

Small Group Health Plan



Your Guide to Choosing the Best Plan for Your Employees

For effective dates:
January 1, 2026

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The Central Valley's Local Health Care Plan

Because Your Community Is Our Community

Community Care Health is not your traditional health insurer. We see our members as family, which is why we are focused not only on designing the strongest portfolio of products, member tools, and services, but also on building a stronger community for us to share.



REINVESTMENT in the community. Your premium dollar **remains** here in the Central Valley



PARTNERS with our community through **employment, charity** and **local spending**



RESPONSIVE to customer needs because we are **part of the local community** and **best understand the Central Valley**

The Power of Being Local

Because Community Care Health is locally based and part of the community which we serve, we are able to both tailor plans that meet the unique needs of our members while also providing a level of responsiveness unmatched by nationwide health plans.



Customer Service



Account Management



Leadership



Hospital Relationships

Community Care Health Representatives Are Based Right Here in the Central Valley

Community Health System

Community Health System is a locally owned, not-for-profit, public-benefit organization based in Fresno, California. Community is the region's largest healthcare provider and private employer.

- › Locally Owned, Not-For-Profit
- › Region's Largest Healthcare Provider and Private Employer
- › Comprised of Medical Foundation, Health Plan (Community Care Health) and Acute-Care Hospitals
- › 3rd Largest HMO in the Central Valley
- › Physician Residency Program with UCSF
- › Level 1 Trauma and Comprehensive Burn Center (only one between Los Angeles and Sacramento)



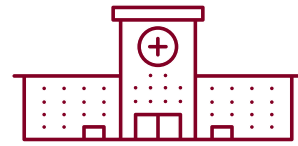
COMMUNITY
HEALTH SYSTEM



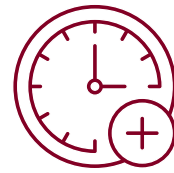
A Powerful Network for Comprehensive Care



2,500+
Primary Care Providers
and Specialists



1,400
Practice Sites



20
Urgent Care Centers



Coverage Wherever Our Members Live, Work & Study

Where Am I Covered?



Covered Care Outside of the Area

Community Care Health provides continuing coverage while you or your family are traveling outside of the area (including children away at school) - giving you peace of mind that you and your family will always have access to the care you need, wherever you are.



From
Pediatrics
 to **Geriatrics**
 and every -tric of the trade



Care. Of All Kinds.

From bumps and bruises to your family's long-term needs, Community Health Partners has over 400 providers to give you the care you need every step of the way.

Find the provider you've been looking for at
CommunityHealthPartners.org

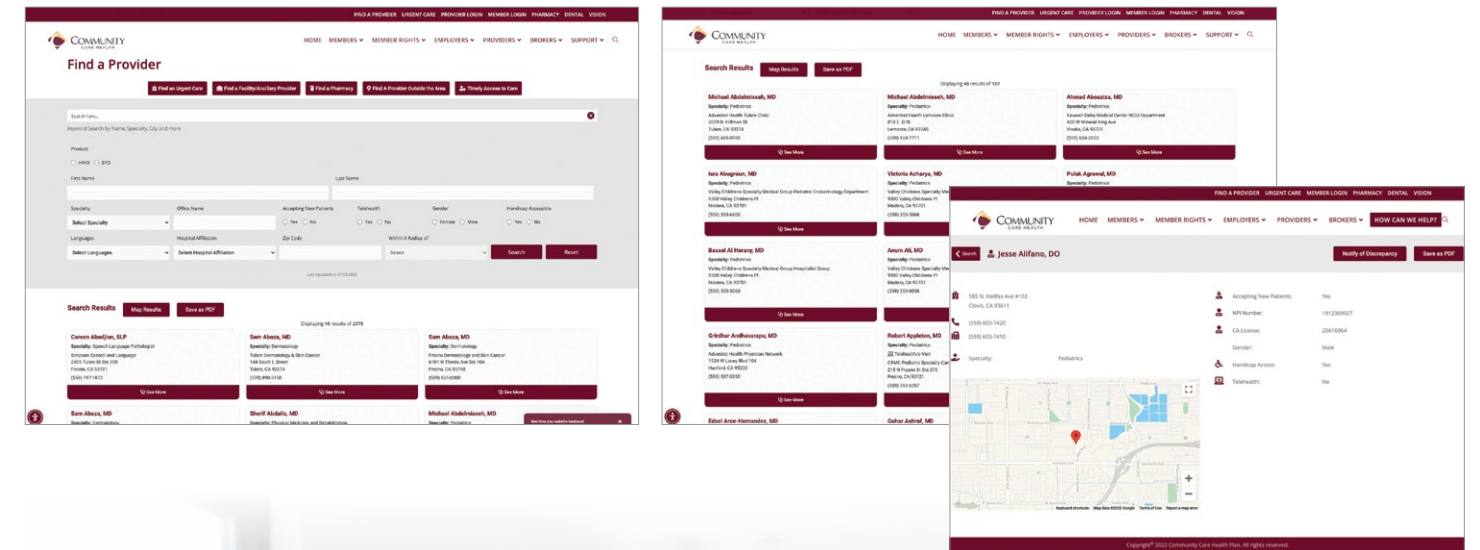


Provider Directory

Find a Provider

Community Care Health ensures access to a broad network of primary care providers, specialists, practice sites and urgent care locations. Thanks to our online Provider Directory, also available on our Mobile App, members can search and find in-network providers based on specialty, location, service area and more.

<https://www.communitycarehealth.org/find-a-provider>

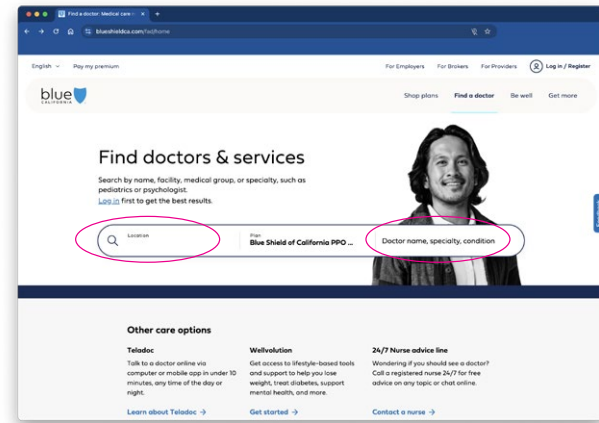


Covered Care Outside of the Area (Within California)

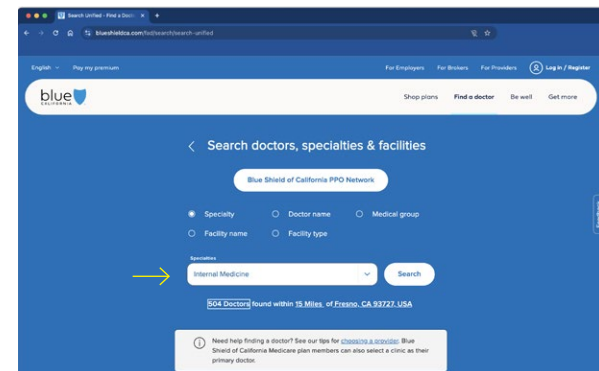
There may be situations in which you need access to medical care outside of the Community Care Health Service Area. When you need to locate a provider in the State of California, outside of Fresno, Kings, Madera or Tulare counties, follow the steps outlined below. Referral and prior authorization requirements of your benefit plan apply.

Go to <https://blueshieldca.com/networkppo>

PPO Plan (within CA)

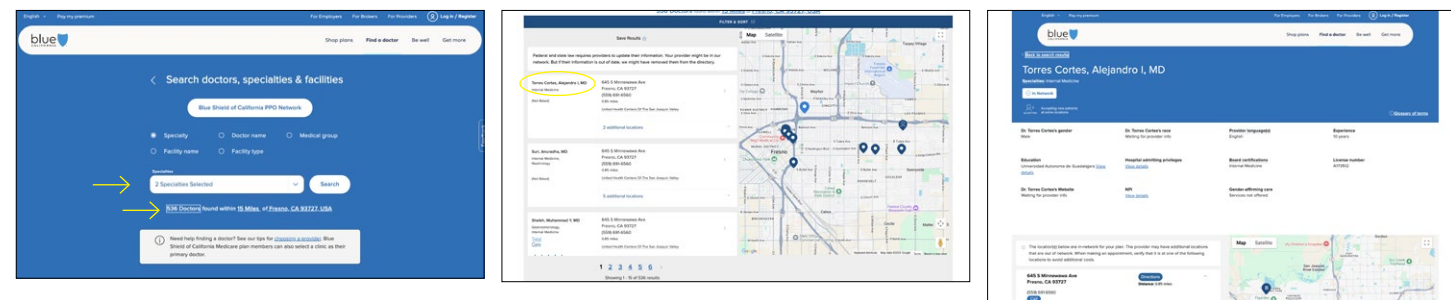


Enter your address in Location > select Doctor name, specialty, condition > and choose what you are searching for.



Example of search result

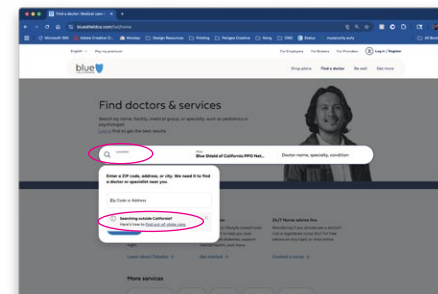
Scroll and click on any result to view full descriptions of physician, practice or facility.



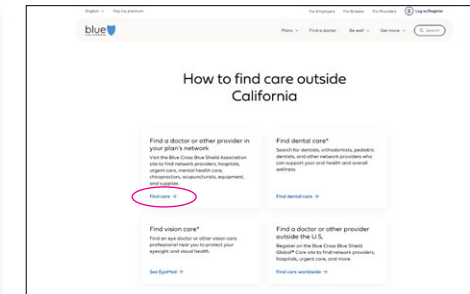
Covered Care Outside of the Area (Outside California)

There may be situations in which you need to access emergent or urgent medical care outside of the State of California. In those situations, please follow the steps outlined below.

