



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:
<a href="#">What is the overall deductible?</a>	\$3,200 Self-Only Coverage \$3,400 Each Individual with Family Coverage \$6,400 Family Coverage	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> .
<a href="#">Are there services covered before you meet your 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 preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<a href="#">Are there other deductibles for specific services?</a>	No.	You don’t have to meet <a href="#">deductibles</a> for a specific service.
<a href="#">What is the out-of-pocket limit for this plan?</a>	\$8,300 Individual / \$16,600 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.
<a href="#">What is not included in the 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> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.communitycarehealth.org">www.communitycarehealth.org</a> or call 1-559-724-4995 for a list of <u>network providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	25% <u>coinsurance</u>	Not covered	None
	Specialist visit	25% <u>coinsurance</u>	Not covered	<u>Referral</u> is not required. This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services. Preauthorization may be required for some procedures and services provided by specialists, but is not required for the specialist visit itself.
	<u>Preventive</u> <u>care</u> / <u>screening</u> / <u>immunization</u>	No Charge, <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	25% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	25% <u>coinsurance</u>	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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.communitycarehealth.org">www.communitycarehealth.org</a>	Generic drugs	25% <a href="#">coinsurance</a> , up to \$250 per <a href="#">prescription</a> , after <a href="#">deductible</a>	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	25% <a href="#">coinsurance</a> , up to \$250 per <a href="#">prescription</a> , after <a href="#">deductible</a>	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.
	Non-preferred brand drugs	25% <a href="#">coinsurance</a> , up to \$250 per <a href="#">prescription</a> , after <a href="#">deductible</a>	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>	25% <a href="#">coinsurance</a> , up to \$250 per <a href="#">prescription</a> , after <a href="#">deductible</a>	Not covered	Up to a 30-day supply (retail <a href="#">prescription</a> ). Subject to <a href="#">formulary</a> guidelines.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	25% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	25% <a href="#">coinsurance</a>	Not covered	None
<b>If you need immediate medical attention</b>	<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>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	Non- <a href="#">Plan Providers</a> covered when temporarily outside the service area.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	25% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	25% <a href="#">coinsurance</a>	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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	25% <a href="#">coinsurance</a> / individual visit; 25% <a href="#">coinsurance</a> / individual visit for other outpatient services visit	Not covered	<b>Mental / Behavioral Health/ Substance Abuse</b> 25% <a href="#">coinsurance</a> / group visit
	Inpatient services	25% <a href="#">coinsurance</a>	Not covered	None
<b>If you are pregnant</b>	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 services	25% <a href="#">coinsurance</a>	Not covered	None
	Childbirth/delivery facility services	25% <a href="#">coinsurance</a>	Not covered	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	25% <a href="#">coinsurance</a>	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: 25% <a href="#">coinsurance</a> / visit	Not covered	None
	<a href="#">Habilitation services</a>	Outpatient: 25% <a href="#">coinsurance</a> / 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>	25% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required.
	<a href="#">Hospice services</a>	No Charge	Not covered	<a href="#">Preauthorization</a> is required.
<b>If your child needs dental or eye care</b>	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.

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)	
	Children's dental check-up	No Charge, <u>deductible</u> 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.)

- Cosmetic Surgery
- Dental Care (Adults)
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Abortion
- Acupuncture
- Chiropractic Care
- Infertility Treatment
- 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](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](http://HealthInsuranceMarketplace.gov). For more information about the [Marketplace](http://HealthCare.gov), 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, kwijjigo 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>	\$3,200
■ <a href="#">Specialist coinsurance</a>	25%
■ 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>
<b>In this example, Peg would pay:</b>	
Cost Sharing	
<a href="#">Deductibles</a>	\$3,200
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,660</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>	\$3,200
■ <a href="#">Specialist coinsurance</a>	25%
■ 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>
<b>In this example, Joe would pay:</b>	
Cost Sharing	
<a href="#">Deductibles</a>	\$3,200
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,720</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>	\$3,200
■ <a href="#">Specialist coinsurance</a>	25%
■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other (blood work) <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>
<b>In this example, Mia would pay:</b>	
Cost Sharing	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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