Acupuncture (plan provider preferred)</li> <li>• Infertility Treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Bariatric Surgery</li> </ul> |

**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](http://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](http://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](http://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                                                                   | 1-559-724-4995 or <a href="http://www.communitycarehealth.org">www.communitycarehealth.org</a>            |
| Department of Labor's Employee Benefits Security Administration                              | 1-866-444-EBSA (3273) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> |
| Department of Health & Human Services, Center for Consumer Information & Insurance oversight | 1-877-267-2323 X61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a>                         |
| California Department of Insurance                                                           | 1-850-927-HELP (4357) or <a href="http://www.insurance.ca.gov">www.insurance.ca.gov</a>                   |
| California Department of Managed Health Care                                                 | 1-888-466-2219 or <a href="http://www.healthhelp.ca.gov/">www.healthhelp.ca.gov/</a>                      |

**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 1-559-724-4995.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-559-724-4995.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-559-724-4995.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-559-724-4995.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,150 |
| ■ <a href="#">Specialist copayment</a>                          | \$50    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 25%     |
| ■ Other (blood work) <a href="#">coinsurance</a>                | 25%     |

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,150        |
| <a href="#">Copayments</a>        | \$50           |
| <a href="#">Coinsurance</a>       | \$1,600        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,860</b> |

### Managing Joe's Type 2 Diabetes

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,150 |
| ■ <a href="#">Specialist copayment</a>                          | \$50    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 25%     |
| ■ Other (blood work) <a href="#">coinsurance</a>                | 25%     |

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$100          |
| <a href="#">Copayments</a>        | \$900          |
| <a href="#">Coinsurance</a>       | \$400          |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,420</b> |

### Mia's Simple Fracture

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,150 |
| ■ <a href="#">Specialist copayment</a>                          | \$50    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 25%     |
| ■ Other (x-ray) <a href="#">coinsurance</a>                     | 25%     |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,800        |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$100          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,100</b> |

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