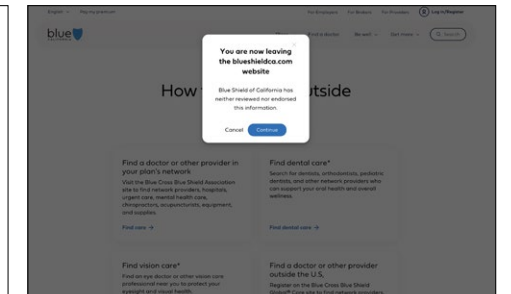
Go to <https://blueshieldca.com/networkppo>



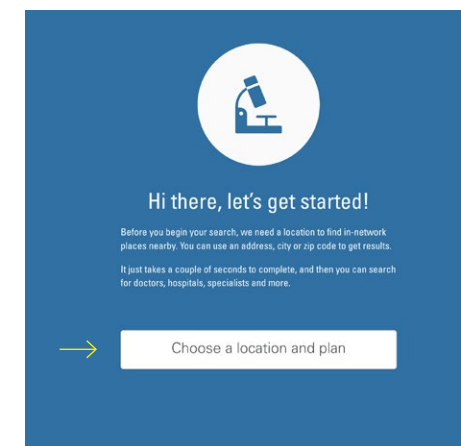
1. Enter in zip code outside of California. Pulldown menu will appear. Click on 'find out of state care'.



2. Click 'Find care'. You will be taken to a new window.



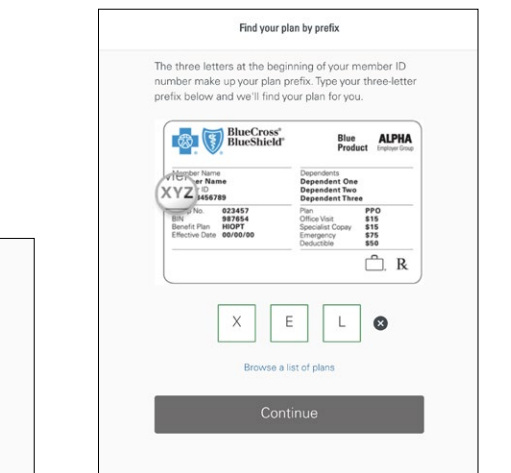
3. Select "Continue" to search providers outside of California.



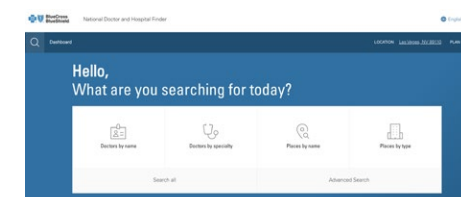
4. Click on 'Choose a location and plan'.



5. On the pop-up window, re-enter your address. Click on 'Yes, this is correct'.

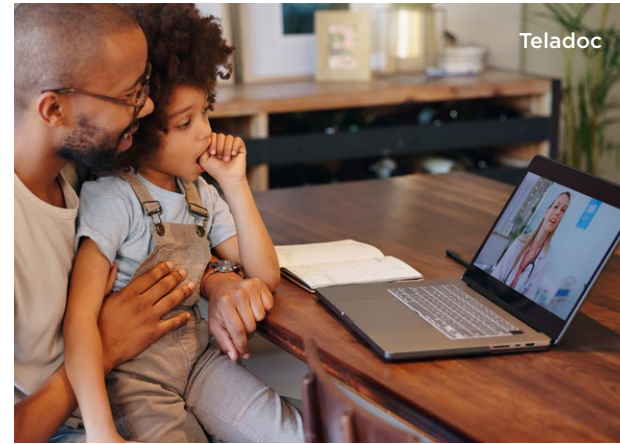
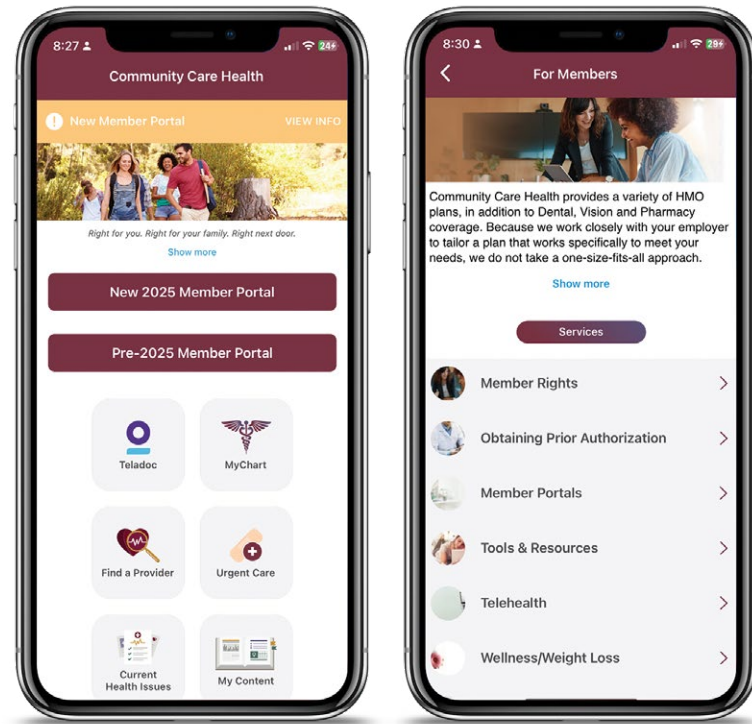


6. Enter "XEL" and click "Continue".



7. You can now search by name, specialty, facility name or facility type.

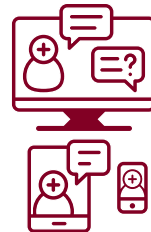
Innovative Customer Tools



Mobile App



Pharmacy Benefit Portal



Teladoc



Member Portal



MyHealthMate powered by MyChart



Online Provider, Pharmacy and Urgent Care Directory

Remote Access to Care



Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits. Set up your account today so when you need care now, a Teladoc doctor is just a call or click away.



SET UP YOUR ACCOUNT

Set up your account by phone, web or mobile app.

Online:
Go to Teladoc.com and click "set up account."

Mobile App:
Download the app and click "Activate account." Visit teladoc.com/mobile to download the app.

Call Teladoc:
Teladoc can help you register your account over the phone.



PROVIDE MEDICAL HISTORY

Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.



REQUEST A CONSULT

Once your account is set up, request a consult anytime you need care. And talk to a doctor by phone, web or mobile app.

Talk to a doctor anytime!

Teladoc.com
1-800-Teladoc



MEMBER NOTICE

Before the start of your visit, Teladoc will ask you to agree to telehealth as an acceptable way to receive health care services.

You have a right to access Teladoc's records of your visit as required by California law.

Teladoc will share their records of your visit with your primary care physician, unless you object. If you object, please tell your Teladoc provider during your visit.

Services that you receive from Teladoc are available at in-network cost-sharing. Your out-of-pocket costs for services from Teladoc will be applied to your deductible or out-of-pocket maximum, if applicable.

Teladoc is not your only option. You may also receive these services on an in-person basis or via telehealth, if available, from your primary care physician, treating specialist, or from another participating provider. Those services will be provided according to the timeliness and geographic access standards required by California law.

If you are currently receiving telehealth services for a mental or behavioral health condition from a participating provider, you may continue to receive those services from that provider.

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Updated 4.22.2022

Welcome to the New Community Care Health Member Portal!

We are thrilled to introduce an all-new member portal experience designed to help you seamlessly manage your healthcare journey.

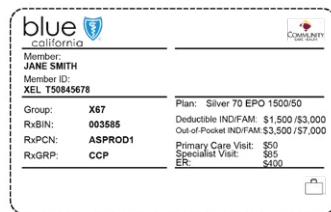
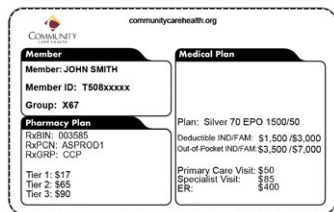
The all-new Community Care Health member portal provides seamless access to help you manage your healthcare journey, including coverage and benefit details, the ability to review claims, print ID cards and more!

Since this is a new portal, you will have to register using your new Member ID number, which can be found on your Member ID cards that were recently mailed out. Once you have received, simply follow the instructions below or download the Member Portal Quick Reference Guide (QR code) to get started.

If you have any questions, please call Customer Service at 559-724-4995 or toll-free at 1 (844) 516-0181.

Note: If you need to pull claim information or an Explanation of Benefits (EOB) from claims prior to 12/31/24, you will need to use the original portal, <https://hconlinex.healthcomp.com/cch>, and login credentials.

STEP 1 - ENTER YOUR MEMBER INFORMATION



A verification code may be sent to you during this process to confirm your identity. If you do not receive this code, please check your junk/spam folders.

STEP 2 - SET UP SECURITY QUESTIONS

Choose and answer three security questions. These will help secure your account and allow for password recovery if needed.

STEP 3 - CREATE YOUR USERNAME AND PASSWORD

Finally, create a unique username and password to access your account. Be sure to choose a password that is secure and easy for you to remember. Once these steps are complete, you'll have full access to your member portal and all its features!

To get started, you'll need to provide the following details:

- Member ID: Your member ID, located on your new member ID card, begins with T508.
- First Name
- Last Name
- Date of Birth
- Email Address (Optional)
- Last Four Digits of Your SSN: You will be prompted to enter this after attempting to proceed to the next step.



Scan qr code to view member portal quick reference guide.

