COMMUNITY CARE HEALTH

Small Group Health Plan

Your Guide to Choosing the Best Plan for Your Employees

For effective dates:
January 1, 2024 through December 31, 2024

Updated January 1, 2024

communitycarehealth.org

What's Inside

The Central Valley's Local Health Care Plan

Because Your Community Is Our Community

Community Care Health (CCH) 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 CCH 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.

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)

A Powerful Network for Comprehensive Care

2,500+
Primary Care Providers and Specialists

1,400
Practice Sites

20
Urgent Care Centers

Community Medical Centers

Community Health Partners

Valley Children's Hospital

SimpleBehavioral

SimpleMSK

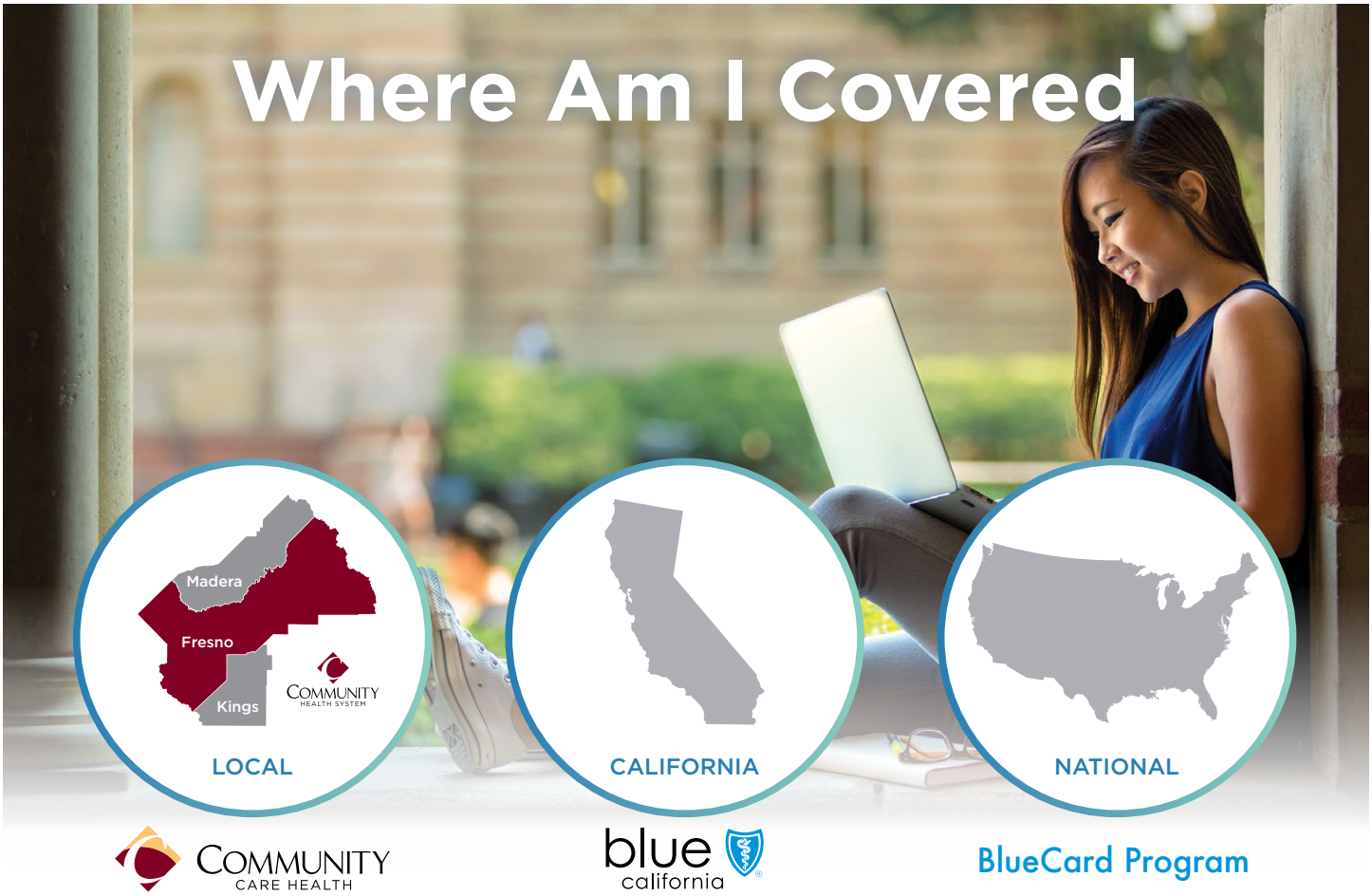
Delta Dental

vsp vision care

Medimpact

weightwatchers reimagined

Coverage Wherever Our Members Live, Work & Study



COMMUNITY CARE HEALTH

blue california

BlueCard Program

Covered Care Outside of the Area

CCH 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.

PICTURE PERFECT CARE FOR YOUR WHOLE FAMILY

With the strength of a community this large, finding the right provider for you becomes easy. From a doctor who knows you and is always ready to answer the little questions to a team of specialists ready to walk you through life's biggest challenges, you can always count on care that's with you every step of the way.

We believe every person deserves a healthcare team that works around their needs, every day, and that some of today's health-related issues simply can't be put off until tomorrow. Which is why our primary care providers are now accepting new patients and **same-day appointments.**

To get the care you need, when you need it, visit us at **CommunityHealthPartners.org**

