

Small Group Health Plan



Your Guide to Choosing the Best Plan for Your Employees

For effective dates:

January 1, 2023 through December 31, 2023

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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



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>



Coverage Wherever Our Members Live, Work & Study

Where Am I Covered





LOCAL



CALIFORNIA



NATIONAL





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.



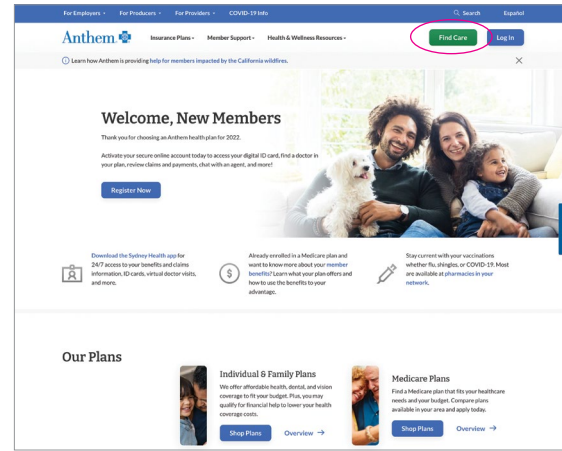
Covered Care Outside of the Area (Within California)

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.

Finding a Provider

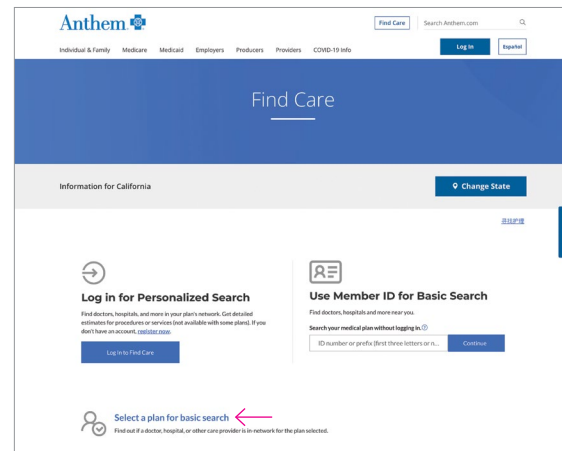
Go to <https://www.anthem.com/ca/>

To locate a provider, click on “Find Care” located at the top right of the page.

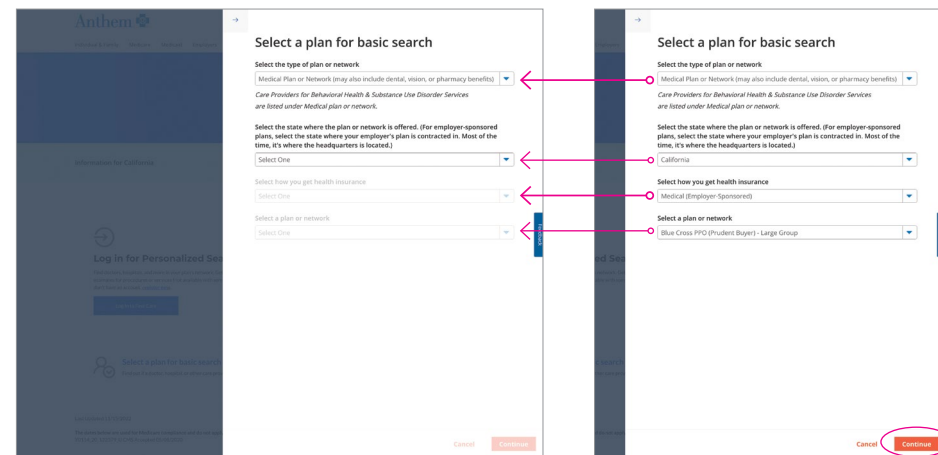


You have now been directed to the Find Care page.

Click on “Select a plan for basic search”



A slider will appear from the right side with (4) pulldowns

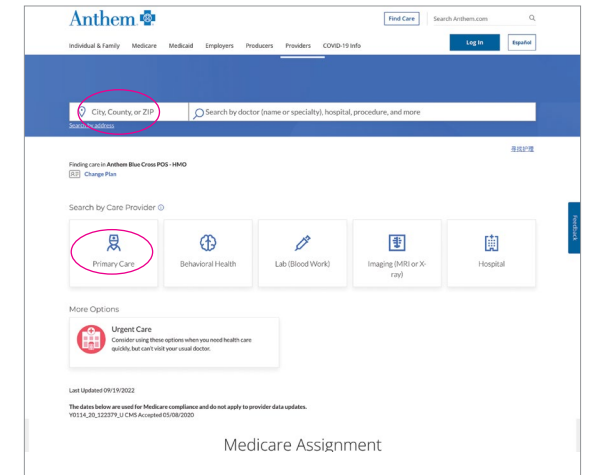


Please select the following and then click on “Continue”.

1. Medical Plan or Network
2. California
3. Medical (Employer-Sponsored)
4. Blue Cross PPO Prudent Buyer - (Large Group)

You are now in the search page

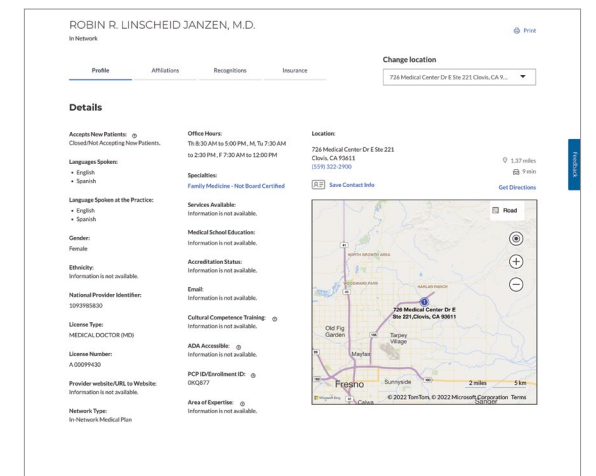
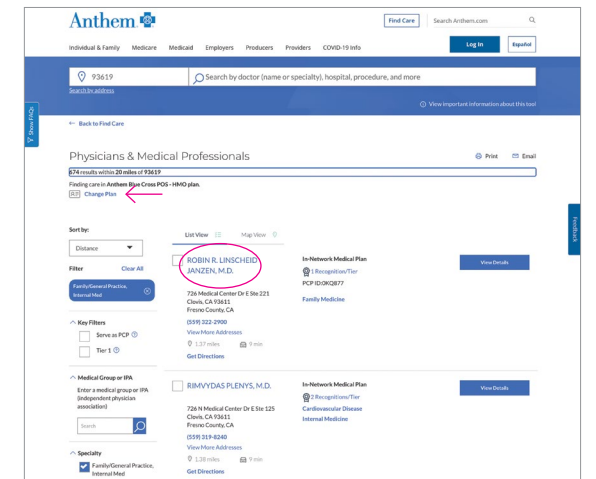
1. Enter in the City, County or Zip
2. Select the type of provider



Example of search result

Click on provider name for full detail

Click on “Change Plan” to start over



Covered Care Outside of the Area (Outside California)

CCH is pleased to introduce our members to a tool that will assist you in locating providers to meet your health care needs when you are outside the state of California. This guide will provide you with step by step instructions on how to locate a provider.