Words you should know:

1. **EPO:** An Exclusive Provider Organization (EPO) offers in-network coverage through our Community Care Health network. Out-of-network services are covered for emergency and urgent care. Community Care Health does not require the selection of PCP and referrals are not required to see specialists.
2. **HMO:** A Health Maintenance Organization (HMO) offers healthcare services through a network of providers who agree to provide services to its members. Community Care Health's HMO plans provides coverage in partnership with primary care physicians and specialists, urgent care centers, and hospitals. Community Care Health offers a large network of local providers in addition to access to care through the Anthem network in California, and HealthSmart PCHS outside of California.
3. **Primary Care Physician (PCP):** A PCP is considered your main doctor and you will be required to choose a PCP when you enroll. Your PCP is typically a family physician or generalist and is responsible for managing the majority of your healthcare. You can see your PCP for new and undiagnosed illnesses or injuries, chronic ongoing conditions, and preventive care. If you need a referral to a specialist, you will obtain one from your PCP.
4. **Actuarial Value:** The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, members would be responsible for 30% of the costs of all covered benefits. However, members could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on their actual health care needs and the terms of their policy.
5. **Plan Deductible:** The set amount members pay for most covered services within a plan year before the health plan begins paying. This is included in the out-of-pocket maximum.
6. **Embedded Accumulation:** Each individual family member will begin paying copays or coinsurance after meeting his or her individual deductible, or when the family deductible is satisfied, whichever comes first. Also, individual family members are not subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met, whichever comes first. Not all services are subject to the deductible and/or out-of-pocket maximum.
7. **Referral:** Your PCP helps make the decision about whether specialist services are necessary for you. Our EPO plans do not require a referral to see a specialist. Under the HMO, members can self-refer Emergency and Urgent Care, Dermatology, Behavioral Health and Substance Abuse (Halcyon), Allergy, Chiropractic, and OBGYN services.
8. **Prior Authorization:** Prior Authorization is the process of evaluating medical services prior to the provision of services in order to determine Medical Necessity, appropriateness, and benefit coverage. Services requiring Prior Authorization should not be scheduled until a Provider receives approval from Community Care Health. Community Care Health reserves the right to deny payment for authorized services if it is determined that inaccurate information was provided to support the authorization request.
9. **Out-of-pocket Maximum:** The maximum amount an individual or family will pay for all covered services in a year before the plan starts paying 100% for most or all covered services. Copays and Coinsurance credit toward the maximum out-of-pocket specified for each plan.
10. **Preventive Care at No Charge:** Most preventive services are covered at no charge and are not subject to the deductible.
11. **Copay:** The set amount members will pay for certain services.
12. **Coinsurance:** The percentage of the total cost for certain services that a member will pay after meeting the deductible up to the out-of-pocket maximum.

Your Medical Plan Options

Community Care Health offers all four categories of coverage, known as “metal plans” — Bronze, Silver, Gold, and Platinum. These four categories offer varying copays, coinsurance, and deductibles for essential health benefits.

Our plans provide your employees with access to care and resources to stay healthy, active, and productive — top doctors and hospitals providing high-quality, personalized care, focusing on prevention and innovative health promotion programs.

Exclusive Provider Organization (EPO) Plans — Our EPO plans offer in-network coverage through our Community Care Health network. Out-of-network services are covered for emergency and urgent care. Community Care Health does not require the selection of PCP and referrals are not required to see specialists.

Copay HMO Plans — Our copay HMO plans feature first dollar for covered services and prescriptions. Copay plans feature mostly set fees and have no deductible, helping you know in advance how much you’ll pay for services like doctor’s office visits and prescriptions.

Deductible HMO Plans — Our deductible HMO plans offer a more affordable option with competitive benefits. PCP and Specialist office visits are not subject to the deductible and telehealth is also a first dollar benefit.

HSA-Qualified High Deductible Health Plans (HDHP) — These deductible HMO plans can be paired with a health savings account (HSA). Employees can contribute pretax or tax-deductible dollars* to the HSA and use that money to pay for qualified medical expenses. For a complete list of qualified medical expenses, see IRS Publication 502, Medical and Dental Expenses, at [irs.gov/publications](https://www.irs.gov/publications).

Deductible HMO with HRA Plan — These deductible plan options can be paired with a health reimbursement arrangement (HRA), which you’ll set up for your employees. You contribute money into your employees’ HRAs, which they can use to pay for the health care services they receive. Because this money isn’t considered part of their wages it will not be subject to federal taxes. Community Care Health allows limited employer funding for the following plans:

- Gold 80 HMO HRA 2150/35 - employee only coverage up to \$400, employee plus one or more up to \$800
- Silver 70 HMO HRA 2250/50 - employee only coverage up to \$1,000, employee plus one or more up to \$2,000

Infertility — All Community Care Health plans offer infertility benefits as a buy-up option. Coverage is provided by Participating Providers for services such as natural and stimulated artificial insemination, gamete intrafallopian transfer and cryopreservation. A limited number of services are covered per individual, please refer to the EOC supplement for complete information.

Chiropractic and Acupuncture — Acupuncture benefits are included in all plans. Coverage for chiropractic services is included in a selection of our plan options. Please see benefit summary pages for details regarding the inclusion of chiropractic benefits. Members are covered for a combined total of 20 visits per year. The total maximum number of visits does not apply to acupuncture treatment of nausea or as part of a comprehensive pain management program.

Pediatric Dental and Vision — All plans include coverage for pediatric dental and vision exams and services up to the age of 19. Pediatric vision exams and materials are provided through DeltaVision, available through our partnership with Delta Dental. Pediatric dental coverage is through Delta Dental’s DeltaCare USA DHMO. All pediatric dental services must be obtained through a primary care dentist which can be chosen or assigned.

*Tax references relate to federal income tax only. Consult with your financial or tax adviser for information about state income tax laws. Federal and state tax laws and regulations are subject to change.

Exclusive Provider Organization (EPO)

The EPO offers in-network coverage through our Community Care Health network. Out-of-network services are covered for emergency and urgent care.

Community Care Health does not require the selection of a PCP and referrals are not required to see specialists.

Please note that some specialist’s offices may require referral before they will make an appointment.



Community Care Health does not require the selection of a PCP and referrals are not required to see specialists.

	EPO	HMO
PCP Selection/Assignment Required		X
PCP Referral Required for Specialty Care		X
Access to Community Care Health Participating Providers	X	X
Access to Community Health System and Other Participating Hospitals in the Area	X	X
Services Must be Medically Necessary/Authorized	X	X
Authorized Care Outside of the Area	X	X
All Emergency and Urgent Care Covered at In-Network Benefit Level	X	X

Platinum EPO Plan

COMMUNITY CARE HEALTH EPO PLANS 1/1/26 THROUGH 12/31/26		Platinum 90 EPO 0/15		Platinum 90 EPO 0/25	
Amounts per Accumulation Period ⁽¹⁾		Individual	Family	Individual	Family
Medical Deductible ⁽¹⁾		\$0	\$0	\$0	\$0
Prescription Drug Deductible ⁽¹⁾		\$0	\$0	\$0	\$0
Out-of-Pocket Maximum ⁽¹⁾		\$2,500	\$5,000	\$2,550	\$5,100
COVERED BENEFITS		Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS
IN OFFICE SERVICES					
Primary Care Office Visits			\$15 / Visit		\$25 / Visit
Urgent Care Visits			\$15 / Visit		\$25 / Visit
Specialist Office Visits			\$30 / Visit		\$50 / Visit
Preventive physical exams, immunizations, and related laboratory services ⁽²⁾			\$0		\$0
Prenatal and Postpartum Office Visit			No Charge		No Charge
Well-Baby and Well-Child Exams ⁽²⁾			\$0		\$0
Allergy Injections			\$30 / Visit		\$50 / Visit
Outpatient Physical, Occupational and Speech Therapy			\$15 / Visit		\$25 / Visit
Laboratory Tests and Services			\$20 / Visit		\$20 / Visit
Radiology Services (x-rays, diagnostic imaging)			\$40 / Visit		\$75 / Visit
Advanced Radiology (including but not limited to MRI, MRA, MRS, CT Scan, PET, MUGA SPECT)			\$150 / Procedure		\$200 / Procedure
Outpatient Surgery (per procedure)			\$250 / Procedure		\$400 / Procedure
EMERGENCY SERVICES					
Emergency Room Visit (waived if admitted directly to hospital)			\$250 / Visit		\$250 / Visit
Emergency and Non-Emergency Medical Transportation			\$150 / Trip		\$150 / Trip
PRESCRIPTION DRUG COVERAGE ⁽⁶⁾					
Tier 1: Most generic drugs and low-cost preferred brands 30-day supply (retail)/90-day supply (mail order)			\$5 / \$10		\$5 / \$10
Tier 2: Non-preferred generic and Preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)			\$15 / \$30		\$15 / \$30
Tier 3: Non-preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)			\$25 / \$50		\$25 / \$50
Tier 4: Specialty Items/Drugs 30-day supply (retail only)			20% Coinsurance ⁽⁶⁾ (Up to \$250 Per 30-Day Supply)		20% Coinsurance ⁽⁶⁾ (Up to \$250 Per 30-Day Supply)
HOSPITALIZATION					
Facility Fee			\$250 / Admission		\$500 / Admission
Physician/Surgeon Fees			No Charge		No Charge
Skilled nursing facility services (maximum 100 days per accumulation period)			\$250 / Admission		\$500 / Admission
MENTAL HEALTH AND CHEMICAL DEPENDENCY					
Individual Office Visit			\$15 / Visit		\$25 / Visit
Inpatient Hospitalization			\$250 / Admission		\$500 / Admission
OTHER BENEFITS					
Teladoc Visit			\$10 / Visit		\$10 / Visit
Acupuncture/Chiropractic Office Visits (20 visit per year combined) ⁽⁶⁾			\$15 / Visit		\$25 / Visit
Durable Medical Equipment			10% Coinsurance ⁽⁶⁾		20% Coinsurance ⁽⁶⁾
Prosthetics and Orthotics			10% Coinsurance ⁽⁶⁾		20% Coinsurance ⁽⁶⁾
Pediatric Eye Exam			No Charge		No Charge
Pediatric Optical (Eyewear)			1 Pair Per Accumulation Period		1 Pair Per Accumulation Period
Home Health Services (up to 2 hours per visit / up to 3 visits per day / maximum of 100 visits per accumulation period)			No Charge		No Charge
Hospice Care (Inpatient and Outpatient)			No Charge		No Charge