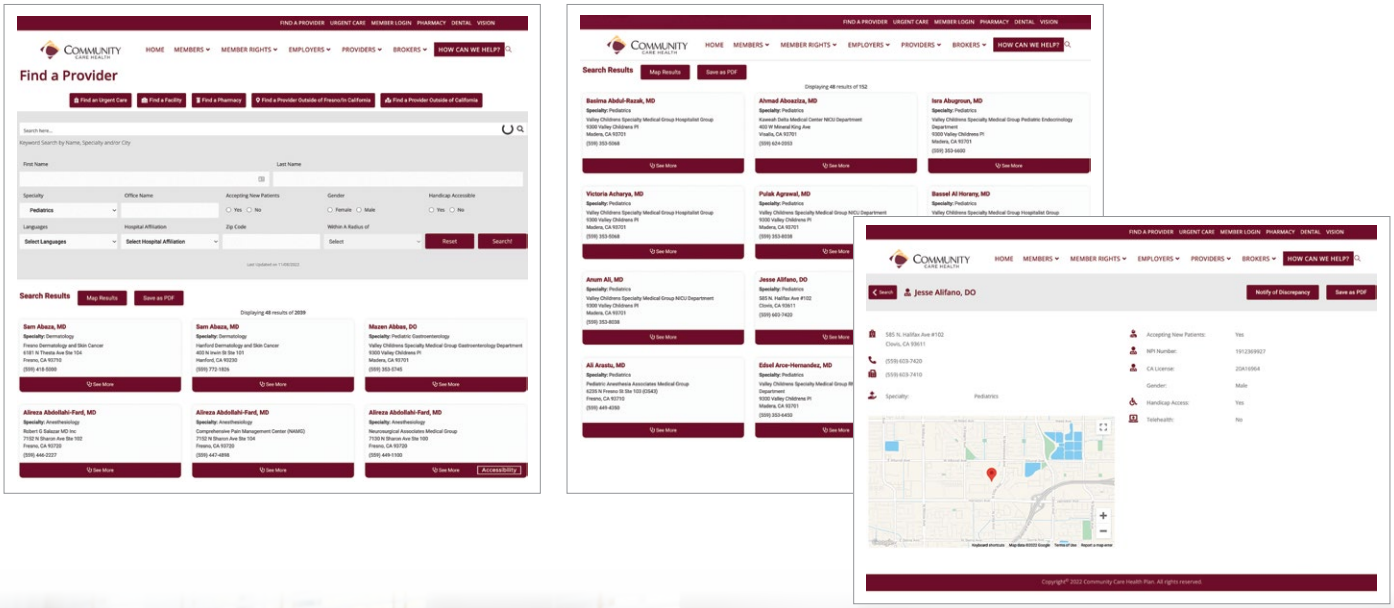
COMMUNITY HEALTH PARTNERS

Provider Directory

Find a Provider

CCH 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

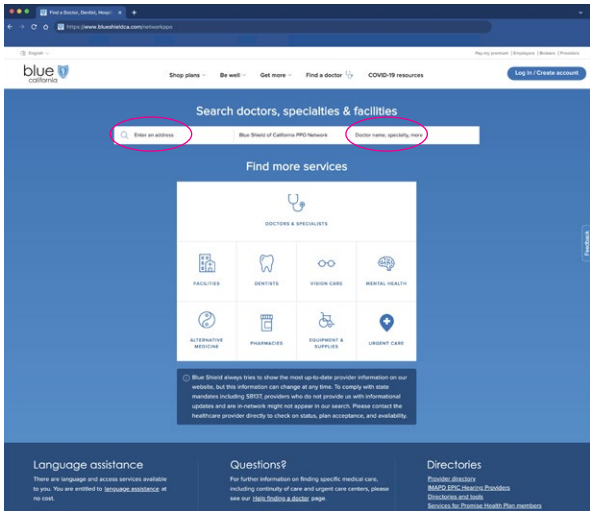


Covered Care Outside of the Area (Within California)

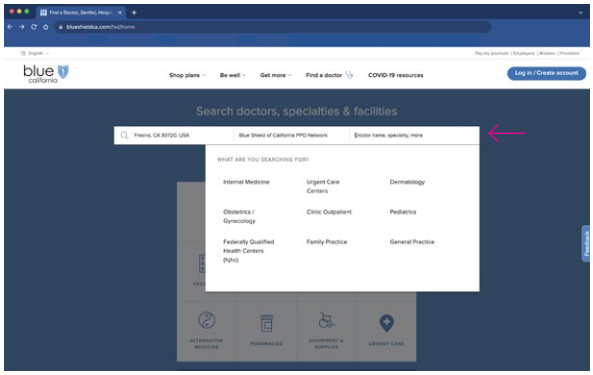
There will be situations where you will need access to medical care outside of the CCH Service