HealthSmart Provider Search Tool

To access the HealthSmart Provider search tool, go to <https://providerlookup.healthsmart.com>.

Click on **Find a Provider** button.

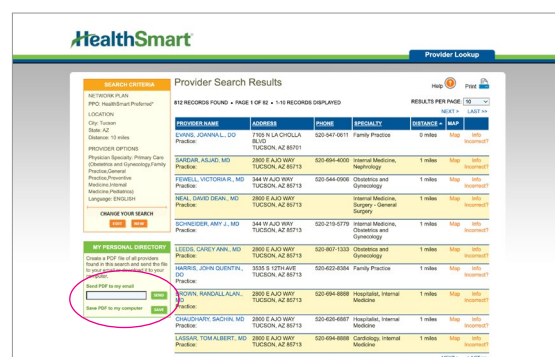
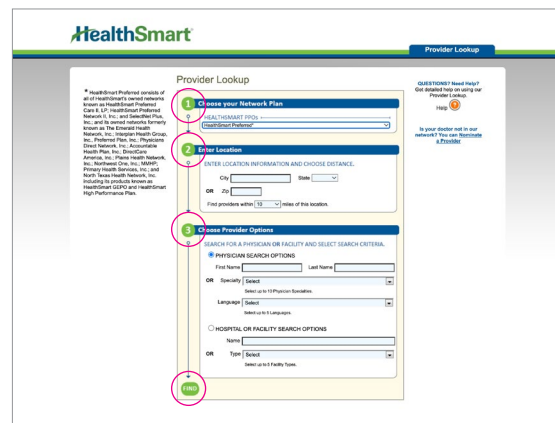
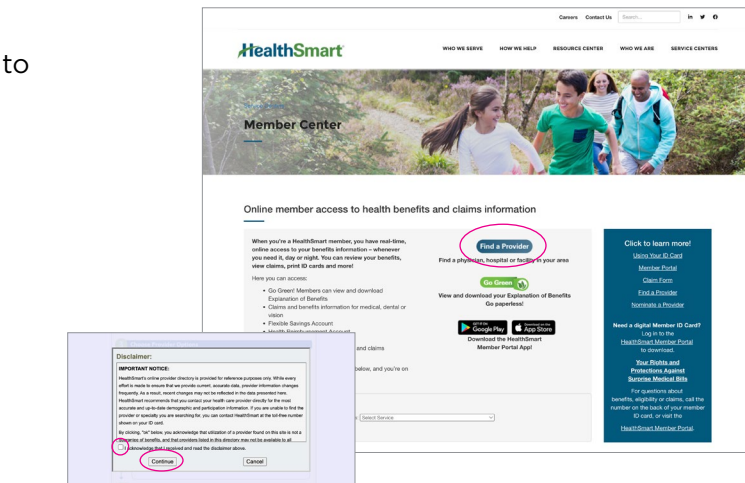
A **Disclaimer** popup will appear. Acknowledge the disclaimer by checking the box and click 'Continue'.

Choose Your Network Plan

For all states with the exception of Alabama, Colorado, Georgia, Idaho, Maryland, Massachusetts, New Hampshire, New Jersey, New York, North Carolina, Oregon, Pennsylvania, South Carolina, Tennessee and Utah select "HealthSmart Preferred".

Fill in the correct information in **Box 2** and **Box 3**, click **FIND** when complete.

Example of Search Results

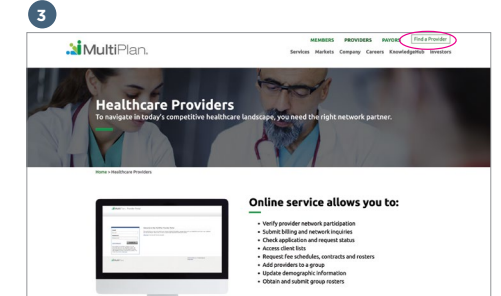
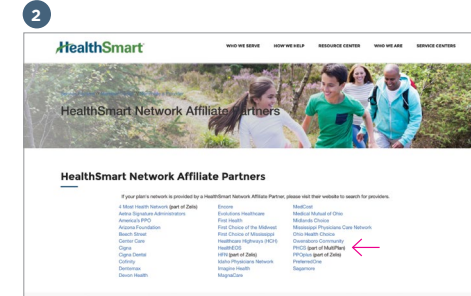
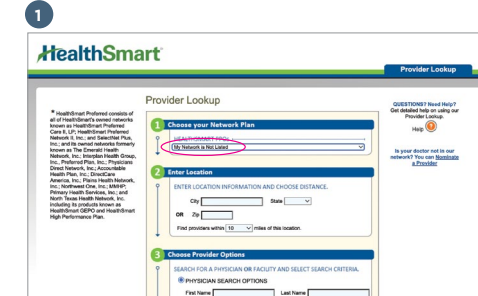


Option to save search to your computer or email it.

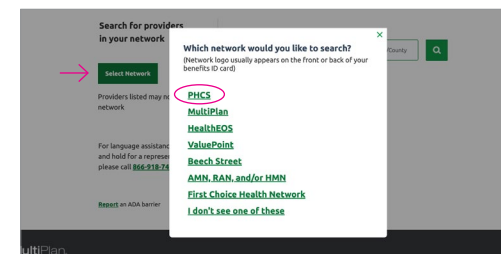
Covered Care Outside of the Area (Outside California)

For Alabama, Colorado, Georgia, Idaho, Maryland, Massachusetts, New Hampshire, New Jersey, New York, North Carolina, Oregon, Pennsylvania, South Carolina, Tennessee and Utah, go to <https://providerlookup.healthsmart.com>.

1. When selecting the Network, scroll down and select "My Network is Not Listed." You will automatically be taken to the 'HealthSmart Network Affiliated Partners' page.
2. Select 'PHCS (part of MultiPlan)'. 3. At the top of the screen, click on "Find a Provider".