All Plans are Medicare Part D Creditable

Gold EPO Plan

COMMUNITY CARE HEALTH EPO PLANS 1/1/26 THROUGH 12/31/26		Gold 80 EPO 250/30		Gold 80 EPO 500/30		Gold 80 EPO 750/30		Gold 80 EPO 1500/35	
Amounts per Accumulation Period ⁽¹⁾		Individual	Family	Individual	Family	Individual	Family	Individual	Family
Medical Deductible ⁽¹⁾		\$250	\$500	\$500	\$1,000	\$750	\$1,500	\$1,500	\$3,000
Prescription Drug Deductible ⁽¹⁾		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Out-of-Pocket Maximum ⁽¹⁾		\$8,000	\$16,000	\$8,000	\$16,000	\$8,000	\$16,000	\$9,100	\$18,200
COVERED BENEFITS		Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS
IN OFFICE SERVICES									
Primary Care Office Visits			\$30 / Visit		\$30 / Visit		\$30 / Visit		\$35 / Visit
Urgent Care Visits			\$30 / Visit		\$30 / Visit		\$30 / Visit		\$35 / Visit
Specialist Office Visits			\$60 / Visit		\$60 / Visit		\$60 / Visit		\$50 / Visit
Preventive physical exams, immunizations, and related laboratory services ⁽²⁾			\$0		\$0		\$0		\$0
Prenatal and Postpartum Office Visit			No Charge		No Charge		No Charge		No Charge
Well-Baby and Well-Child Exams ⁽²⁾			\$0		\$0		\$0		\$0
Allergy Injections			\$60 / Visit		\$60 / Visit		\$60 / Visit		\$50 / Visit
Outpatient Physical, Occupational and Speech Therapy			\$30 / Visit		\$30 / Visit		\$30 / Visit		\$35 / Visit
Laboratory Tests and Services			\$40 / Visit		\$40 / Visit		\$40 / Visit		\$35 / Visit
Radiology Services (x-rays, diagnostic imaging)			\$60 / Visit		\$100 / Visit		\$100 / Visit		\$35 / Visit
Advanced Radiology (including but not limited to MRI, MRA, MRS, CT Scan, PET, MUGA SPECT)		X	\$250 / Procedure	X	\$300 / Procedure	X	\$300 / Procedure	X	\$200 / Procedure
Outpatient Surgery (per procedure)		X	\$300 / Procedure	X	\$450 / Procedure	X	\$450 / Procedure	X	\$500 / Procedure
EMERGENCY SERVICES									
Emergency Room Visit (waived if admitted directly to hospital)		X	\$250 / Visit	X	\$300 / Visit	X	\$300 / Visit	X	\$250 / Visit
Emergency and Non-Emergency Medical Transportation		X	\$250 / Trip	X	\$250 / Trip	X	\$250 / Trip	X	\$250 / Trip
PRESCRIPTION DRUG COVERAGE ⁽⁶⁾									
Tier 1: Most generic drugs and low-cost preferred brands 30-day supply (retail)/90-day supply (mail order)			\$15 / \$30		\$15 / \$30		\$10 / \$20		\$5 / \$10
Tier 2: Non-preferred generic and Preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)			\$30 / \$60		\$45 / \$90		\$45 / \$90		\$25 / \$50
Tier 3: Non-preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)			\$55 / \$110		\$75 / \$150		\$75 / \$150		\$50 / \$100
Tier 4: Specialty Items/Drugs 30-day supply (retail only)			20% Coinsurance ⁽⁶⁾ (Up to \$250 Per 30-Day Supply)		20% Coinsurance ⁽⁶⁾ (Up to \$250 Per 30-Day Supply)		20% Coinsurance ⁽⁶⁾ (Up to \$250 Per 30-Day Supply)		20% Coinsurance ⁽⁶⁾ (Up to \$250 Per 30-Day Supply)
HOSPITALIZATION									
Facility Fee		X	\$600 / Day (Up to 5 Days)	X	\$600 / Day (Up to 5 Days)	X	\$600 / Day (Up to 5 Days)	X	\$600 / Day (Up to 5 Days)
Physician/Surgeon Fees			No Charge		No Charge		No Charge		No Charge
Skilled nursing facility services (maximum 100 days per accumulation period)		X	\$300 / Day (Up To 5 Days)	X	\$300 / Day (Up To 5 Days)	X	\$300 / Day (Up To 5 Days)	X	\$250 / Day (Up To 5 Days)
MENTAL HEALTH AND CHEMICAL DEPENDENCY									
Individual Office Visit			\$30 / Visit		\$30 / Visit		\$30 / Visit		\$35 / Visit
Inpatient Hospitalization		X	\$600 / Day (Up to 5 Days)	X	\$600 / Day (Up to 5 Days)	X	\$600 / Day (Up to 5 Days)	X	\$600 / Day (Up to 5 Days)
OTHER BENEFITS									
Teladoc Visit			\$10 / Visit		\$10 / Visit		\$10 / Visit		\$10 / Visit
Acupuncture/Chiropractic Office Visits (20 visit per year combined) ⁽⁶⁾			\$30 / Visit		\$30 / Visit		\$30 / Visit		\$35 / Visit
Durable Medical Equipment			20% Coinsurance ⁽⁶⁾		20% Coinsurance ⁽⁶⁾		20% Coinsurance ⁽⁶⁾		20% Coinsurance ⁽⁶⁾
Prosthetics and Orthotics			20% Coinsurance ⁽⁶⁾		20% Coinsurance ⁽⁶⁾		20% Coinsurance ⁽⁶⁾		20% Coinsurance ⁽⁶⁾
Pediatric Eye Exam			No Charge		No Charge		No Charge		No Charge
Pediatric Optical (Eyewear)			1 Pair Per Accumulation Period		1 Pair Per Accumulation Period		1 Pair Per Accumulation Period		1 Pair Per Accumulation Period
Home Health Services (up to 2 hours per visit / up to 3 visits per day / maximum of 100 visits per accumulation period)			\$30 / Visit		No Charge		No Charge		\$35 / Visit
Hospice Care (Inpatient and Outpatient)			No Charge		No Charge		No Charge		No Charge

All Plans are Medicare Part D Creditable

Silver EPO Plan

COMMUNITY CARE HEALTH EPO PLANS 1/1/26 THROUGH 12/31/26		Silver 70 EPO 1500/50		Silver 70 HDHP EPO 3200/25	
Amounts per Accumulation Period ⁽¹⁾		Individual	Family	Individual	Family
Medical Deductible ⁽¹⁾		\$1,500	\$3,000	\$3,200 *	\$6,400 *
Prescription Drug Deductible ⁽¹⁾		\$500	\$1,000	Combined	Combined
Out-of-Pocket Maximum ⁽¹⁾		\$9,100	\$18,200	\$8,300	\$16,600
COVERED BENEFITS		Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS
IN OFFICE SERVICES					
Primary Care Office Visits			\$50 / Visit	X	25% Coinsurance ⁽⁵⁾
Urgent Care Visits			\$50 / Visit	X	25% Coinsurance ⁽⁵⁾
Specialist Office Visits			\$85 / Visit	X	25% Coinsurance ⁽⁵⁾
Preventive physical exams, immunizations, and related laboratory services ⁽²⁾			\$0		\$0
Prenatal and Postpartum Office Visit			No Charge		No Charge
Well-Baby and Well-Child Exams ⁽²⁾			\$0		\$0
Allergy Injections			\$85 / Visit	X	25% Coinsurance ⁽⁵⁾
Outpatient Physical, Occupational and Speech Therapy			\$50 / Visit	X	25% Coinsurance ⁽⁵⁾
Laboratory Tests and Services			\$40 / Visit	X	25% Coinsurance ⁽⁵⁾
Radiology Services (x-rays, diagnostic imaging)			\$85 / Visit	X	25% Coinsurance ⁽⁵⁾
Advanced Radiology (including but not limited to MRI, MRA, MRS, CT Scan, PET, MUGA SPECT)		X	20% Coinsurance ⁽⁵⁾	X	25% Coinsurance ⁽⁵⁾
Outpatient Surgery (per procedure)			20% Coinsurance ⁽⁵⁾	X	25% Coinsurance ⁽⁵⁾
EMERGENCY SERVICES					
Emergency Room Visit (waived if admitted directly to hospital)		X	\$400 / Visit	X	25% Coinsurance ⁽⁵⁾
Emergency and Non-Emergency Medical Transportation		X	\$250 / Trip	X	25% Coinsurance ⁽⁵⁾
PRESCRIPTION DRUG COVERAGE ⁽⁶⁾					
Tier 1: Most generic drugs and low-cost preferred brands 30-day supply (retail)/90-day supply (mail order)			\$17 / \$34	X	25% Coinsurance ⁽⁵⁾ (Up To \$250)
Tier 2: Non-preferred generic and Preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)		X	\$65 / \$130	X	25% Coinsurance ⁽⁵⁾ (Up To \$250)
Tier 3: Non-preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)		X	\$90 / \$180	X	25% Coinsurance ⁽⁵⁾ (Up To \$250)
Tier 4: Specialty Items/Drugs 30-day supply (retail only)		X	20% Coinsurance ⁽⁵⁾ (Up To \$250 Per 30-Day Supply)	X	25% Coinsurance ⁽⁵⁾ (Up To \$250 Per 30-Day Supply)
HOSPITALIZATION					
Facility Fee		X	20% Coinsurance ⁽⁵⁾	X	25% Coinsurance ⁽⁵⁾
Physician/Surgeon Fees			20% Coinsurance ⁽⁵⁾	X	25% Coinsurance ⁽⁵⁾
Skilled nursing facility services (maximum 100 days per accumulation period)		X	20% Coinsurance ⁽⁵⁾	X	25% Coinsurance ⁽⁵⁾
MENTAL HEALTH AND CHEMICAL DEPENDENCY					
Individual Office Visit			\$50 / Visit	X	25% Coinsurance ⁽⁵⁾
Inpatient Hospitalization		X	20% Coinsurance ⁽⁵⁾	X	25% Coinsurance ⁽⁵⁾
OTHER BENEFITS					
Teladoc Visit			\$10 / Visit	X	\$10 / Visit
Acupuncture/Chiropractic Office Visits (20 visit per year combined) ⁽⁸⁾			\$50 / Visit	X	25% Coinsurance ⁽⁵⁾
Durable Medical Equipment			20% Coinsurance ⁽⁵⁾	X	25% Coinsurance ⁽⁵⁾
Prosthetics and Orthotics			20% Coinsurance ⁽⁵⁾	X	25% Coinsurance ⁽⁵⁾
Pediatric Eye Exam			No Charge		No Charge
Pediatric Optical (Eyewear)			1 Pair Per Accumulation Period		1 Pair Per Accumulation Period
Home Health Services (up to 2 hours per visit / up to 3 visits per day / maximum of 100 visits per accumulation period)			\$45 / Visit	X	25% Coinsurance ⁽⁵⁾
Hospice Care (Inpatient and Outpatient)			No Charge	X	No Charge