Area. When you need to locate a provider in the State of California, outside of Fresno, Kings or Madera counties, follow the steps outlined below.

Go to https://blueshieldca.com/networkppo

PPO Plan (within CA)

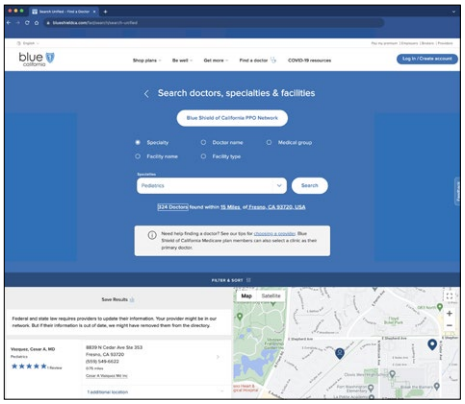


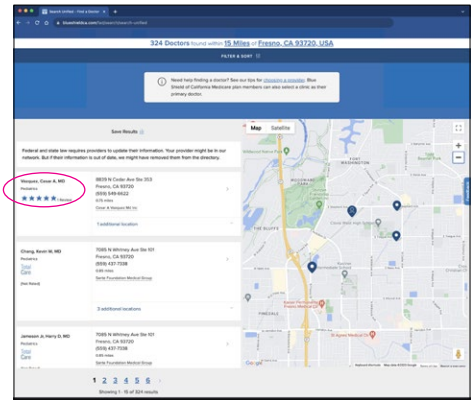
Enter your address > select Doctor name, specialty, more > and choose what you are searching for.