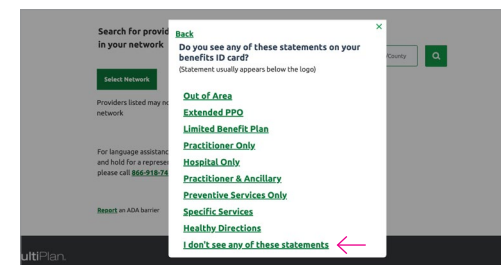


Click on "Select Network." A popup with network options will appear. Choose "PHCS" from the list.



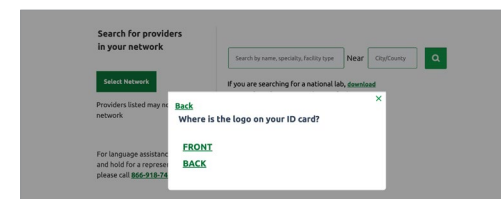
After selecting PHCS, popup #2 will appear. Do you see any of these statements on your benefits ID card?

Bypass it by selecting "I don't see any of these statements."



Popup #3 may appear: Where is the logo on your ID card?

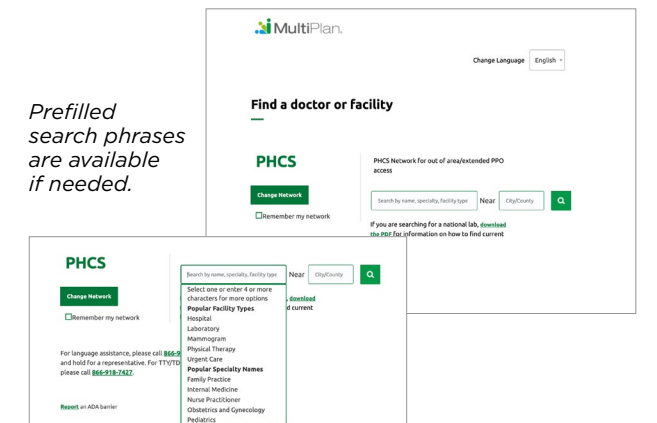
Answer the question and be directed to the provider search page where you can search by name, specialty, facility type, NPI # or license #.



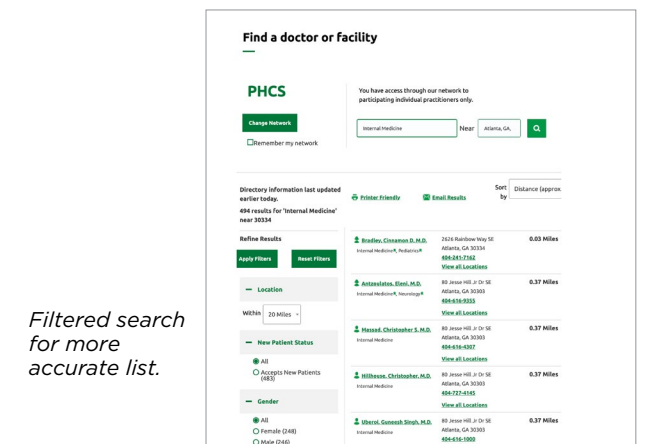
Provider Search Page

Fill in the correct information in the search boxes, click the Q icon when complete.

Prefilled search phrases are available if needed.

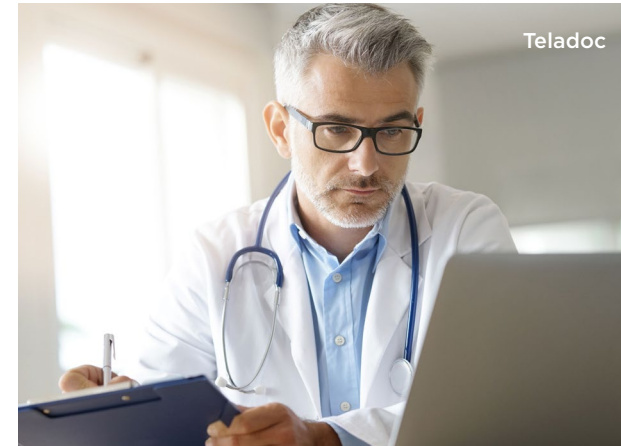


Example of Search Results



Filtered search for more accurate list.

Innovative Customer Tools



CCH Mobile App



CCH Member Portal



Teladoc



Pharmacy Benefit Portal



Teladoc



Online Chat (Coming Soon)



MyHealthMate powered by MyChart



Online Provider, Pharmacy and Urgent Care Directory

Remote Access to Care



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



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



MEMBER NOTICE

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

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

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

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

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

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

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Updated 4.22.2022

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.

NEW - 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](https://www.irs.gov/publications).

Deductible HMO with HRA Plan — These deductible plan options can be paired with a health reimbursement arrangement (HRA), which you'll set up for your employees. You contribute money into your employees' HRAs, which they can use to pay for the health care services they receive. Because this money isn't considered part of their wages it will not be subject to federal taxes. 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. Vision exams and materials are provide through our partnership with MES Vision. 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 2700/25
- Bronze 60 HDHP HMO 7000/0

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

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:

- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- Referral:** Your PCP helps make the decision about whether specialist services are necessary for you. Our EPO plans do not require a referral to see a specialist. Under the HMO, members can self-refer Emergency and Urgent Care, Dermatology, Behavioral Health and Substance Abuse (Halcyon), Allergy, Chiropractic, and OBGYN services.
- 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.
- 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.
- Preventive Care at No Charge:** Most preventive services are covered at no charge and are not subject to the deductible.
- Copay:** The set amount members will pay for certain services.
- 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)

New for 2023

CCH is excited to add our Exclusive Provider Organization (EPO) plan options for your health coverage solutions.