* Members with Family Coverage subject to IRS minimum deductible of \$3,400/individual.

All Plans are Medicare Part D Creditable

Footnotes for EPO Plans

- In a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out-of-pocket maximum amount. Cost sharing payments (deductibles, copayments and coinsurance, but not yet premiums) made by each individual in a family contribute to the family deductible and out-of-pocket maximums. The family deductible may be satisfied by a combination of individual deductible payments, after which member copays or coinsurance apply until the family out of pocket maximum is reached. Once the family out-of-pocket maximum is reached, the plan pays all costs for covered services for all family members. Cost sharing payments for all in-network services accumulate toward the deductible, if deductible applies to that service, and the out-of-pocket maximum. Enrollees shall pay no more than the cost sharing that would apply for the same covered services received from an in-network provider if services for the medically necessary treatment of a mental health or substance use disorder are not available in-network within geographic and timely access standards and are incurred out-of-network.
- Includes preventive services with a rating of A or B from the US Preventive Services Task Force; immunizations for children, adolescents and adults recommended by the Centers for Disease Control; and preventive care and screenings supported by the Health Resources and Services Administration for infants, children, adolescents and women. If preventive care is received at the time of other services, the applicable copayment for such services other than preventive care may apply.
- Other Practitioner Office Visits includes office visits not provided by Primary Care Physicians or Specialty Physicians, and office visits not specified in another benefit category.
- E-Visit consultations conducted through Teladoc have a \$10 copayment per visit.
- Of contracted rates
- Member cost share will not exceed 50% of the cost to the plan or \$250 per individual prescription of up to a 30-day supply of a covered drug. 90-day supply cost share applies to maintenance medications filled by mail order only.
- Other outpatient services include, but are not limited to: mental health psychological testing; mental health outpatient monitoring of drug therapy; substance use disorder treatment for withdrawal; day treatment such as partial hospitalization and intensive outpatient program; outpatient behavioral health treatment for pervasive developmental disorder and autism delivered at home; and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
- The annual visit limitation shall not apply to acupuncture visits that are for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.
- Member cost share for out-of-network COVID services is 50% of the reasonable and customary value (R&C) of the services, plus the difference, if any, between R&C and the provider's billed charges. Any costs incurred by the member do not accrue toward the member's Out of Pocket Maximum.

Additional Notes:

- In order to be covered, services may require Prior Authorization. Community Care Health does not require a referral in order to see a specialist, however, some specialists may require one before they will schedule an appointment. Please consult the complete Evidence of Coverage for additional information on referral and Prior Authorization requirements.
- Upon request from a Member or prescriber, a pharmacist may, but is not required to dispense a partial fill of a prescription for an oral, solid dosage form of a Schedule II controlled substance in accordance with Section 4052.10 of the California Business and Professions Code. The Cost Sharing for a partial fill of a prescription will be prorated.
- Evidence of Coverage (EOC): This EOC document, which describes the health care coverage under Community Care Health's Group Subscriber Contract with your group.

Platinum HMO Plan

COMMUNITY CARE HEALTH HMO PLANS 1/1/26 THROUGH 12/31/26	Platinum 90 HMO 0/10/250		Platinum 90 HMO 0/10/500		Platinum 90 HMO 0/25		Platinum 90 HMO 0/20†	
	Individual	Family	Individual	Family	Individual	Family	Individual	Family
Amounts per Accumulation Period ⁽¹⁾								
Medical Deductible ⁽¹⁾	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Prescription Drug Deductible ⁽¹⁾	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Out-of-Pocket Maximum ⁽¹⁾	\$3,000	\$6,000	\$3,500	\$7,000	\$2,500	\$5,000	\$4,500	\$9,000
COVERED BENEFITS	Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS
IN OFFICE SERVICES								
Primary Care Office Visits		\$10 / Visit		\$10 / Visit		\$25 / Visit		\$20 / Visit
Urgent Care Visits		\$10 / Visit		\$10 / Visit		\$25 / Visit		\$20 / Visit
Specialist Office Visits		\$20 / Visit		\$20 / Visit		\$50 / Visit		\$30 / Visit
Preventive physical exams, immunizations, and related laboratory services ⁽²⁾		\$0		\$0		\$0		\$0
Prenatal and Postpartum Office Visit		No Charge		No Charge		No Charge		No Charge
Well-Baby and Well-Child Exams ⁽²⁾		\$0		\$0		\$0		\$0
Allergy Injections		\$20 / Visit		\$20 / Visit		\$50 / Visit		\$30 / Visit
Outpatient Physical, Occupational and Speech Therapy		\$10 / Visit		\$10 / Visit		\$25 / Visit		\$20 / Visit
Laboratory Tests and Services		\$20 / Visit		\$20 / Visit		\$20 / Visit		\$20 / Visit
Radiology Services (x-rays, diagnostic imaging)		\$40 / Visit		\$40 / Visit		\$75 / Visit		\$30 / Visit
Advanced Radiology (including but not limited to MRI, MRA, MRS, CT Scan, PET, MUGA SPECT)		\$150 / Procedure		\$150 / Procedure		\$200 / Procedure		\$100 / Procedure
Outpatient Surgery (per procedure)		\$250 / Procedure		\$300 / Procedure		\$400 / Procedure		\$100 / Procedure
EMERGENCY SERVICES								
Emergency Room Visit (waived if admitted directly to hospital)		\$250 / Visit		\$200 / Visit		\$250 / Visit		\$150 / Visit
Emergency and Non-Emergency Medical Transportation		\$150 / Trip		\$150 / Trip		\$150 / Trip		\$150 / Trip
PRESCRIPTION DRUG COVERAGE ⁽⁶⁾								
Tier 1: Most generic drugs and low-cost preferred brands 30-day supply (retail)/90-day supply (mail order)		\$5 / \$10		\$5 / \$10		\$5 / \$10		\$5 / \$10
Tier 2: Non-preferred generic and Preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)		\$15 / \$30		\$15 / \$30		\$15 / \$30		\$20 / \$40
Tier 3: Non-preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)		\$25 / \$50		\$25 / \$50		\$25 / \$50		\$30 / \$60
Tier 4: Specialty Items/Drugs 30-day supply (retail only)		20% Coinsurance ⁽⁵⁾ (Up to \$250 Per 30-Day Supply)		20% Coinsurance ⁽⁵⁾ (Up to \$250 Per 30-Day Supply)		20% Coinsurance ⁽⁵⁾ (Up to \$250 Per 30-Day Supply)		20% Coinsurance ⁽⁵⁾ (Up to \$250 Per 30-Day Supply)
HOSPITALIZATION								
Facility Fee		\$250 / Admission		\$500 / Admission		\$500 / Admission		\$250 / Day (Up To 5 Days)
Physician/Surgeon Fees		No Charge		No Charge		No Charge		No Charge
Skilled nursing facility services (maximum 100 days per accumulation period)		\$250 / Admission		\$250 / Admission		\$500 / Admission		\$150 / Day (Up To 5 Days)
MENTAL HEALTH AND CHEMICAL DEPENDENCY								
Individual Office Visit		\$10 / Visit		\$10 / Visit		\$25 / Visit		\$20 / Visit
Inpatient Hospitalization		\$250 / Admission		\$500 / Admission		\$500 / Admission		\$250 / Day (Up To 5 Days)
OTHER BENEFITS								
Teladoc Visit		\$10 / Visit		\$10 / Visit		\$10 / Visit		\$0 / Visit
Acupuncture/Chiropractic Office Visits (20 visit per year combined) ⁽⁸⁾		\$10 / Visit		\$10 / Visit		\$25 / Visit		\$20 / Visit
Durable Medical Equipment		10% Coinsurance ⁽⁵⁾		10% Coinsurance ⁽⁵⁾		20% Coinsurance ⁽⁵⁾		10% Coinsurance ⁽⁵⁾
Prosthetics and Orthotics		10% Coinsurance ⁽⁵⁾		10% Coinsurance ⁽⁵⁾		20% Coinsurance ⁽⁵⁾		10% Coinsurance ⁽⁵⁾
Pediatric Eye Exam		No Charge		No Charge		No Charge		No Charge
Pediatric Optical (Eyewear)		1 Pair Per Accumulation Period		1 Pair Per Accumulation Period		1 Pair Per Accumulation Period		1 Pair Per Accumulation Period
Home Health Services	(up to 2 hours per visit / up to 3 visits per day / maximum of 100 visits per accumulation period)	No Charge		No Charge		No Charge		\$20 / Visit
Hospice Care (Inpatient and Outpatient)		No Charge		No Charge		No Charge		No Charge