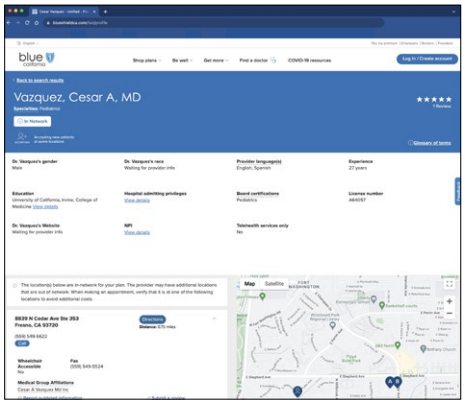


Example of search result

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



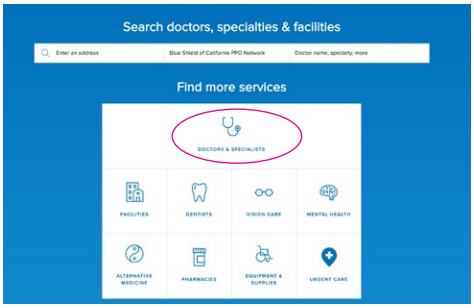




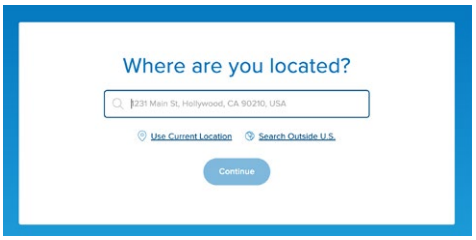
Covered Care Outside of the Area (Outside California)

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

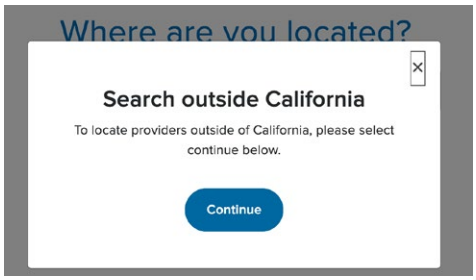
Go to https://blueshieldca.com/networkppo



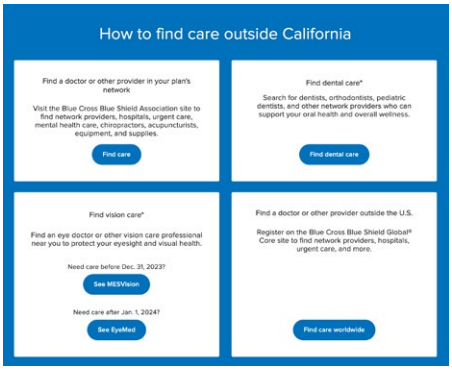
1. Select Doctors and Specialists



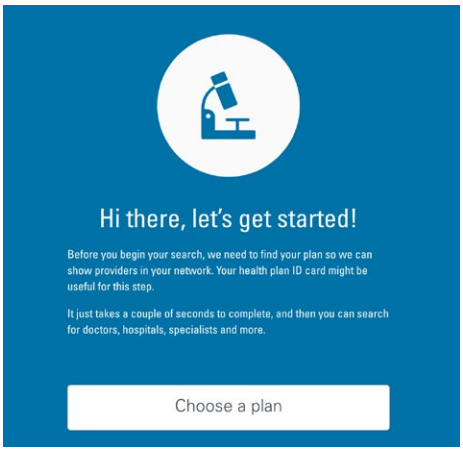
2. Enter Your Address



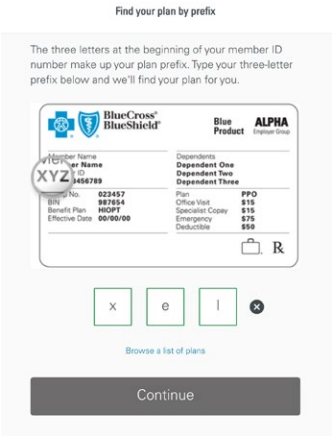
3. Select “Continue” to Search Providers Outside of California



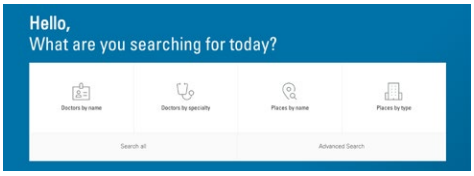
4. Click on “Find Care”