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

EPO Plans

CCH EPO PLANS 1/1/23 THROUGH 12/31/23	Platinum 90 EPO 0/15		Platinum 90 EPO 0/25		Gold 80 EPO 250/30		Gold 80 EPO 500/30	
	Individual	Family	Individual	Family	Individual	Family	Individual	Family
Amounts per Accumulation Period ⁽¹⁾								
Medical Deductible	\$0	\$0	\$0	\$0	\$250	\$500	\$500	\$1,000
Prescription Drug Deductible	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Out-of-Pocket Maximum	\$1,750	\$3,500	\$2,550	\$5,100	\$6,500	\$13,000	\$6,500	\$13,000
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		\$15 / visit		\$25 / visit		\$30 / visit		\$30 / visit
Urgent Care Services		\$15 / visit		\$25 / visit		\$30 / visit		\$30 / visit
Specialist Office Visits		\$30/ visit		\$50 / visit		\$60 / visit		\$60 / 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		\$0		\$0		\$0		\$0
Allergy Injections		\$30 / visit		\$50 / visit		\$60 / visit		\$60 / visit
Outpatient Physical, Occupational and Speech Therapy		\$15 / visit		\$25 / visit		\$30 / visit		\$30 / visit
Laboratory Tests and Services		\$20 / visit		\$20 / visit		\$40 / visit		\$40 / visit
Radiology Services (x-rays, diagnostic imaging)		\$40 / visit		\$75 / visit		\$60 / visit		\$100 / visit
Advanced Radiology (including but not limited to MRI, MRA, MRS, CT Scan, PET, MUGA SPECT)		\$150 / procedure		\$200 / procedure	X	\$250 / procedure	X	\$300 / procedure
Outpatient Surgery Facility Fee		\$250 / procedure		\$400 / procedure	X	\$300 / procedure	X	\$450 / procedure
EMERGENCY SERVICES								
Emergency Room Facility Fee (waived if admitted to the hospital)		\$250 / visit		\$250 / visit	X	\$250 / visit	X	\$300 / visit
Emergency and Non-Emergency Medical Transportation		\$150 / trip		\$150 / trip	X	\$250 / trip	X	\$250 / trip
PRESCRIPTION DRUG COVERAGE ⁽⁶⁾								
Tier 1: Most generic drugs and low-cost preferred brands 30-day supply/90-day supply		\$5 / \$10		\$5 / \$10		\$15 / \$30		\$15 / \$30
Tier 2: Non-preferred generic drugs and Preferred brand name drugs 30-day supply/90-day supply		\$15 / \$30		\$15 / \$30		\$30 / \$60		\$45 / \$90
Tier 3: Non-preferred brand name drugs 30-day supply/90-day supply		\$25 / \$50		\$25 / \$50		\$55 / \$110		\$75 / \$150
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	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)		\$250 / admission		\$500 / admission	X	\$300 / day (Up to 5 days)	X	\$300 / day (Up to 5 days)
MENTAL HEALTH AND CHEMICAL DEPENDENCY								
Individual Office Visit		\$15 / visit		\$25 / visit		\$30 / visit		\$30 / visit
Inpatient Hospitalization		\$250 / admission		\$500 / admission	X	\$600 / day (Up to 5 days)	X	\$600 / day (Up to 5 days)
OTHER BENEFITS								
Teladoc Consultations ⁽⁴⁾		\$10 / visit		\$10 / visit		\$10 / visit		\$10 / visit
Acupuncture ⁽⁸⁾ / Chiropractic Office Visits (20 visit per year combined)		\$15/ visit		\$25 / visit		\$30 / visit		\$30 / visit
Durable Medical Equipment		10% coinsurance ⁽⁵⁾		20% coinsurance ⁽⁵⁾		20% coinsurance ⁽⁵⁾		20% coinsurance ⁽⁵⁾
Prosthetics and Orthotics		10% 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	No Charge		No Charge		\$30 / visit		No Charge
Hospice Care (Inpatient and Outpatient)		No Charge		No Charge		No Charge		No Charge

All Plans are Medicare Part D Creditable *All plans can be customized and offered as either an HMO or EPO

EPO Plans

CCH EPO PLANS 1/1/23 THROUGH 12/31/23	Gold 80 EPO 750/30		Gold 80 EPO 1500/35		Silver 70 EPO 1500/50		Silver 70 HDHP EPO 2850/20	
	Individual	Family	Individual	Family	Individual	Family	Individual	Family
Amounts per Accumulation Period ⁽¹⁾								
Medical Deductible	\$750	\$1,500	\$1,500	\$3,000	\$1,500	\$3,000	\$2,850	\$5,700
Prescription Drug Deductible	\$0	\$0	\$0	\$0	\$500	\$1,000	Combined	Combined
Out-of-Pocket Maximum	\$6,500	\$13,000	\$9,100	\$18,200	\$9,100	\$18,200	\$7,050	\$14,100
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		\$35 / visit		\$50 / visit	X	20% coinsurance ⁽⁵⁾
Urgent Care Services		\$30 / visit		\$35 / visit		\$50 / visit	X	20% coinsurance ⁽⁵⁾
Specialist Office Visits		\$60 / visit		\$50 / visit		\$85 / visit	X	20% coinsurance ⁽⁵⁾
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		\$0		\$0		\$0		\$0
Allergy Injections		\$60 / visit		\$50 / visit		\$85 / visit	X	20% coinsurance ⁽⁵⁾
Outpatient Physical, Occupational and Speech Therapy		\$30 / visit		\$35 / visit		\$50 / visit	X	20% coinsurance ⁽⁵⁾
Laboratory Tests and Services		\$40 / visit		\$35 / visit		\$40 / visit	X	20% coinsurance ⁽⁵⁾
Radiology Services (x-rays, diagnostic imaging)		\$100 / visit		\$35 / visit		\$85 / visit	X	20% coinsurance ⁽⁵⁾
Advanced Radiology (including but not limited to MRI, MRA, MRS, CT Scan, PET, MUGA SPECT)	X	\$300 / procedure	X	\$200 / procedure	X	20% coinsurance ⁽⁵⁾	X	20% coinsurance ⁽⁵⁾
Outpatient Surgery Facility Fee	X	\$450 / procedure	X	\$500 / procedure		20% coinsurance ⁽⁵⁾	X	20% coinsurance ⁽⁵⁾
EMERGENCY SERVICES								
Emergency Room Facility Fee (waived if admitted to the hospital)	X	\$300 / visit	X	\$250 / visit	X	\$400 / visit	X	20% coinsurance ⁽⁵⁾
Emergency and Non-Emergency Medical Transportation	X	\$250 / trip	X	\$250 / trip	X	\$250 / trip	X	20% coinsurance ⁽⁵⁾
PRESCRIPTION DRUG COVERAGE ⁽⁶⁾								
Tier 1: Most generic drugs and low-cost preferred brands 30-day supply/90-day supply		\$10 / \$20		\$5 / \$10	X	\$17 / \$34	X	20% coinsurance ⁽⁵⁾ (Up to \$250)
Tier 2: Non-preferred generic drugs and Preferred brand name drugs 30-day supply/90-day supply		\$45 / \$90		\$25 / \$50	X	\$65 / \$130	X	20% coinsurance ⁽⁵⁾ (Up to \$250)
Tier 3: Non-preferred brand name drugs 30-day supply/90-day supply		\$75 / \$150		\$50 / \$100	X	\$90 / \$180	X	20% coinsurance ⁽⁵⁾ (Up to \$250)
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	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	\$600 / day (Up to 5 days)	X	\$600 / day (Up to 5 days)	X	20% coinsurance ⁽⁵⁾	X	20% coinsurance ⁽⁵⁾
Physician/Surgeon Fees		No Charge		No Charge		20% coinsurance ⁽⁵⁾	X	20% coinsurance ⁽⁵⁾
Skilled nursing facility services (maximum 100 days per accumulation period)	X	\$300 / day (Up to 5 days)	X	\$250 / day (Up to 5 days)	X	20% coinsurance ⁽⁵⁾	X	20% coinsurance ⁽⁵⁾
MENTAL HEALTH AND CHEMICAL DEPENDENCY								
Individual Office Visit		\$30 / visit		\$35 / visit		\$50 / visit	X	20% coinsurance ⁽⁵⁾
Inpatient Hospitalization	X	\$600 / day (Up to 5 days)	X	\$600 / day (Up to 5 days)	X	20% coinsurance ⁽⁵⁾	X	20% coinsurance ⁽⁵⁾
OTHER BENEFITS								
Teladoc Consultations ⁽⁴⁾		\$10 / visit		\$10 / visit		\$10 / visit	X	\$10 / visit
Acupuncture ⁽⁸⁾ / Chiropractic Office Visits (20 visit per year combined)		\$30 / visit		\$35 / visit		\$50 / visit	X	20% coinsurance ⁽⁵⁾
Durable Medical Equipment		20% coinsurance ⁽⁵⁾		20% coinsurance ⁽⁵⁾		20% coinsurance ⁽⁵⁾	X	20% coinsurance ⁽⁵⁾
Prosthetics and Orthotics		20% coinsurance ⁽⁵⁾		20% coinsurance ⁽⁵⁾		20% coinsurance ⁽⁵⁾	X	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	No Charge		\$35 / visit		\$45 / visit	X	20% coinsurance ⁽⁵⁾
Hospice Care (Inpatient and Outpatient)		No Charge		No Charge		No Charge	X	No Charge