† Denotes Covered California mirrored plan design

All Plans are Medicare Part D Creditable

Gold HMO Plan

COMMUNITY CARE HEALTH HMO PLANS 1/1/26 THROUGH 12/31/26	Gold 80 HMO 250/35†		Gold 80 HMO 500/35		Gold 80 HMO 750/30		Gold 80 HMO 1000/35	
	Individual	Family	Individual	Family	Individual	Family	Individual	Family
Amounts per Accumulation Period ⁽¹⁾								
Medical Deductible ⁽¹⁾	\$250	\$500	\$500	\$1,000	\$750	\$1,500	\$1,000	\$2,000
Prescription Drug Deductible ⁽¹⁾	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Out-of-Pocket Maximum ⁽¹⁾	\$7,800	\$15,600	\$7,000	\$14,000	\$7,000	\$14,000	\$7,750	\$15,500
COVERED BENEFITS	Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS
IN OFFICE SERVICES								
Primary Care Office Visits		\$35 / Visit		\$35 / Visit		\$30 / Visit		\$35 / Visit
Urgent Care Visits		\$35 / Visit		\$35 / Visit		\$30 / Visit		\$35 / Visit
Specialist Office Visits		\$55 / Visit		\$75 / Visit		\$60 / Visit		\$50 / Visit
Preventive physical exams, immunizations, and related laboratory services ⁽²⁾		\$0		\$0		\$0		\$0
Prenatal and Postpartum Office Visit		No Charge		No Charge		No Charge		No Charge
Well-Baby and Well-Child Exams ⁽²⁾		\$0		\$0		\$0		\$0
Allergy Injections		\$55 / Visit		\$75 / Visit		\$60 / Visit		\$50 / Visit
Outpatient Physical, Occupational and Speech Therapy		\$35 / Visit		\$35 / Visit		\$30 / Visit		\$35 / Visit
Laboratory Tests and Services		\$35 / Visit		\$75 / Visit		\$40 / Visit		\$35 / Visit
Radiology Services (x-rays, diagnostic imaging)		\$55 / Visit		\$100 / Visit		\$100 / Visit		\$35 / Visit
Advanced Radiology (including but not limited to MRI, MRA, MRS, CT Scan, PET, MUGA SPECT)	X	\$250 / Procedure	X	\$200 / Procedure	X	\$300 / Procedure	X	\$200 / Procedure
Outpatient Surgery (per procedure)	X	\$300 / Procedure	X	\$600 / Procedure	X	\$600 / Procedure	X	\$500 / Procedure
EMERGENCY SERVICES								
Emergency Room Visit (waived if admitted directly to hospital)	X	\$250 / Visit	X	\$200 / Visit	X	\$400 / Visit	X	\$250 / Visit
Emergency and Non-Emergency Medical Transportation	X	\$250 / Trip	X	\$250 / Trip	X	\$250 / Trip	X	\$250 / Trip
PRESCRIPTION DRUG COVERAGE ⁽⁶⁾								
Tier 1: Most generic drugs and low-cost preferred brands 30-day supply (retail)/90-day supply (mail order)		\$15 / \$30		\$20 / \$40		\$10 / \$20		\$5 / \$10
Tier 2: Non-preferred generic and Preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)		\$40 / \$80		\$50 / \$100		\$45 / \$90		\$25 / \$50
Tier 3: Non-preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)		\$70 / \$140		\$80 / \$160		\$75 / \$150		\$50 / \$100
Tier 4: Specialty Items/Drugs 30-day supply (retail only)		20% Coinsurance ⁽⁵⁾ (Up to \$250 Per 30-Day Supply)		20% Coinsurance ⁽⁵⁾ (Up to \$250 Per 30-Day Supply)		20% Coinsurance ⁽⁵⁾ (Up to \$250 Per 30-Day Supply)		20% Coinsurance ⁽⁵⁾ (Up to \$250 Per 30-Day Supply)
HOSPITALIZATION								
Facility Fee	X	\$600 / Day (Up To 5 Days)	X	\$1,500 / Admission	X	\$600 / Day (Up To 5 Days)	X	\$600 / Day (Up To 5 Days)
Physician/Surgeon Fees		No Charge		No Charge		No Charge		No Charge
Skilled nursing facility services (maximum 100 days per accumulation period)	X	\$300 / Day (Up To 5 Days)	X	\$175 / Admission	X	\$300 / Day (Up To 5 Days)	X	\$250 / Day (Up To 5 Days)
MENTAL HEALTH AND CHEMICAL DEPENDENCY								
Individual Office Visit		\$35 / Visit		\$35 / Visit		\$30 / Visit		\$35 / Visit
Inpatient Hospitalization	X	\$600 / Day (Up To 5 Days)	X	\$1,500 / Admission	X	\$600 / Day (Up To 5 Days)	X	\$600 / Day (Up To 5 Days)
OTHER BENEFITS								
Teladoc Visit		\$0 / Visit		\$10 / Visit		\$10 / Visit		\$10 / Visit
Acupuncture/Chiropractic Office Visits (20 visit per year combined) ⁽⁸⁾		\$35 / Visit		\$35 / Visit		\$30 / Visit		\$35 / Visit
Durable Medical Equipment		20% Coinsurance ⁽⁵⁾		20% Coinsurance ⁽⁵⁾		20% Coinsurance ⁽⁵⁾		20% Coinsurance ⁽⁵⁾
Prosthetics and Orthotics		20% Coinsurance ⁽⁵⁾		20% Coinsurance ⁽⁵⁾		20% Coinsurance ⁽⁵⁾		20% Coinsurance ⁽⁵⁾
Pediatric Eye Exam		No Charge		No Charge		No Charge		No Charge
Pediatric Optical (Eyewear)		1 Pair Per Accumulation Period		1 Pair Per Accumulation Period		1 Pair Per Accumulation Period		1 Pair Per Accumulation Period
Home Health Services	(up to 2 hours per visit / up to 3 visits per day / maximum of 100 visits per accumulation period)	\$30 / Visit		\$35 / Visit		No Charge		\$35 / Visit
Hospice Care (Inpatient and Outpatient)		No Charge		No Charge		No Charge		No Charge

† Denotes Covered California mirrored plan design

All Plans are Medicare Part D Creditable

HRA Plan

COMMUNITY CARE HEALTH HMO PLANS 1/1/26 THROUGH 12/31/26		Gold 80 HMO HRA 2150/35		Silver 70 HMO HRA 2250/50	
Amounts per Accumulation Period ⁽¹⁾		Individual	Family	Individual	Family
Medical Deductible ⁽¹⁾		\$2,150	\$4,300	\$2,250	\$4,500
Prescription Drug Deductible ⁽¹⁾		\$0	\$0	\$300	\$600
Out-of-Pocket Maximum ⁽¹⁾		\$7,550	\$15,100	\$8,900	\$17,800
COVERED BENEFITS		Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS
IN OFFICE SERVICES					
Primary Care Office Visits			\$35 / Visit		\$50 / Visit
Urgent Care Visits			\$35 / Visit		\$50 / Visit
Specialist Office Visits			\$50 / Visit		\$85 / Visit
Preventive physical exams, immunizations, and related laboratory services ⁽²⁾			\$0		\$0
Prenatal and Postpartum Office Visit			No Charge		No Charge
Well-Baby and Well-Child Exams ⁽²⁾			\$0		\$0
Allergy Injections			\$50 / Visit		\$85 / Visit
Outpatient Physical, Occupational and Speech Therapy		X	\$35 / Visit		\$50 / Visit
Laboratory Tests and Services		X	25% Coinsurance ⁽⁵⁾		\$40 / Visit
Radiology Services (x-rays, diagnostic imaging)		X	25% Coinsurance ⁽⁵⁾		\$85 / Visit
Advanced Radiology (including but not limited to MRI, MRA, MRS, CT Scan, PET, MUGA SPECT)		X	25% Coinsurance ⁽⁵⁾		\$300 / Procedure
Outpatient Surgery (per procedure)		X	25% Coinsurance ⁽⁵⁾		20% Coinsurance ⁽⁵⁾
EMERGENCY SERVICES					
Emergency Room Visit (waived if admitted directly to hospital)		X	25% Coinsurance ⁽⁵⁾	X	\$400 / Visit
Emergency and Non-Emergency Medical Transportation		X	25% Coinsurance ⁽⁵⁾	X	\$250 / Trip
PRESCRIPTION DRUG COVERAGE ⁽⁶⁾					
Tier 1: Most generic drugs and low-cost preferred brands 30-day supply (retail)/90-day supply (mail order)			\$15 / \$30		\$17 / \$34
Tier 2: Non-preferred generic and Preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)			\$30 / \$60	X	\$65 / \$130
Tier 3: Non-preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)			\$45 / \$90	X	\$90 / \$180
Tier 4: Specialty Items/Drugs 30-day supply (retail only)			20% Coinsurance ⁽⁵⁾ (Up to \$250 Per 30-Day Supply)	X	20% Coinsurance ⁽⁵⁾ (Up to \$250 Per 30-Day Supply)
HOSPITALIZATION					
Facility Fee		X	25% Coinsurance ⁽⁵⁾	X	20% Coinsurance ⁽⁵⁾
Physician/Surgeon Fees		X	No Charge		20% Coinsurance ⁽⁵⁾
Skilled nursing facility services (maximum 100 days per accumulation period)		X	25% Coinsurance ⁽⁵⁾	X	20% Coinsurance ⁽⁵⁾
MENTAL HEALTH AND CHEMICAL DEPENDENCY					
Individual Office Visit			\$35 / Visit		\$50 / Visit
Inpatient Hospitalization		X	25% Coinsurance ⁽⁵⁾	X	20% Coinsurance ⁽⁵⁾
OTHER BENEFITS					
Teladoc Visit			\$10 / Visit		\$10 / Visit
Acupuncture/Chiropractic Office Visits (20 visit per year combined) ⁽⁸⁾			\$35 / Visit		\$50 / Visit
Durable Medical Equipment			50% Coinsurance ⁽⁵⁾		20% Coinsurance ⁽⁵⁾
Prosthetics and Orthotics			50% Coinsurance ⁽⁵⁾		20% Coinsurance ⁽⁵⁾
Pediatric Eye Exam			No Charge		No Charge
Pediatric Optical (Eyewear)			1 Pair Per Accumulation Period		1 Pair Per Accumulation Period
Home Health Services	(up to 2 hours per visit / up to 3 visits per day / maximum of 100 visits per accumulation period)		No Charge		\$45 / Visit
Hospice Care (Inpatient and Outpatient)			No Charge		No Charge