5. On the Pop-Up Window, Click on “Choose Plan” and Re-Enter Your Address

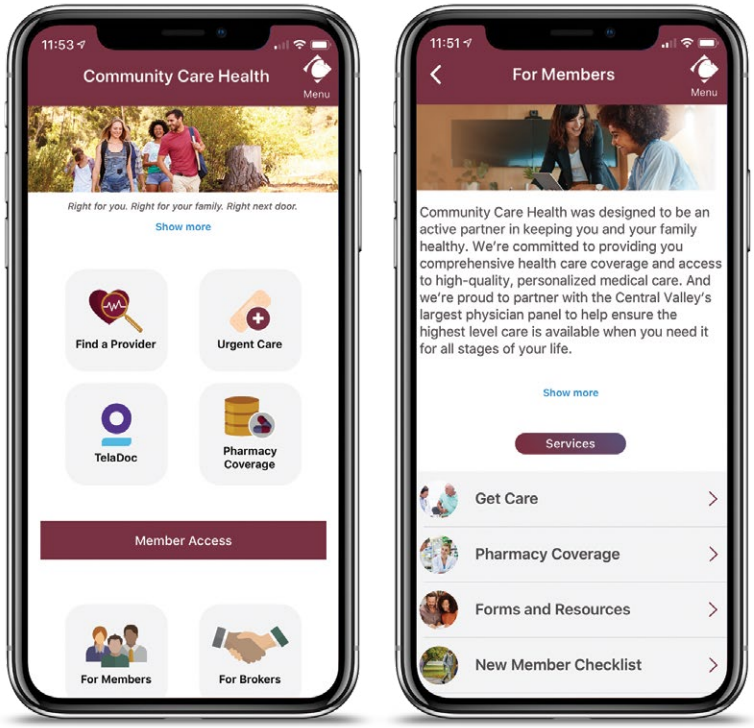


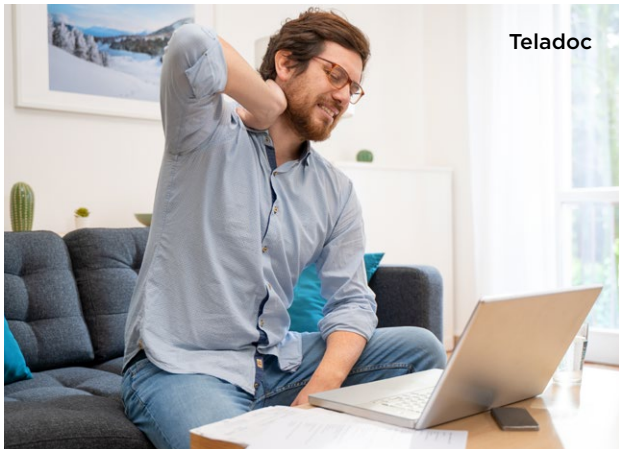
6. Enter “XEL” and Click “Continue”



7. You Can Now Search by Name, Specialty, Facility Name or Facility Type

Innovative Customer Tools





CCH Mobile App

CCH Member Portal

Teladoc

Pharmacy Benefit Portal

Online Chat (Coming Soon)

MyHealthMate powered by MyChart

Online Provider, Pharmacy and Urgent Care Directory

Remote Access to Care

COMMUNITY CARE HEALTH

TELADOC

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**.

1

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.

2

PROVIDE MEDICAL HISTORY

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

3

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

Available on the iPhone App Store

ANDROID APP ON Google play

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.

Updated 4.22.2022

Your Medical Plan Options

CCH 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 CCH network. Out-of-network services are covered for emergency and urgent care. CCH 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.

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. CCH 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 CCH 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.

Health Payment Accounts

Pairing a health savings account (HSA) or a health reimbursement arrangement (HRA) with your health plan is a solution that gives you and your employees the opportunity to save on health premiums, become wise healthcare consumers, and realize tax benefits.

HSA

Advantage to Employer

- Tax benefit
- Flexibility with account contributions as employer can choose to contribute or not
- Reduced record-keeping
- Offer employees a vehicle for saving for health-related expenses in retirement
- Employees manage their own HSA funds and become more informed consumers of their own health care

Advantage to Employee

- Tax-free contributions and interest
- Asset accumulation
- Tax-free spending for health care related expenses
- Investments with interest
- Assets are portable and owned by the employee
- Payroll-based deductions for convenient account funding

Choose your own financial institution for account administration. Accounts are employee owned. Any administrative fees may be paid by the employer or the employee.

Available to eligible employees enrolled in the following plans:

- Silver 70 HDHP HMO 2850/25
- Bronze 60 HDHP HMO 7050/0
- Silver 70 HDHP EPO 2850/25

HRA

Advantage to Employer

- Increased employee retention
- Can be integrated with Flexible Spending Account
- Employer control over plan design and fund rollover
- Additional tax-favored benefit

Advantage to Employee

- Can be paired with a traditional plan
- Funded entirely by the employer
- Asset accumulation
- Funds are available from the first day of coverage
- Provides for some first dollar benefits in addition to preventive care

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There are multiple types of HRAs available, ranging from limited to more comprehensive coverage.

