
 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 <https://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> ?	\$6,300/Individual or \$12,600/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, <a href="#">Preventative care</a> , some office visits, laboratory test, habilitation services, rehabilitation services, hospice services, children’s eye exam, children’s glasses, and children’s dental checkup.	This <a href="#">plan</a> covers some items and services even if you haven’t yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services 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. \$500/Individual or \$1,000/Family for Tiers 1, 2, 3 and 4 prescription drugs. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.”
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$8,200 Individual / \$16,400 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their <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/employer-member">https://cchphealthplan.com/employer-member</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 plan 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 of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<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	\$65 <a href="#">Copay</a> /Visit <a href="#">deductible</a> applies after first 3 non-preventive visits	Not Covered	None
	<a href="#">Specialist</a> visit	\$95 <a href="#">Copay</a> /Visit <a href="#">deductible</a> applies after first 3 non-preventive visits	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 preventative. Ask your doctor if the services you need are preventative. 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)	\$40 <a href="#">Copay</a> /Visit (Lab) <a href="#">deductible</a> does not apply 40% <a href="#">coinsurance</a> /Visit (X-Ray)	Not Covered	None
	Imaging (CT/PET scans, MRIs)	40% <a href="#">coinsurance</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="https://cchphealthplan.com/employer-member">https://cchphealthplan.com/employer-member</a>	Tier 1 - Generic drugs	\$18 <a href="#">Copay</a> /Prescription (Retail) \$36 <a href="#">Copay</a> /Prescription (Mail Order)	Not Covered	Covered 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	40% <a href="#">coinsurance</a> up to \$500/Prescription (Retail) 40% <a href="#">coinsurance</a> up to \$1500/Prescription (Mail Order)	Not Covered	
	Tier 3 - Non-preferred brand drugs	40% <a href="#">coinsurance</a> up to \$500/Prescription (Retail)	Not Covered	If your prescription is not listed on the formulary, you can request for

\* 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)	
		40% <a href="#">coinsurance</a> up to \$1500/Prescription (Mail Order)		<a href="#">Preauthorization</a> .
	Tier 4 - <a href="#">Specialty drugs</a>	40% <a href="#">coinsurance</a> up to \$500/Prescription (Retail)	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> required.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	Not Covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	40% <a href="#">coinsurance</a> / Visit	40% <a href="#">coinsurance</a> / Visit	<a href="#">coinsurance</a> is waived if admitted into the hospital.
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a> / Trip	40% <a href="#">coinsurance</a> / Trip	None
	<a href="#">Urgent care</a>	\$65 <a href="#">Copay</a> /Visit <a href="#">deductible</a> applies after first 3 non-preventive visits	Not Covered	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> required.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> required.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Outpatient Office Visit: No Charge <a href="#">deductible</a> does not apply Other Outpatient Visits: 40% <a href="#">coinsurance</a> up to \$65	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	40% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> required.
<b>If you are pregnant</b>	Office visits	No Charge <a href="#">deductible</a> does not apply	Not Covered	
	Childbirth/delivery professional services	40% <a href="#">coinsurance</a>	Not Covered	<a href="#">Cost Sharing</a> does not apply for preventive services. Depending on the type of service, a

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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)	
	Childbirth/delivery facility services	40% <a href="#">coinsurance</a>	Not Covered	copayment may apply. Maternity care may include test and services described elsewhere in this document (i.e ultrasound).
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	40% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Rehabilitation services</a>	\$65 <a href="#">Copay</a> /Visit <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Habilitation services</a>	\$65 <a href="#">Copay</a> /Visit <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Skilled nursing care</a>	40% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> required. Limited to 100 covered days every calendar year.
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Hospice services</a>	No Charge <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> required.
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge <a href="#">deductible</a> does not apply	Not Covered	1 covered exam every calendar year
	Children's glasses	No Charge <a href="#">deductible</a> does not apply	Not Covered	1 paid 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 <a href="#">deductible</a> does not apply	Not Covered	1 covered exam every 6 months

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

**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 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 at 1-888-775-7888, submit a grievance form through our member portal at <https://cchphealthplan.com/employer-member>, or file your complaint in writing to, Chinese Community Health Plan, 445 Grant Avenue, Suite 700, San Francisco, CA 94108. If you have grievance against Chinese Community Health Plan, you can also contact the California Department of Managed Care, at 1-800-466-2219 or <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

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*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](#) \$6300
- [Specialist](#) [coinsurance](#) \$95
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$4,840</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$6,300
Copayments	\$500
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$7,860</b>

**Managing Joe's type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$6300
- [Specialist](#) [coinsurance](#) \$95
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$500</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,200
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$3,100
<b>The total Joe would pay is</b>	<b>\$5,100</b>

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$6300
- [Specialist](#) [coinsurance](#) \$95
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

**This EXAMPLE event includes services like:**

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

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

<i>Cost Sharing</i>	
Deductibles	\$1,700
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,000</b>

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

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