† Denotes Covered California mirrored plan design

All Plans are Medicare Part D Creditable

Silver HMO Plan

COMMUNITY CARE HEALTH HMO PLANS 1/1/26 THROUGH 12/31/26		Silver 70 HMO 2250/50		Silver 70 HDHP HMO 3200/25†	
Amounts per Accumulation Period ⁽¹⁾		Individual	Family	Individual	Family
Medical Deductible ⁽¹⁾		\$2,250	\$4,500	\$3,200*	\$6,400*
Prescription Drug Deductible ⁽¹⁾		\$300	\$600	Combined	Combined
Out-of-Pocket Maximum ⁽¹⁾		\$8,900	\$17,800	\$8,300	\$16,600
COVERED BENEFITS		Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS
IN OFFICE SERVICES					
Primary Care Office Visits			\$50 / Visit	X	25% Coinsurance ⁽⁵⁾
Urgent Care Visits			\$50 / Visit	X	25% Coinsurance ⁽⁵⁾
Specialist Office Visits			\$85 / Visit	X	25% Coinsurance ⁽⁵⁾
Preventive physical exams, immunizations, and related laboratory services ⁽²⁾			\$0		\$0
Prenatal and Postpartum Office Visit			No Charge		No Charge
Well-Baby and Well-Child Exams ⁽²⁾			\$0		\$0
Allergy Injections			\$85 / Visit	X	25% Coinsurance ⁽⁵⁾
Outpatient Physical, Occupational and Speech Therapy			\$50 / Visit	X	25% Coinsurance ⁽⁵⁾
Laboratory Tests and Services			\$40 / Visit	X	25% Coinsurance ⁽⁵⁾
Radiology Services (x-rays, diagnostic imaging)			\$85 / Visit	X	25% Coinsurance ⁽⁵⁾
Advanced Radiology (including but not limited to MRI, MRA, MRS, CT Scan, PET, MUGA SPECT)			\$300 / Procedure	X	25% Coinsurance ⁽⁵⁾
Outpatient Surgery (per procedure)			20% Coinsurance ⁽⁵⁾	X	25% Coinsurance ⁽⁵⁾
EMERGENCY SERVICES					
Emergency Room Visit (waived if admitted directly to hospital)		X	\$400 / Visit	X	25% Coinsurance ⁽⁵⁾
Emergency and Non-Emergency Medical Transportation		X	\$250 / Trip	X	25% Coinsurance ⁽⁵⁾
PRESCRIPTION DRUG COVERAGE ⁽⁶⁾					
Tier 1: Most generic drugs and low-cost preferred brands 30-day supply (retail)/90-day supply (mail order)			\$17 / \$34	X	25% Coinsurance ⁽⁵⁾ (Up To \$250)*
Tier 2: Non-preferred generic and Preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)		X	\$65 / \$130	X	25% Coinsurance ⁽⁵⁾ (Up To \$250)*
Tier 3: Non-preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)		X	\$90 / \$180	X	25% Coinsurance ⁽⁵⁾ (Up To \$250)*
Tier 4: Specialty Items/Drugs 30-day supply (retail only)		X	20% Coinsurance ⁽⁵⁾ (Up to \$250 Per 30-Day Supply)	X	25% Coinsurance ⁽⁵⁾ (Up to \$250 Per 30-Day Supply)
HOSPITALIZATION					
Facility Fee		X	20% Coinsurance ⁽⁵⁾	X	25% Coinsurance ⁽⁵⁾
Physician/Surgeon Fees			20% Coinsurance ⁽⁵⁾	X	25% Coinsurance ⁽⁵⁾
Skilled nursing facility services (maximum 100 days per accumulation period)		X	20% Coinsurance ⁽⁵⁾	X	25% Coinsurance ⁽⁵⁾
MENTAL HEALTH AND CHEMICAL DEPENDENCY					
Individual Office Visit			\$50 / Visit	X	25% Coinsurance ⁽⁵⁾
Inpatient Hospitalization		X	20% Coinsurance ⁽⁵⁾	X	25% Coinsurance ⁽⁵⁾
OTHER BENEFITS					
Teladoc Visit			\$10 / Visit	X	\$0 / Visit
Acupuncture/Chiropractic Office Visits (20 visit per year combined) ⁽⁸⁾			\$50 / Visit	X	25% Coinsurance ⁽⁵⁾
Durable Medical Equipment			20% Coinsurance ⁽⁵⁾	X	25% Coinsurance ⁽⁵⁾
Prosthetics and Orthotics			20% Coinsurance ⁽⁵⁾	X	25% Coinsurance ⁽⁵⁾
Pediatric Eye Exam			No Charge		No Charge
Pediatric Optical (Eyewear)			1 Pair Per Accumulation Period		1 Pair Per Accumulation Period
Home Health Services	(up to 2 hours per visit / up to 3 visits per day / maximum of 100 visits per accumulation period)		\$45 / Visit	X	25% Coinsurance ⁽⁵⁾
Hospice Care (Inpatient and Outpatient)			No Charge	X	No Charge

* Members with Family Coverage subject to IRS minimum deductible of \$3,400/individual

† Denotes Covered California mirrored plan design

All Plans are Medicare Part D Creditable

Bronze HMO Plan

COMMUNITY CARE HEALTH HMO PLANS 1/1/26 THROUGH 12/31/26		Bronze 60 HDHP HMO 7200/0†		Bronze 60 HMO 6300/65	
Amounts per Accumulation Period ⁽¹⁾		Individual	Family	Individual	Family
Medical Deductible ⁽¹⁾		\$7,200	\$14,400	\$6,300	\$12,600
Prescription Drug Deductible ⁽¹⁾		Combined	Combined	\$500	\$1,000
Out-of-Pocket Maximum ⁽¹⁾		\$7,200	\$14,400	\$8,500	\$17,000
COVERED BENEFITS		Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS
IN OFFICE SERVICES					
Primary Care Office Visits		X	No Charge	X	\$65 / Visit †
Urgent Care Visits		X	No Charge	X	\$65 / Visit †
Specialist Office Visits		X	No Charge	X	\$95 / Visit †
Preventive physical exams, immunizations, and related laboratory services ⁽²⁾			\$0		\$0
Prenatal and Postpartum Office Visit			No Charge		No Charge
Well-Baby and Well-Child Exams ⁽²⁾			\$0		\$0
Allergy Injections		X	No Charge	X	\$95 / Visit
Outpatient Physical, Occupational and Speech Therapy		X	No Charge		\$65 / Visit
Laboratory Tests and Services		X	No Charge		\$40 / Visit
Radiology Services (x-rays, diagnostic imaging)		X	No Charge	X	40% Coinsurance ⁽⁵⁾
Advanced Radiology (including but not limited to MRI, MRA, MRS, CT Scan, PET, MUGA SPECT)		X	No Charge	X	40% Coinsurance ⁽⁵⁾
Outpatient Surgery (per procedure)		X	No Charge	X	40% Coinsurance ⁽⁵⁾
EMERGENCY SERVICES					
Emergency Room Visit (waived if admitted directly to hospital)		X	No Charge	X	40% Coinsurance ⁽⁵⁾
Emergency and Non-Emergency Medical Transportation		X	No Charge	X	40% Coinsurance ⁽⁵⁾
PRESCRIPTION DRUG COVERAGE ⁽⁶⁾					
Tier 1: Most generic drugs and low-cost preferred brands 30-day supply (retail)/90-day supply (mail order)		X	No Charge		\$18 / \$36
Tier 2: Non-preferred generic and Preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)		X	No Charge	X	40% Coinsurance ⁽⁵⁾ (Up To \$500)
Tier 3: Non-preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)		X	No Charge	X	40% Coinsurance ⁽⁵⁾ (Up To \$500)
Tier 4: Specialty Items/Drugs 30-day supply (retail only)		X	20% Coinsurance ⁽⁵⁾ (Up To \$250 Per 30-Day Supply)	X	20% Coinsurance ⁽⁵⁾ (Up To \$250 Per 30-Day Supply)
HOSPITALIZATION					
Facility Fee		X	No Charge	X	40% Coinsurance ⁽⁵⁾
Physician/Surgeon Fees		X	No Charge	X	40% Coinsurance ⁽⁵⁾
Skilled nursing facility services (maximum 100 days per accumulation period)		X	No Charge	X	40% Coinsurance ⁽⁵⁾
MENTAL HEALTH AND CHEMICAL DEPENDENCY					
Individual Office Visit		X	No Charge	X	\$65 / Visit †
Inpatient Hospitalization		X	No Charge	X	40% Coinsurance ⁽⁵⁾
OTHER BENEFITS					
Teladoc Visit		X	\$0 / Visit	X	\$10 / Visit †
Acupuncture/Chiropractic Office Visits (20 visit per year combined) ⁽⁶⁾		X	No Charge	X	\$65 / Visit †
Durable Medical Equipment		X	No Charge	X	40% Coinsurance ⁽⁵⁾
Prosthetics and Orthotics		X	No Charge	X	40% Coinsurance ⁽⁵⁾
Pediatric Eye Exam			No Charge		No Charge
Pediatric Optical (Eyewear)			1 Pair Per Accumulation Period		1 Pair Per Accumulation Period
Home Health Services (up to 2 hours per visit / up to 3 visits per day / maximum of 100 visits per accumulation period)		X	No Charge	X	40% Coinsurance ⁽⁵⁾
Hospice Care (Inpatient and Outpatient)		X	No Charge		No Charge

* Deductible waived for the first three non-preventive visits.