All Plans are Medicare Part D Creditable *All plans can be customized and offered as either an HMO or EPO

Footnotes for EPO Plans

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

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 Plans

AMOUNTS PER ACCUMULATION PERIOD	Platinum HMO 0/10/250		Platinum HMO 0/10/500	
	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	\$3,500	\$7,000
COVERED BENEFITS	Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS
In Office Services				
Primary Care Office Visits		\$10 / visit		\$10 / visit
Urgent Care Visits		\$10 / visit		\$10 / visit
Specialist Office Visits		\$20 / visit		\$20 / 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		\$20 / visit		\$20 / visit
Outpatient Physical, Occupational and Speech Therapy		\$10 / visit		\$10 / visit
Laboratory Tests and Services		\$20 / visit		\$20 / visit
Radiology Services (x-rays, diagnostic imaging)		\$40 / visit		\$40 / visit
Advanced Radiology (including but not limited to MRI, MRA, MRS, CT Scan, PET, MUGA SPECT)		\$150 / procedure		\$150 / procedure
Outpatient Surgery (per procedure)		\$250 / procedure		\$300 / procedure
Emergency Services				
Emergency Room Visit (waived if admitted directly to hospital)		\$250 / visit		\$200 / visit
Emergency and Non-Emergency Medical Transportation		\$150 / trip		\$150 / trip
Prescription Drugs ⁵				
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		\$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		\$250 / admission
Mental Health and Chemical Dependency				
Individual Office Visit		\$10 / visit		\$10 / 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		\$10 / visit		\$10 / visit
Durable Medical Equipment		10% coinsurance ⁵		10% coinsurance ⁵
Prosthetics and Orthotics		10% coinsurance ⁵		10% 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

Platinum HMO Plans

AMOUNTS PER ACCUMULATION PERIOD	Platinum HMO 0/25		Platinum 90 HMO 0/20	
	Individual	Family	Individual	Family
Medical Deductible ¹	\$0	\$0	\$0	\$0
Prescription Drug Deductible ¹	\$0	\$0	\$0	\$0
Out-of-Pocket Maximum ¹	\$2,500	\$5,000	\$4,500	\$9,000
COVERED BENEFITS	Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS
In Office Services				
Primary Care Office Visits		\$25 / visit		\$20 / visit
Urgent Care Visits		\$25 / visit		\$20 / visit
Specialist Office Visits		\$50 / visit		\$30 / 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		\$30 / visit
Outpatient Physical, Occupational and Speech Therapy		\$25 / visit		\$20 / visit
Laboratory Tests and Services		\$20 / visit		\$20 / visit
Radiology Services (x-rays, diagnostic imaging)		\$75 / visit		\$30 / visit
Advanced Radiology (including but not limited to MRI, MRA, MRS, CT Scan, Pet, MUGA SPECT)		\$200 / procedure		\$100 / procedure
Outpatient Surgery (per procedure)		\$400 / procedure		\$100 / procedure
Emergency Services				
Emergency Room Visit (waived if admitted directly to hospital)		\$250 / visit		\$150 / visit
Emergency and Non-Emergency Medical Transportation		\$150 / trip		\$150 / trip
Prescription Drugs 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		\$15 / \$30		\$20 / \$40
Tier 3: Non-preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)		\$25 / \$50		\$30 / \$60
Tier 4: Specialty Items/Drugs 30-day supply (retail only)		20% coinsurance ⁵ (Up to \$250 per 30-day supply)		10% coinsurance ⁵ (Up to \$250 per 30-day supply)
Hospitalization				
Facility Fee		\$500 / admission		\$250/day (Up to 5 days)
Physician/Surgeon Fees		No Charge		No Charge
Skilled nursing facility services (maximum 100 days per accumulation period)		\$500 / admission		\$150/day (Up to 5 days)
Mental Health and Chemical Dependency				
Individual Office Visit		\$25 / visit		\$20 / visit
Inpatient Hospitalization		\$500 / admission		\$250/day (Up to 5 days)
Other Benefits				
Teladoc Visit		\$10 / visit		\$0 / visit
Acupuncture/Chiropractic Office Visits (20 visit per year combined) ⁸		\$25 / visit		\$20 / visit Acupuncture only
Durable Medical Equipment		20% coinsurance ⁵		10% coinsurance ⁵
Prosthetics and Orthotics		20% coinsurance ⁵		10% 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		\$20 / visit
Hospice Care (Inpatient and Outpatient)		No Charge		No Charge

