
 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, 1-888-775-7888. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-888-775-7888 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$2,000 Individual \$4,000 Family	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Preventive services, some office visits, Tier 1 drugs, children’s eye exam, children’s glasses, and children’s dental check-ups.	For example, this <a href="#">plan</a> covers certain <a href="#">preventative services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventative services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. Drug Deductible: \$250 Individual/ \$500 Family. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this plan begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$5,000 Individual / \$10,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> and health care this <a href="#">plan</a> doesn’t cover, and out-of-network services.	Even though you pay these expenses, they don’t count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://cchphealthplan.com/cchp-doctors">https://cchphealthplan.com/cchp-doctors</a> or call 1-888-775- 7888 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan’s <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider’s charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	This <a href="#">plan</a> will pay some or all costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before the <a href="#">specialist</a> .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <a href="#">Copay</a> /Visit	Not Covered	None
	<a href="#">Specialist</a> visit	\$30 <a href="#">Copay</a> /Visit	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your doctor if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$25 <a href="#">Copay</a> /Visit	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$250 <a href="#">Copay</a> /Visit	Not Covered	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.cchphealthplan.com/employer-member.com">www.cchphealthplan.com/employer-member.com</a>	Tier 1 - Generic drugs	\$10 <a href="#">Copay</a> /Prescription (Retail) \$20 <a href="#">Copay</a> /Prescription (Mail Order)	Not Covered	Covers up to 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Mail order prescription only covered at participating pharmacies and Chinese Hospital Pharmacy. Mail order is not available for Tier 4 - <a href="#">Specialty drugs</a> .
	Tier 2 - Preferred brand drugs	\$30 <a href="#">Copay</a> /Prescription (Retail) \$60 <a href="#">Copay</a> /Prescription (Mail Order)	Not Covered	
	Tier 3 - Non-preferred brand drugs	\$60 <a href="#">Copay</a> /Prescription (Retail) \$120 <a href="#">Copay</a> /Prescription (Mail Order)	Not Covered	We will cover prescription filled out-of-network if they are related to care for a medical emergency or urgently needed care.
	Tier 4 - <a href="#">Specialty drugs</a>	20% Coinsurance up to \$250/Prescription (Retail)	Not Covered	If your prescription is not listed on the formulary, you can request for <a href="#">Preauthorization</a> .
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$250 <a href="#">Copay</a> (Chinese Hospital)/ \$750 <a href="#">Copay</a> (Other Contracted Facilities)	Not Covered	<a href="#">Preauthorization</a> required.
	Physician/surgeon fees	No Charge	Not Covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250 <a href="#">Copay</a> /Visit	\$250 <a href="#">Copay</a> /Visit	<a href="#">Copay</a> is waived if admitted.
	<a href="#">Emergency medical</a>	\$100 <a href="#">Copay</a> /Visit	\$100 <a href="#">Copay</a> /Visit	None

\* For more information about limitations and exceptions, see the plan or policy document at [www.cchphealthplan.com](http://www.cchphealthplan.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">transportation</a>			
	<a href="#">Urgent care</a>	\$25 <a href="#">Copay</a> /Visit	\$25 <a href="#">Copay</a> /Visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <a href="#">Copay</a> /day (Chinese Hospital)/ \$750 <a href="#">Copay</a> / day (Other Contracted Facilities) up to first 5 days	Not Covered	<a href="#">Preauthorization</a> required.
	Physician/surgeon fees	No Charge	Not Covered	<a href="#">Preauthorization</a> required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <a href="#">Copay</a> /Visit	Not Covered	Other outpatient services include: Mental health partial hospitalization, Mental health intensive outpatient treatment, Substance use disorder day treatment, and Substance use disorder intensive outpatient treatment.
	Inpatient services	\$250 <a href="#">Copay</a> /day up to 5 days	Not Covered	<a href="#">Preauthorization</a> required.
If you are pregnant	Office visits	No Charge	Not Covered	<a href="#">Cost Sharing</a> does not apply for preventive services. Depending on the type of services, a copayment may apply. Maternity care may include test and services described elsewhere in this document (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	\$250 <a href="#">Copay</a> /day up to 5 days	Not Covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Rehabilitation services</a>	\$25 <a href="#">Copay</a> /Visit	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Habilitation services</a>	\$25 <a href="#">Copay</a> /Visit	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Skilled nursing care</a>	No Charge for first 10 days, then \$100 <a href="#">Copay</a> /per day	Not Covered	<a href="#">Preauthorization</a> required. Limited to 100 covered days every calendar year.
	<a href="#">Durable medical equipment</a>	20% <a href="#">Coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Hospice services</a>	No Charge	Not Covered	<a href="#">Preauthorization</a> required.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	1 covered exam every calendar year
	Children's glasses	No Charge	Not Covered	1 pair per calendar year - Frames will be covered in full from the VSP Pediatric Collection (or contact lenses in lieu of glasses)
	Children's dental check-up	No Charge	Not Covered	1 covered exam every 6 months

\* For more information about limitations and exceptions, see the plan or policy document at [www.cchphealthplan.com](http://www.cchphealthplan.com).

## 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](#).)

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"><li>• Chiropractic Care</li><li>• Cosmetic Surgery</li><li>• Dental Care (Adult)</li></ul> | <ul style="list-style-type: none"><li>• Hearing Aids</li><li>• Infertility treatment</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S</li></ul> | <ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine eye care (Adult)</li><li>• Routine foot care</li><li>• Weight loss program</li></ul> |
|--|---|---|

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

- |   |   |
|---|---|
| <ul style="list-style-type: none"><li>• Acupuncture</li></ul> | <ul style="list-style-type: none"><li>• Bariatric Surgery</li></ul> |
|---|---|

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: California Department of Managed Health Care 1-888-466-2219. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information 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: Chinese Community Health Plan, 445 Grant Avenue, Suite 700, San Francisco, CA 94108. If you have a grievance against Chinese Community Health Plan, you can also contact the California Department of Managed Health Care, at 1-888-466-2219 or

1. <http://www.dmhc.ca.gov>

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

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 1-415-834-2118

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-415-834-2118

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-415-834-2118

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

## About these Coverage Examples:



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

### Peg is Having a Baby

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$30
- Hospital (facility) [copayment](#) \$250/day
- Other [coinsurance](#) 20%

#### This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$9,940</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$700
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,760</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$30
- Hospital (facility) [copayment](#) \$250/day
- Other [coinsurance](#) 20%

#### This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$1,700</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$3100
<b>The total Joe would pay is</b>	<b>\$3,900</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$30
- Hospital (facility) [copayment](#) \$250/day
- Other [coinsurance](#) 20%

#### This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$1,350</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,300
Copayments	\$100
Coinsurance	\$50
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,450</b>