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, go to www.contracostahealthplan.org. 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.contracostahealthplan.org or call 1-877-661-6230 (Press 6) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$** 0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	**No**	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	**No**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Yes. Individual $1,500/Family $3,000 out-of-pocket maximum per calendar year.**	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?	Premiums, any balance-billed charges, and health care this plan doesn't cover.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.contracostahealthplan.org **or call 1-877-661-6230 (Press 2)** for a list of participating 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).
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	$5/visit (Waived at CCRMC)	Not Applicable	
	Specialist visit	$5/visit (Waived at CCRMC)	Not Applicable	
	Preventive care/screening/ immunization	No Charge	Not Applicable	CCHP does not charge for specified services, including, those rated A or B by the US Preventive Services Task Force, recommended immunizations, preventive care for children and adolescents, and additional preventive care and screenings for women.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not Applicable	
	Imaging (CT/PET scans, MRIs)	No charge	Not Applicable	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	$5/Prescription (retail and mail order)	Not Applicable	Covers up to a 90-day supply (retail prescription); up to a 90-day supply (mail order prescription).
	Preferred brand drugs	$10/Prescription (retail and mail order)	Not Applicable	
	Non-preferred brand drugs	$10/Prescription (retail and mail order)	Not Applicable	Requires prior authorization.
	Specialty drugs	$10/Prescription	Not Applicable	Requires prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$5/visit (Waived at CCRMC)	Not Applicable	
	Physician/surgeon fees	$5/visit (Waived at CCRMC)	Not Applicable	
If you need immediate	Emergency room care	No Charge	No Charge	

[* For more information about limitations and exceptions, see the plan or policy document at [www.contracostahealthplan.org].]

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)	
medical attention	Emergency medical transportation	No Charge	No Charge	Emergency ambulance transportation to the first hospital or urgent care center which actually accepts the subscriber for emergency care or medically necessary transportation as requested by the provider and authorized in advanced by the Plan.
	Urgent care	$5 Co-pay unless for mental health or chemical dependency (Waived at CCRMC)	No Charge	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Applicable	
	Physician/surgeon fees	No Charge	Not Applicable	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	Not Applicable	
	Inpatient services	No Charge	Not Applicable	
If you are pregnant	Office visits	No Charge	Not Applicable	
	Childbirth/delivery professional services	No Charge	Not Applicable	
	Childbirth/delivery facility services	No Charge	Not Applicable	
If you need help recovering or have other special health needs	Home health care	$10/visit	Not Applicable	
	Rehabilitation services	$10/visit	Not Applicable	
	Habilitation services	$10/visit	Not Applicable	
	Skilled nursing care	No Charge	Not Applicable	Limited to 100 days per benefit period if at a Skilled Nursing Facility.
	Durable medical equipment	No Charge	Not Applicable	
	Hospice services	No Charge	Not Applicable	

[* For more information about limitations and exceptions, see the plan or policy document at [www.contracostahealthplan.org].]

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 your child needs dental or eye care	Children's eye exam	$5/visit (Waived at CCRMC)	Not Applicable	Limited to one exam per year
	Children's glasses	Not Covered	Not Applicable	Lenses for Keratoconus are covered one per affected eye per year at an established schedule of benefits rate.
	Children's dental check-up	Not Covered	Not Applicable	

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.)

- Acupuncture
- Bariatric surgery (unless medically necessary)
- Chiropractic services
- Cosmetic surgery
- Dental care
- DNA testing
- Experimental Services
- Hearing aids
- Infertility Treatment other than Artificial Insemination Long-term care
- Non-emergency care when traveling outside the service area
- Non-emergency Transportation
- Private-duty nursing (unless medically necessary)
- Weight loss programs

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

- Routine eye care
- Routine foot care

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 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: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? Yes

[* For more information about limitations and exceptions, see the plan or policy document at [www.contracostahealthplan.org].]

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-877-661-6230 (Oprima 2)

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[* For more information about limitations and exceptions, see the plan or policy document at [www.contracostahealthplan.org].]

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	**$0**
Specialist *[cost sharing]*	**$10**
Hospital (facility) *[cost sharing]*	**%0**
Other *[cost sharing]*	**%0**

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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$20**

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

The plan's overall deductible	**$0**
Specialist *[cost sharing]*	**$10**
Hospital (facility) *[cost sharing]*	**%0**
Other *[cost sharing]*	**%0**

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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$485
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	**$485**

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

The plan's overall deductible	**$0**
Specialist *[cost sharing]*	**$10**
Hospital (facility) *[cost sharing]*	**%0**
Other *[cost sharing]*	**%0**

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	**$2,442**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$70**

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