All Plans are Medicare Part D Creditable

Gold HMO Plans

AMOUNTS PER ACCUMULATION PERIOD	Gold 80 HMO 250/35		Gold 80 HMO 500/35	
	Individual	Family	Individual	Family
Medical Deductible ¹	\$250	\$500	\$500	\$1,000
Prescription Drug Deductible ¹	\$0	\$0	\$0	\$0
Out-of-Pocket Maximum ¹	\$7,800	\$15,600	\$7,000	\$14,000
COVERED BENEFITS	Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS
In Office Services				
Primary Care Office Visits		\$35 / visit		\$35 / visit
Urgent Care Visits		\$35 / visit		\$35 / visit
Specialist Office Visits		\$55 / visit		\$75 / 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		\$55 / visit		\$75 / visit
Outpatient Physical, Occupational and Speech Therapy		\$35 / visit		\$35 / visit
Laboratory Tests and Services		\$35 / visit		\$75 / visit
Radiology Services (x-rays, diagnostic imaging)		\$55 / visit		\$100 / visit
Advanced Radiology (including but not limited to MRI, MRA, MRS, CT Scan, Pet, MUGA SPECT)	X	\$250 / procedure	X	\$200 / procedure
Outpatient Surgery (per procedure)	X	\$300 / procedure	X	\$600 / procedure
Emergency Services				
Emergency Room Visit (waived if admitted directly to hospital)	X	\$250 / visit	X	\$200 / visit
Emergency and Non-Emergency Medical Transportation	X	\$250 / trip	X	\$250 / trip
Prescription Drugs ⁶				
Tier 1: Most generic drugs and low-cost preferred brands 30-day supply (retail)/90-day supply (mail order)		\$15 / \$30		\$20 / \$40
Tier 2: Non-preferred generic and Preferred brand name drugs 30-day supply (retail)/90-day supply		\$40 / \$80		\$50 / \$100
Tier 3: Non-preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)		\$70 / \$140		\$80 / \$160
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	X	\$600/day (Up to 5 days)	X	\$1,500 / admission
Physician/Surgeon Fees		No Charge		No Charge
Skilled nursing facility services (maximum 100 days per accumulation period)	X	\$300/day (Up to 5 days)	X	\$175 / admission
Mental Health and Chemical Dependency				
Individual Office Visit		\$35 / visit		\$35 / visit
Inpatient Hospitalization	X	\$600/day (Up to 5 days)	X	\$1,500 / admission
Other Benefits				
Teladoc Visit		\$0 / visit		\$10 / visit
Acupuncture/Chiropractic Office Visits (20 visit per year combined) ⁸		\$35 / visit Acupuncture only		\$35 / visit
Durable Medical Equipment		20% coinsurance ⁵		20% coinsurance ⁵
Prosthetics and Orthotics		20% 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)		\$30 / visit		\$35 / visit
Hospice Care (Inpatient and Outpatient)		No Charge		No Charge

All Plans are Medicare Part D Creditable

Gold HMO Plans

	Gold 80 HMO 750/30		Gold 80 HMO 1000/35	
AMOUNTS PER ACCUMULATION PERIOD	Individual	Family	Individual	Family
Medical Deductible ¹	\$750	\$1,500	\$1,000	\$2,000
Prescription Drug Deductible ¹	\$0	\$0	\$0	\$0
Out-of-Pocket Maximum ¹	\$6,500	\$13,000	\$7,750	\$13,600
COVERED BENEFITS	Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS
In Office Services				
Primary Care Office Visits		\$30 / visit		\$35 / visit
Urgent Care Visits		\$30 / visit		\$35 / visit
Specialist Office Visits		\$60 / 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		\$60 / visit		\$50 / visit
Outpatient Physical, Occupational and Speech Therapy		\$30 / visit		\$35 / visit
Laboratory Tests and Services		\$40 / visit		\$35 / visit
Radiology Services (x-rays, diagnostic imaging)		\$100 / visit		\$35 / visit
Advanced Radiology (including but not limited to MRI, MRA, MRS, CT Scan, Pet, MUGA SPECT)	X	\$300 / procedure	X	\$200 / procedure
Outpatient Surgery (per procedure)	X	\$600 / procedure	X	\$500 / procedure
Emergency Services				
Emergency Room Visit (waived if admitted directly to hospital)	X	\$400 / visit	X	\$250 / visit
Emergency and Non-Emergency Medical Transportation	X	\$250 / trip	X	\$250 / trip
Prescription Drugs ⁶				
Tier 1: Most generic drugs and low-cost preferred brands 30-day supply (retail)/90-day supply (mail order)		\$10 / \$20		\$5 / \$10
Tier 2: Non-preferred generic and Preferred brand name drugs 30-day supply (retail)/90-day supply		\$45 / \$90		\$25 / \$50
Tier 3: Non-preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)		\$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)
Hospitalization				
Facility Fee	X	\$600/day (Up to 5 days)	X	\$600/day (Up to 5 days)
Physician/Surgeon Fees		No Charge		No Charge
Skilled nursing facility services (maximum 100 days per accumulation period)	X	\$300/day (Up to 5 days)	X	\$250/day (Up to 5 days)
Mental Health and Chemical Dependency				
Individual Office Visit		\$30 / visit		\$35 / visit
Inpatient Hospitalization	X	\$600/day (Up to 5 days)	X	\$600/day (Up to 5 days)
Other Benefits				
Teladoc Visit		\$10 / visit		\$10 / visit
Acupuncture/Chiropractic Office Visits (20 visit per year combined) ⁸		\$30 / visit		\$35 / visit
Durable Medical Equipment		20% coinsurance ⁵		20% coinsurance ⁵
Prosthetics and Orthotics		20% 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		\$35 / visit
Hospice Care (Inpatient and Outpatient)		No Charge		No Charge

All Plans are Medicare Part D Creditable

HRA Plans

	Gold 80 HMO HRA 2150/35		Silver 70 HMO HRA 2250/50	
AMOUNTS PER ACCUMULATION PERIOD	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	\$15,600
COVERED BENEFITS	Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS
In Office Services				
Primary Care Office Visits		\$35 / visit		\$50 / visit
Urgent Care Visits		\$35 / visit		\$50 / visit
Specialist Office Visits		\$50 / visit		\$85 / visit
Preventive physical exams, immunizations, and related laboratory services ²		\$0		\$0
Prenatal and Postpartum Office Visit		No Charge		No Charge
Well-Baby and Well-Child Exams ²		\$0		\$0
Allergy Injections		\$50 / visit		\$85 / visit
Outpatient Physical, Occupational and Speech Therapy	X	\$35 / visit		\$50 / visit
Laboratory Tests and Services	X	25% coinsurance ⁵		\$40 / visit
Radiology Services (x-rays, diagnostic imaging)	X	25% coinsurance ⁵		\$85 / visit
Advanced Radiology (including but not limited to MRI, MRA, MRS, CT Scan, Pet, MUGA SPECT)	X	25% coinsurance ⁵		\$300 / procedure
Outpatient Surgery (per procedure)	X	25% coinsurance ⁵		20% coinsurance ⁵
Emergency Services				
Emergency Room Visit (waived if admitted directly to hospital)	X	25% coinsurance ⁵	X	\$400 / visit
Emergency and Non-Emergency Medical Transportation	X	25% coinsurance ⁵	X	\$250 / trip
Prescription Drugs 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		\$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

