**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 or by calling 1-855-343-2247. 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/ or call 1-855-343-2247 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $6,300 Individual / $12,600 Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care 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 plan covers some items and services even if you haven't yet met the deductible amount, but a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. Generic, brand and specialty prescription drugs. **$500** Individual / **$1000** Family. There are no other specific deductibles. | You must pay all of the cost for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | $8,150 Individual / $16,300 Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Copayment for certain services, premiums, balancing-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out–of–pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.communitycarehealth.org or call 1-855-343-2247 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |

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

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 provider's office or clinic** | Primary care visit to treat an injury or illness | $65 / visit | Not covered | Deductible waived for first three visits combined for non-preventive primary care, specialty care, other urgent care, mental/behavioral health and substance use disorder outpatient services. |
| | Specialist visit | $95 / visit | Not covered | Referral is required. This plan will pay some or all of the costs to see a specialist for covered services, but only if you have a referral before you see the specialist. Preauthorization may be required for some procedures and services provided by specialists, but is not required for the specialist visit itself. Deductible waived for first three visits combined for non-preventive primary care, specialty care, other urgent care, mental/behavioral health and substance use disorder outpatient services. |
| | Preventive care/screening/ immunization | No Charge, deductible does not apply | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | X-ray: 40% coinsurance / encounter<br>Lab test: $40 / encounter, deductible does not apply. | 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) | |
| | Imaging (CT/PET scans, MRIs) | 40% coinsurance | Not covered | None |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.communitycarehealth.org | Generic drugs | Retail: $18 / prescription after drug deductible, Mail order: $36 / prescription after drug deductible | Not covered | Up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Subject to formulary guidelines. |
| | Preferred brand drugs | 40% coinsurance, up to $500 per prescription, after drug deductible | Not covered | Up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Subject to formulary guidelines. |
| | Non-preferred brand drugs | 40% coinsurance, up to $500 per prescription, after drug deductible | Not covered | Up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Subject to formulary guidelines. |
| | Specialty drugs | 40% coinsurance, up to $500 per prescription, after drug deductible | Not covered | Up to a 30-day supply (retail prescription). Subject to formulary guidelines. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 40% coinsurance | Not covered | Preauthorization is required. |
| | Physician/surgeon fees | 40% coinsurance | Not covered | None |
| **If you need immediate medical attention** | Emergency room care | 40% coinsurance | 40% coinsurance | Copayment waived if admitted to hospital as inpatient. |
| | Emergency medical transportation | 40% coinsurance | 40% coinsurance | None |
| | Urgent care | $65 / visit | $65 / visit | Non- Plan Providers covered when temporarily outside the service area. Deductible waived for first three visits combined for non-preventive primary care, specialty care, other urgent care, mental/behavioral health and substance use disorder outpatient services. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 40% coinsurance | Not covered | Preauthorization is required. |

| 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) | |
| | Physician/surgeon fees | 40% coinsurance | Not covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $65 / individual visit: deductible waived for the 1st 3 non-preventive visits<br>$65 /individual visit for other outpatient services: deductible waived for the 1st 3 non-preventive visits | Not covered | **Mental / Behavioral health/ Substance Abuse**<br>$35 / group visit. Deductible waived for the 1st 3 non-preventive visits |
| | Inpatient services | 40% coinsurance | Not covered | None |
| **If you are pregnant** | Office visits | No Charge, deductible does not apply. | Not covered | Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 40% coinsurance | Not covered | None |
| | Childbirth/delivery facility services | 40% coinsurance | Not covered | None |
| **If you need help recovering or have other special health needs** | Home health care | 40% coinsurance | Not covered | Up to 2 hours / visit, up to 3 visits per day / up to 100 visits per benefit year. |
| | Rehabilitation services | Outpatient: $65 / visit, deductible does not apply | Not covered | None |
| | Habilitation services | Outpatient: $65 / visit, deductible does not apply | Not covered | None |
| | Skilled nursing care | 40% coinsurance | Not covered | Up to 100 days limit / benefit period |
| | Durable medical equipment | 40% coinsurance | Not covered | Preauthorization is required. |
| | Hospice services | No Charge, deductible does not apply | Not covered | Preauthorization is required. |
| **If your child needs dental or eye care** | Children's eye exam | No Charge, deductible does not apply | Not covered | Coverage limited to one exam/year. |
| | Children's glasses | No Charge, deductible does not apply | Not covered | Limited to one pair of glasses / year from select frames and lenses. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Children's dental check-up | No Charge, deductible does not apply | Not covered | Limited to two check-ups / year. |

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic Surgery
- Dental Care (Adults)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Abortion
- Chiropractic Care
- Acupuncture (plan provider preferred)
- Bariatric Surgery

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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 | 1-855-343-2247 or www.communitycarehealth.org |
| Department of Labor's Employee Benefits Security Administration | 1-866-444-EBSA (3273) or www.dol.gov/ebsa/healtheform |
| Department of Health & Human Services, Center for Consumer Information & Insurance oversight | 1-877-267-2323 X61565 or www.cciio.cms.gove |
| California Department of Insurance | 1-850-927-HELP (4357) or www.insurance.ca.gov |
| California Department of Managed Health Care | 1-888-466-2219 or www.healthhelp.ca.gov/ |

**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 1-855-343-2247.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-343-2247.

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-855-343-2247.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-343-2247.

*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** | **$6,300** |
| **Specialist copayment** | **$95** |
| **Hospital (facility) coinsurance** | **40%** |
| **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)*

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $6,300 |
| Copayments | $500 |
| Coinsurance | $1,400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$8,260** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$6,300** |
| **Specialist copayment** | **$95** |
| **Hospital (facility) coinsurance** | **40%** |
| **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)*

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $2,300 |
| Copayments | $200 |
| Coinsurance | $1,200 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$3,720** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$6,300** |
| **Specialist copayment** | **$95** |
| **Hospital (facility) coinsurance** | **40%** |
| **Other (X-ray) coinsurance** | **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)*

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $2,100 |
| Copayments | $300 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,400** |

The plan would be responsible for the other costs of these EXAMPLE covered services.