A monthly administrative fee per employee account, is paid by you, the employer. Administration is available through our preferred vendor, Administrative Solutions, Inc.

Available to employees enrolled in the following plans:

- Gold 80 HMO HRA 2150/35
- Silver 70 HMO HRA 2250/50

- **Easy online access** — Your employees can take advantage of 24-hour access to their health plan and Health Payment Account through the vendor website and mobile app (if applicable).
- **A variety of payment options** — No matter which account type you choose to offer; your employees will get convenient payment options that make access to their Health Payment Account funds simple while reducing paperwork.
- **To learn more** about your account options, contact your CCH representative.

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.

Refer to IRS Publication 502 for a list of qualified medical and dental expenses.

Understanding Health Plans

CCH 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. The following pages provide a summary of each plan and what your members can expect to pay for certain, commonly accessed benefits.

Words you should know:

1. **EPO:** An Exclusive Provider Organization (EPO) offers in-network coverage through our CCH network. Out-of-network services are covered for emergency and urgent care. CCH 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. CCH’s HMO plans provides coverage in partnership with primary care physicians and specialists, urgent care centers, and hospitals. CCH 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 (SimpleBehavioral), 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 CCH. CCH 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.

Exclusive Provider Organization (EPO)

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

CCH 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.

	EPO	HMO
PCP Selection/Assignment Required		X
PCP Referral Required for Specialty Care		X
Access to CCH 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

CCH EPO PLANS 1/1/24 THROUGH 12/31/24	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]	$2,000	$4,000	$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 Servies (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 directy 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 [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
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) [8]		$15 / Visit		$25 / Visit
Durable Medical Equipment		10% Coinsurance [5]		20% Coinsurance [5]
Prosthetics and Orthotics		10% 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		No Charge
Hospice Care (Inpatient and Outpatient)		No Charge		No Charge

All Plans are Medicare Part D Creditable

Gold EPO Plan

CCH EPO PLANS 1/1/24 THROUGH 12/31/24	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]	$6,800	$13,600	$6,800	$13,600	$6,800	$13,600	$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 Servies (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 directy 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 [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	$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) [8]		$30 / Visit		$30 / 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		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

CCH EPO PLANS 1/1/24 THROUGH 12/31/24	Silver 70 EPO 1500/50		Silver 70 HDHP EPO 2850/25	
Amounts per Accumulation Period [1]	**Individual**	**Family**	**Individual**	**Family**
Medical Deductible [1]	$1,500	$3,000	$2,850	$5,700
Prescription Drug Deductible [1]	$500	$1,000	Combined	Combined
Out-of-Pocket Maximum [1]	$9,100	$18,200	$7,500	$15,000
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 Servies (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 directy 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)	X	$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	20% 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

All Plans are Medicare Part D Creditable

Footnotes for EPO Plans

1. 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.
2. 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.
3. 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.
4. E-Visit consultations conducted through Teladoc have a $10 copayment per visit.
5. Of contracted rates
6. Member cost share will not exceed $200 per individual prescription of up to a 30-day supply of a covered oral anti-cancer drug. 90-day supply cost share applies to maintenance medications filled by mail order only.
7. 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.
8. 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.

Additional Notes:

- In order to be covered, services may require Prior Authorization. CCH 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

CCH HMO PLANS 1/1/24 THROUGH 12/31/24	Platinum 90 HMO 0/10/250		Platinum 90 HMO 0/10/500		Platinum 90 HMO 0/25		Platinum 90 HMO 0/20†	
Amounts per Accumulation Period [1]	Individual	Family	Individual	Family	Individual	Family	Individual	Family
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]	$2,250	$4,500	$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 Servies (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 directy 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

CCH HMO PLANS 1/1/24 THROUGH 12/31/24	Gold 80 HMO 250/35†		Gold 80 HMO 500/35		Gold 80 HMO 750/30		Gold 80 HMO 1000/35	
Amounts per Accumulation Period [1]	Individual	Family	Individual	Family	Individual	Family	Individual	Family
Medical Deductible [1]	$250	$500	$500	$1,000	$750	$1,500	$1,000	$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	$6,500	$13,000	$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 Servies (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 directy 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