† Denotes Covered California mirrored plan design

All Plans are Medicare Part D Creditable

Footnotes for HMO Plans

Cost-share amounts for in-network services accumulate toward the out-of-pocket maximum.

Preventive services are available at no cost share except for services from non-participating providers. For a complete list of preventive services, please refer to the *Evidence of Coverage*, or communitycarehealth.org.

Community Care Health plans do not include any limitations or restrictions for pre-existing conditions.

- In a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out-of-pocket maximum amount. Cost sharing payments (deductibles, copayments and coinsurance, but not yet premiums) made by each individual in a family contribute to the family deductible and out-of-pocket maximums. The family deductible may be satisfied by a combination of individual deductible payments, after which member copays or coinsurance apply until the family out of pocket maximum is reached. Once the family out-of-pocket maximum is reached, the plan pays all costs for covered services for all family members. Cost sharing payments for all in-network services accumulate toward the deductible, if deductible applies to that service, and the out-of-pocket maximum. Enrollees shall pay no more than the cost sharing that would apply for the same covered services received from an in-network provider if services for the medically necessary treatment of a mental health or substance use disorder are not available in-network within geographic and timely access standards and are incurred out-of-network.
- Includes preventive services with a rating of A or B from the US Preventive Services Task Force; immunizations for children, adolescents and adults recommended by the Centers for Disease Control; and preventive care and screenings supported by the Health Resources and Services Administration for infants, children, adolescents and women. If preventive care is received at the time of other services, the applicable copayment for such services other than preventive care may apply.
- Other Practitioner Office Visits includes office visits not provided by Primary Care Physicians or Specialty Physicians, and office visits not specified in another benefit category.
- E-Visit consultations conducted through Teladoc have a \$0 copayment per visit.
- Of contracted rates
- Member cost share will not exceed 50% of the cost to the plan or \$250* per individual prescription of up to a 30-day supply of a covered drug. 90-day supply cost share applies to maintenance medications filled by mail order only.
- Other outpatient services include, but are not limited to: mental health psychological testing; mental health outpatient monitoring of drug therapy; substance use disorder treatment for withdrawal; day treatment such as partial hospitalization and intensive outpatient program; outpatient behavioral health treatment for pervasive developmental disorder and autism delivered at home; and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
- The annual visit limitation shall not apply to acupuncture visits that are for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.
- Member cost share for out-of-network COVID services is 50% of the reasonable and customary value (R&C) of the services, plus the difference, if any, between R&C and the provider's billed charges. Any costs incurred by the member do not accrue toward the member's Out of Pocket Maximum.

Additional Notes:

- In order to be covered, most services require a referral from your Primary Care Physicians, and may also require Prior Authorization by your Primary Care Physicians medical group. Please consult the complete Evidence of Coverage for additional information on referral and Prior Authorization requirements.
- Upon request from a Member or prescriber, a pharmacist may, but is not required to dispense a partial fill of a prescription for an oral, solid dosage form of a Schedule II controlled substance in accordance with Section 4052.10 of the California Business and Professions Code. The Cost Sharing for a partial fill of a prescription will be prorated.
- Evidence of Coverage (EOC): This EOC document, which describes the health care coverage under Community Care Health's Group Subscriber Contract with your group.
- Primary Care Physicians (PCP): Means a participating physician who practices in the area of family practices, internal medicine, pediatrics, general practices or obstetrics/gynecology and acts as the coordinator of care, including such responsibilities as supervising continuity of care, record keeping and initiating referral to specialist physicians for members who select a primary care physician.

* \$500 for Bronze Plans

Health & Wellness Programs

Community Care Health Partners with WeightWatchers®

healthy habits, simplified

WW MEMBER ADAM Y. -70 LB[^]

WW MEMBER NIKKI M. -72 LB[^]

no quick fixes
Meet the program built on groundbreaking nutritional and behavior change research.

nutrition made simple
Get an eating plan for *your* body, 200 foods you don't need to track, and 12,000-plus recipes.

an award-winning app
Tap into innovative trackers, on-demand workouts, meditations, and more.

24/7 support
Find a sense of belonging and always-on support at in-person and virtual Workshops.

tailored diabetes support
Unlock guidance from a certified diabetes educator, an in-app blood sugar tracker, and diabetes-tailored resources.[†]

[^]People following the WW program can expect to lose 1–2 lb./wk.

Join today for as low as **\$9.75 per month** on select plans—
50% off the retail price!^{*}

Learn more at CommunityCareHealth.WW.com.

Already a WeightWatchers member?

Sync your current account, or call WeightWatchers customer service at 866-204-2885.

^{*}Savings reflect WW's Core membership for your organization's employees. Monthly payment required in advance. You'll be automatically charged each month in accordance with company pricing until you cancel. Pricing will adjust to the standard monthly rate when your employment with your organization terminates or the agreement between your employer and WW terminates.

[†]Reminder: WeightWatchers is not a replacement for medical care. Consult your doctor for any health concerns.

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Health & Wellness Programs

Community Care Health with WeightWatchers® for Diabetics

Live Well with Diabetes

If you have diabetes, you can manage it without starting from scratch. Our wellness partner, WeightWatchers®, has the support and tools you need to make living with diabetes a bit less complicated—and still full of joy.

WeightWatchers offers a **WW for Diabetes program** which offers all the benefits of WW, plus:

- ✓ Unlimited guidance from a Certified Diabetes Educator
- ✓ Personalized meal plan tailored to your individual lifestyle needs
- ✓ Weekly newsletter to help you apply Workshop topics to your diabetes program
- ✓ Content specific to weight loss and diabetes

Then **Now**

"WeightWatchers has done so much more than change the number on the scale. I feel like I've gotten my life back."
—WW MEMBER CHERIA M., LOST 53 POUNDS^{*}

Join WeightWatchers through **Community Care Health** for **discounted pricing*** on select plans!

Visit CommunityCareHealth.WW.com to sign up.

^{*}People following the WW program can expect to lose 1 to 2 pounds per week.

^{**}"As low as" price reflects WW Digital plan for your organization's employees. Monthly payment required in advance. You'll be automatically charged each month in accordance with company pricing until you cancel, your employment with your organization terminates, or the agreement between your employer and WW terminates.

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Health & Wellness Programs



Valley Fitness and Community Care Health have teamed up to give members this offer.

Community Care Health members and their family (any family members enrolled in the medical health plan) can join Valley Fitness with this special offer.

Your special membership features:

- 8 California locations:
 - Atascadero
 - Atwater
 - Fresno - Ashlan
 - Fresno - Maroa
 - Fresno - Herndon
 - Madera
 - Selma
 - Visalia
- Unlimited access to HydroMassage to relax and recover
- Total Body Circuit for full body workout in 30 minutes
- Swimming pools and racquetball at select locations
- Top-of-the-line cardio, free weights and functional training equipment

Standard Rates	\$49 Enrollment Fee	\$29.99 per Month	\$69 Annual Fee	
Discount Rates	\$0 Enrollment Fee	\$24.99* or \$59.00* per Month	Annual Fee Waived	Offer Expires 5/31/26

* Basic Membership: \$24.99 (per person) offers access to all gyms and equipment.
 * Boot Camp Group Training Membership: \$59.00 (per person) includes the basic membership, plus group training: 60 minutes fully body workout, Zumba class, yoga classes and interval training.
 * Only in California
 * Expires May 31, 2026

For more information contact member support: (559) 286-0591 | membersupport@valleyfitness.com

Health & Wellness Programs



Community Care Health is thrilled to partner with local Central Valley favorite, Blue Moon Yoga and Wellness to bring our members an exclusive wellness package designed to support your journey to better health. Blue Moon Yoga offers the perfect space to stretch, strengthen and recharge—whether you’re new to the mat or a seasoned yogi.

4-Class Card:

- Purchase a 4-Class Card for \$70
- Good for any All-Levels hot yoga and pilates classes at any of Blue Moon Yoga's three locations
- No limit for Community Care Health members on 4-Class Card purchases

Membership Discounts:

- Receive 20% off any Blue Moon Yoga membership package
- Requires a three-month commitment
- Discount remains as long as you are a Community Care Health member

Benefits of Hot Yoga:

- **Improved Flexibility & Strength:** The heat helps loosen muscles, allowing for deeper stretching and enhanced muscle tone.
- **Detoxification:** Sweating in a hot room aids in flushing toxins from the body, supporting overall immune health.
- **Stress Reduction:** The calming nature of yoga, combined with a heated environment, promotes relaxation and reduces anxiety.
- **Cardiovascular Health:** Hot yoga increases heart rate and endurance, making it an excellent low-impact cardiovascular workout.



To learn more and to sign up, visit: www.communitycarehealth.org/bluemoon

Health & Wellness Programs

Access Perks



Say goodbye to paying full price and hello to **HUGE SAVINGS!**

You'll enjoy deals at:



Your Favorite Local Shops



Fast Food, Casual, and Fine Dining Restaurants



Online Retailers



Theme Parks You Know and Love



Over 850K Hotels and



Popular Car Rental Providers



Resorts Worldwide



300+ Major Airline Carriers
AND SO MUCH MORE!



1,000,000+

Discounts

50,000

Restaurants

800+

Online Retailers

32%

Average Savings!

Get Started at: communitycarehealth.org/accessperks



Right for You. Right for Your Family. Right Next Door.

(559) 776-7925
sales@communitycarehealth.org

Customer Service
(559) 724-4995
Toll-Free: 1 (844) 516-0181

communitycarehealth.org