All Plans are Medicare Part D Creditable

Silver HMO Plans

AMOUNTS PER ACCUMULATION PERIOD	Silver 70 HMO 2250/50		Silver 70 HDHP HMO 2700/25	
	Individual	Family	Individual	Family
Medical Deductible ¹	\$2,250	\$4,500	\$2,700	\$5,000
Prescription Drug Deductible ¹	\$300	\$600	\$0	\$0
Out-of-Pocket Maximum ¹	\$8,900	\$15,600	\$7,200	\$13,700
COVERED BENEFITS	Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS
In Office Services				
Primary Care Office Visits		\$50 / visit	X	25% coinsurance ⁵
Urgent Care Visits		\$50 / visit	X	25% coinsurance ⁵
Specialist Office Visits		\$85 / visit	X	25% coinsurance ⁵
Preventive physical exams, immunizations, and related laboratory services ²		\$0		\$0
Prenatal and Postpartum Office Visit		No Charge		No Charge
Well-Baby and Well-Child Exams ²		\$0		\$0
Allergy Injections		\$85 / visit	X	25% coinsurance ⁵
Outpatient Physical, Occupational and Speech Therapy		\$50 / visit	X	25% coinsurance ⁵
Laboratory Tests and Services		\$40 / visit	X	25% coinsurance ⁵
Radiology Services (x-rays, diagnostic imaging)		\$85 / visit	X	25% coinsurance ⁵
Advanced Radiology (including but not limited to MRI, MRA, MRS, CT Scan, Pet, MUGA SPECT)		\$300 / procedure	X	25% coinsurance ⁵
Outpatient Surgery (per procedure)		20% coinsurance ⁵	X	25% coinsurance ⁵
Emergency Services				
Emergency Room Visit (waived if admitted directly to hospital)	X	\$400 / visit	X	25% coinsurance ⁵
Emergency and Non-Emergency Medical Transportation	X	\$250 / trip	X	25% coinsurance ⁵
Prescription Drugs 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	X	\$65 / \$130	X	25% coinsurance ⁵ (Up to \$250)
Tier 3: Non-preferred brand name drugs 30-day supply (retail)/90-day supply (mail order)	X	\$90 / \$180	X	25% coinsurance ⁵ (Up to \$250)
Tier 4: Specialty Items/Drugs 30-day supply (retail only)	X	20% coinsurance ⁵ (Up to \$250 per 30-day supply)	X	25% coinsurance ⁵ (Up to \$250 per 30-day supply)
Hospitalization				
Facility Fee	X	20% coinsurance ⁵	X	25% coinsurance ⁵
Physician/Surgeon Fees		20% coinsurance ⁵	X	25% coinsurance ⁵
Skilled nursing facility services (maximum 100 days per accumulation period)	X	20% coinsurance ⁵	X	25% coinsurance ⁵
Mental Health and Chemical Dependency				
Individual Office Visit		\$50 / visit	X	25% coinsurance ⁵
Inpatient Hospitalization	X	25% coinsurance ⁵	X	25% coinsurance ⁵
Other Benefits				
Teladoc Visit		\$10 / visit	X	No Charge
Acupuncture/Chiropractic Office Visits (20 visit per year combined) ⁵		\$50 / visit	X	25% coinsurance ⁵ Acupuncture only
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

Bronze HMO Plans

AMOUNTS PER ACCUMULATION PERIOD	Bronze 60 HDHP HMO 7000/0		Bronze 60 HMO 6300/65	
	Individual	Family	Individual	Family
Medical Deductible ¹	\$7,000	\$14,000	\$6,300	\$12,600
Prescription Drug Deductible ¹	\$0	\$0	\$500	\$1,000
Out-of-Pocket Maximum ¹	\$7,000	\$14,000	\$8,200	\$16,300
COVERED BENEFITS	Subject to Deductible	MEMBER PAYS	Subject to Deductible	MEMBER PAYS
In Office Services				
Primary Care Office Visits	X	No Charge	X	\$65 / visit *
Urgent Care Visits	X	No Charge	X	\$65 / visit *
Specialist Office Visits	X	No Charge	X	\$95 / visit *
Preventive physical exams, immunizations, and related laboratory services ²		\$0		\$0
Prenatal and Postpartum Office Visit		No Charge		No Charge
Well-Baby and Well-Child Exams ²		\$0		\$0
Allergy Injections	X	No Charge	X	\$95 / visit
Outpatient Physical, Occupational and Speech Therapy	X	No Charge		\$65 / visit
Laboratory Tests and Services	X	No Charge		\$40 / visit
Radiology Services (x-rays, diagnostic imaging)	X	No Charge	X	40% coinsurance ⁵
Advanced Radiology (including but not limited to MRI, MRA, MRS, CT Scan, Pet, MUGA SPECT)	X	No Charge	X	40% coinsurance ⁵
Outpatient Surgery (per procedure)	X	No Charge	X	40% coinsurance ⁵
Emergency Services				
Emergency Room Visit (waived if admitted directly to hospital)	X	No Charge	X	40% coinsurance ⁵
Emergency and Non-Emergency Medical Transportation	X	No Charge	X	40% coinsurance ⁵
Prescription Drugs 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	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	No Charge	X	40% coinsurance ⁵ (Up to \$500 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) ⁵	X	\$0 / visit Acupuncture only	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 1st three non-preventive visits

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.

- 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.
- Includes preventive services with a rating of A or B from the US Preventive Services Task Force; immunizations for children, adolescents and adults recommended by the Centers for Disease Control; and preventive care and screenings supported by the Health Resources and Services Administration for infants, children, adolescents and women. If preventive care is received at the time of other services, the applicable copayment for such services other than preventive care may apply.
- Other Practitioner Office Visits includes office visits not provided by Primary Care Physicians or Specialty Physicians, and office visits not specified in another benefit category.
- Of contracted rates
- 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.
- Other outpatient services include, but are not limited to: mental health psychological testing; mental health outpatient monitoring of drug therapy; substance use disorder treatment for withdrawal; day treatment such as partial hospitalization and intensive outpatient program; outpatient behavioral health treatment for pervasive developmental disorder and autism delivered at home; and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
- The annual visit limitation shall not apply to acupuncture visits that are for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain. 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.

Other Benefits



Vision Plans

CCH offers vision plan options through our partnership with MESVision. As one of the largest providers of vision coverage, MESVision gives you and your employees access to a broad and diverse network including:

- Independent Ophthalmologists (MD)
- Independent Optometrist (OD)
- Independent Opticians (OPT)
- Optical Chain Locations Including:
 - LensCrafters
 - Sam's Club
 - Costco
 - Sears Optical
 - Visionworks
 - Pearle Vision
 - Wal-Mart
 - Target Optical
 - And many more...