CCH HMO PLANS 1/1/24 THROUGH 12/31/24		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 Servies (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 directy 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	X	$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

CCH HMO PLANS 1/1/24 THROUGH 12/31/24	Silver 70 HMO 2250/50		Silver 70 HDHP HMO 2850/25†	
Amounts per Accumulation Period [1]	**Individual**	**Family**	**Individual**	**Family**
Medical Deductible [1]	$2,250	$4,500	$2,850	$5,700
Prescription Drug Deductible [1]	$300	$600	Combined	Combined
Out-of-Pocket Maximum [1]	$8,900	$17,800	$7,500	$15,000
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 Servies (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 directy 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)	X	$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	20% 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

† Denotes Covered California mirrored plan design

All Plans are Medicare Part D Creditable

Bronze HMO Plan

CCH HMO PLANS 1/1/24 THROUGH 12/31/24	Bronze 60 HDHP HMO 7050/0†		Bronze 60 HMO 6300/65	
Amounts per Accumulation Period [1]	Individual	Family	Individual	Family
Medical Deductible [1]	$7,050	$14,100	$6,300	$12,600
Prescription Drug Deductible [1]	Combined	Combined	$500	$1,000
Out-of-Pocket Maximum [1]	$7,050	$14,100	$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 Servies (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 directy 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	X	$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) [8]	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.

CCH plans do not include any limitations or restrictions for pre-existing conditions.

1. 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 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.
2. 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.
3. 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.
4. Of contracted rates
5. Member cost share will not exceed $250 per individual prescription of up to a 30-day supply of a covered oral anti-cancer drug. 90-day supply cost share applies to maintenance medications filled by mail order only.
6. 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.
7. 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. Not all plans include chiropractic benefits.

Additional Notes:

- In order to be covered, most services require a referral from your PCP and many also require Prior Authorization by your PCP's medical group. Please consult the complete EOC 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.
- All plans have an unlimited lifetime maximum benefit while insured.
- Plans do not include any pre-existing condition limitations.
- All plans cover essential health benefits, including child dental services, as defined by Affordable Care Act (ACA) regulations. Upon enrollment in the medical plan(s) you've chosen, employees and dependents will be enrolled in a separate child dental plan underwritten by Delta Dental of California.
- This booklet is a summary of available options and is for reference only. The Evidence of Coverage (EOC) contains a complete explanation of benefits, exclusions, and limitations. In the case of any discrepancy, the information in the EOC shall supersede this summary and govern any coverage determination.
- Summary of Benefits and Coverage (SBC) documents for all of our plans are available at https://communitycarehealth.org. These documents provide summary information about your health coverage options, helping you easily compare CCH to other vendor options.

CCH Partners with Weight Watchers

COMMUNITY CARE HEALTH

WeightWatchers

We've partnered with WeightWatchers® to bring you its program at a special discount.

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.†

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.

Health & Wellness Programs

CCH with Weight Watchers for Diabetics

WeightWatchers | COMMUNITY CARE HEALTH

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 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.

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

^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.

COMMUNITY CARE HEALTH

VALLEY FITNESS

Valley Fitness and CCH have teamed up to give members this offer.

CCH 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:

- **14 California locations:**

Atascadero	Gilroy	Modesto
Atwater	Hanford	Selma
Fresno - Ashlan	Los Banos	Stockton
Fresno - Maroa	Madera	Visalia
Fresno - Herndon	Manteca	

- **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	$19.99 per Month	$39 Annual Fee	
Discount Rates	**$0 Enrollment Fee**	**$14.99* or $39.99* per Month**	**Annual Fee Waived**	**Offer Expires N/A**

* Basic membership - $14.99 (per person) offers access to all gyms and equipment.

* Boot Camp Group Training membership - $39.99 (per person) includes the basic membership, plus group training: 60 minutes fully body workout, Zumba class, yoga classes and interval training.

* Only in California

For more information contact Merissa Luna

phone: (559) 286-0591 | email: merissa@valleyfitness.com

COMMUNITY
CARE HEALTH

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

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communitycarehealth.org

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