




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, [www.communitycarehealth.org](http://www.communitycarehealth.org) or by calling 1-559-724-4995. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-559-724-4995 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$2,250 Individual / \$4,500 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> and the other services listed in the “What you will pay” column of the chart starting on page 2, indicates services covered before you meet your deductible.	This <a href="#">plan</a> covers some items and services even if you haven’t yet met the <a href="#">deductible</a> amount, but a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. Generic, brand and specialty prescription drugs. <b>\$300</b> Individual / <b>\$600</b> Family. There are no other specific <a href="#">deductibles</a> .	You must pay all of the cost for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$8,900 Individual / \$17,800 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Copayment</a> for certain services, <a href="#">premiums</a> , <a href="#">balancing-billing</a> charges, and health care this plan doesn’t cover.	Even though you pay these expenses, they don’t count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.communitycarehealth.org">www.communitycarehealth.org</a> or call 1-559-724-4995 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

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

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office</a> or <a href="#">clinic</a>	Primary care visit to treat an injury or illness	\$50 / visit, <a href="#">deductible</a> does not apply	Not covered	<a href="#">None</a>
	<a href="#">Specialist</a> visit	\$85 / visit, <a href="#">deductible</a> does not apply	Not covered	<a href="#">Referral</a> is required. This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services, but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> . Preauthorization may be required for some procedures and services provided by specialists, but is not required for the specialist visit itself.
	<a href="#">Preventive care/screening/immunization</a>	No Charge, <a href="#">deductible</a> does not apply	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-ray: \$85/ encounter, <a href="#">deductible</a> does not apply Lab test: \$40 / encounter, <a href="#">Deductible</a> does not apply.	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$300/ procedure, <a href="#">Deductible</a> does not apply.	Not covered	None
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at	Generic drugs	Retail: \$17 / <a href="#">prescription</a> Mail order: \$34 / <a href="#">prescription</a> , after drug <a href="#">deductible</a>	Not covered	Up to a 30-day supply (retail <a href="#">prescription</a> ); 90-day supply (mail order <a href="#">prescription</a> ). Subject to <a href="#">formulary</a> guidelines.
	Preferred brand drugs	Retail: \$65 / <a href="#">prescription</a> Mail order: \$130 / <a href="#">prescription</a> , after drug <a href="#">deductible</a>	Not covered	Up to a 30-day supply (retail <a href="#">prescription</a> ); 90-day supply (mail order <a href="#">prescription</a> ). Subject to <a href="#">formulary</a> guidelines.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<a href="http://www.communitycarehealth.org">www.communitycarehealth.org</a>	Non-preferred brand drugs	Retail: \$90 / <a href="#">prescription</a> Mail order: \$180 / <a href="#">prescription</a> , after drug <a href="#">deductible</a>	Not covered	Up to a 30-day supply (retail <a href="#">prescription</a> ); 90-day supply (mail order <a href="#">prescription</a> ). Subject to <a href="#">formulary</a> guidelines.
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a> , after drug <a href="#">deductible</a> , up to \$250 per prescription	Not covered	Up to a 30-day supply (retail <a href="#">prescription</a> ). Subject to <a href="#">formulary</a> guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply.	Not covered	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply.	Not covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$400 / visit	\$400 / visit	<a href="#">Copayment</a> waived if admitted to hospital as inpatient.
	<a href="#">Emergency medical transportation</a>	\$250 / trip	\$250 / trip	None
	<a href="#">Urgent care</a>	\$50 / visit, <a href="#">deductible</a> does not apply.	\$50 / visit, <a href="#">deductible</a> does not apply.	Non- <a href="#">Plan Providers</a> covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply.	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 / individual visit; <a href="#">deductible</a> does not apply. No charge for other outpatient services, <a href="#">deductible</a> does not apply.	Not covered	<b><u>Mental / Behavioral Health/ Substance Abuse</u></b> \$25 / group visit, <a href="#">deductible</a> does not apply.
	Inpatient services	20% <a href="#">coinsurance</a>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge, <a href="#">deductible</a> does not apply.	Not covered	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply.	Not covered	None
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	Not covered	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$45 / visit, <a href="#">deductible</a> does not apply	Not covered	Up to 2 hours / visit, up to 3 visits per day / up to 100 visits per benefit year.
	<a href="#">Rehabilitation services</a>	Outpatient: \$50 / visit, <a href="#">deductible</a> does not apply	Not covered	None
	<a href="#">Habilitation services</a>	Outpatient: \$50 / visit, <a href="#">deductible</a> does not apply	Not covered	None
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	Not covered	Up to 100 days limit / benefit period
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply.	Not covered	<a href="#">Preauthorization</a> is required.
	<a href="#">Hospice services</a>	No Charge, <a href="#">deductible</a> does not apply	Not covered	<a href="#">Preauthorization</a> is required.
If your child needs dental or eye care	Children's eye exam	No Charge, <a href="#">deductible</a> does not apply	Not covered	Coverage limited to one exam/year.
	Children's glasses	No Charge, <a href="#">deductible</a> does not apply	Not covered	Limited to one pair of glasses / year from select frames and lenses.
	Children's dental check-up	No Charge, <a href="#">deductible</a> does not apply	Not covered	Limited to two check-ups / year.

**Excluded Services & Other Covered Services:**

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

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

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

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

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

## Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-559-724-4995.

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

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

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

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$2,250
- [Specialist copayment](#) \$85
- Hospital (facility) [coinsurance](#) 20%
- Other (blood work) [copayment](#) \$40

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,300
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$1,000
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,060</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$2,250
- [Specialist copayment](#) \$85
- Hospital (facility) [coinsurance](#) 20%
- Other (blood work) [copayment](#) \$40

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$1,600
<a href="#">Coinsurance</a>	\$200
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,120</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$2,250
- [Specialist copayment](#) \$85
- Hospital (facility) [coinsurance](#) 20%
- Other (blood work) [copayment](#) \$40

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,300
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$50
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,050</b>

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