You can utilize any provider for both your examination and eyewear materials or you can receive your exam from one provider and your materials from another provider. Additionally, your benefit may be used with any frame or you can choose contact lenses in lieu of lenses and frames according to the plan benefit. Your plan will pay up to the plan allowance shown. If an out of network provider is used, employees may have to pay up front and submit the claim to MES for reimbursement up the allowances shown below. Additional plan options are available.

BENEFIT	Frequency		Frequency		Frequency	
Exams	Every 12 Months		Every 12 Months		Every 12 Months	
Frames	Every 24 Months		Every 12 Months		Every 12 Months	
Lenses	Every 24 Months		Every 24 Months		Every 12 Months	
COVERED BENEFITS	In Network Allowance	Out of Network Allowance	In Network Allowance	Out of Network Allowance	In Network Allowance	Out of Network Allowance
Exams	\$10 COPAY		\$10 COPAY		\$10 COPAY	
Ophthalmologic Exam	Covered	Up to \$40	Covered	Up to \$40	Covered	Up to \$40
Optometric Exam	Covered	Up to \$40	Covered	Up to \$40	Covered	Up to \$40
Materials	\$10 COPAY		\$20 COPAY		\$20 COPAY	
Frames*	Up to \$120	Up to \$40	Up to \$120	Up to \$40	Up to \$120	Up to \$40
Single Vision Lenses	Covered	Up to \$30	Covered	Up to \$30	Covered	Up to \$30
Bifocal Lenses	Covered	Up to \$50	Covered	Up to \$50	Covered	Up to \$50
Trifocal Lenses	Covered	Up to \$65	Covered	Up to \$65	Covered	Up to \$65
Polycarbonate Lenses	Up to \$85	Up to \$55	Up to \$85	Up to \$55	Up to \$85	Up to \$55
Standard Progressive Lenses	Covered	Up to \$65	Covered	Up to \$65	Covered	Up to \$65
Premium Progressive Lenses	Up to \$89.50	Up to \$65	Up to \$89.50	Up to \$65	Up to \$89.50	Up to \$65
Ultra Progressive Lenses	Up to \$89.50	Up to \$65	Up to \$89.50	Up to \$65	Up to \$89.50	Up to \$65
Aphakic Monofocal	Covered	Up to \$125	Covered	Up to \$125	Covered	Up to \$125
Aphakic Multifocal	Covered	Up to \$125	Covered	Up to \$125	Covered	Up to \$125
Contact Lenses*	\$10 COPAY		\$20 COPAY		\$20 COPAY	
One Pair Medically Necessary (evaluation, fitting, and materials)	Covered	Up to \$250	Covered	Up to \$250	Covered	Up to \$250
Cosmetic or Convenience* (evaluation, fitting, and materials)	Up to \$120	Up to \$120	Up to \$120	Up to \$120	Up to \$120	Up to \$120
Additional Savings						
Cosmetic Extras - tints, coatings, etc.	20% Discount		20% Discount		20% Discount	
Additional Pairs of Glasses and/or Contact Lenses	20% Discount		20% Discount		20% Discount	
Lasik	Available though LasikPlus® and QualSight® LASIK		Available though LasikPlus® and QualSight® LASIK		Available though LasikPlus® and QualSight® LASIK	

*Additional plan options are available with higher in-network frame and contact lens allowances of \$130 and \$150. Out of network reimbursement levels may vary by plan.

Health & Wellness Programs

CCH Partners with Weight Watchers

healthy habits, simplified

COMMUNITY CARE HEALTH

WeightWatchers

WW MEMBER ADAM Y. -70 LB[^]

WW MEMBER NIKKI M. -72 LB[^]

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.†

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

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

Learn more at CommunityCareHealth.WW.com.

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

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

†Reminder: WeightWatchers is not a replacement for medical care. Consult your doctor for any health concerns. WeightWatchers logo and WeightWatchers are the trademarks of WW International, Inc. ©2023 WW International, Inc. All rights reserved.

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

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

Then **Now**

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

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

Visit CommunityCareHealth.WW.com to sign up.

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

**"As low as" price reflects WW Digital plan for your organization's employees. Monthly payment required in advance. You'll be automatically charged each month in accordance with company pricing until you cancel, your employment with your organization terminates, or the agreement between your employer and WW terminates. WW Logo is the trademark of WW International, Inc. ©2022 WW International, Inc. All rights reserved.

Our Community Is Your Community

CCH is more than a health plan. As members of the very community we serve, we understand our responsibility to give back throughout the year. We are honored to work with these local organizations and events - and look forward to continuing and growing these efforts in the years to come.

Central Valley Food Bank

To help address food insecurity in the Central Valley, CCH employees regularly volunteer at local food banks. During the 2021 holiday season alone, we helped raise funds, package and deliver food and meals for more than 2,000 of our most-in-need neighbors.

Central California Blood Center

During this unprecedented time, the Central California Blood Center is proud to serve as a resource to our medical professionals in the fight against the novel coronavirus virus. CCH supports this mission and is actively working to increase plasma and blood donations from patients who have recovered from COVID-19. Through our Web Site, quarterly Health Matters newsletter, Mobile App and other communications media, we share this important message with thousands of members.

Catholic Charities

Giving is important throughout the year, and especially during the holiday season.

- For the last three years, CCH has worked with Catholic Charities to help organize its Annual Turkey Drive - a fundraising effort that this year alone provided more than 1,200 in-need families with a holiday meal box and turkey for the Thanksgiving holiday.
- CCH supported the efforts of the Adopt-A-Family program— providing gifts to a number of local families.

Fresno Area College Night

From 2019 to 2021 (via a virtual online event), CCH along with the Fresno County Superintendent of Schools, welcomed thousands of students to the Fresno Area College Night.

- **CCH has been a primary sponsor** for the last three years. The all-virtual event allowed for a safe, virus-free gathering and greater participation than ever before.
- More than 5,000 students were able to attend for free - many of whom will be the first generation in their families to attend college.
- With colleges and universities from around the nation, along with breakout sessions designed to answer college planning questions, the Fresno Area College Night is “one-stop-shopping” for all of their higher education needs.

Central California Women’s Conference

In 2022, The Central California Women’s Conference returned on September 20, 2022 after a two-year hiatus. Community Care Health, alongside Community Health System, were proud to be a presenting sponsor. The mission of the Central California Women’s Conference is to empower women in all stages of their lives. This conference serves to educate and facilitate idea-sharing about how to succeed personally and professionally in life while juggling the increasingly complex and diverse demands of family and community. In previous years, this event saw between 3,500-4,000 attendees, drawing in women from across the Central Valley and beyond.



Peace of Mind Happens Here.



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

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