
 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 or call 1-888-775-7888 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 ? | Yes. All services are covered without meeting deductibles | For example, this plan covers certain preventative services without cost sharing and before you meet your deductible. See a list of covered preventative services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No there are no other specific deductibles . | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | \$3,000 Individual / \$6,000 Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Premiums and health care this plan doesn't cover, and out-of-network services | Even though you pay for these expenses, they do not count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider ? | Yes. See https://www.cchphealthplan.com/family-member or call 1-888-775-7888 for a list of network providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network providers might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| 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 | \$15 Copay / Visit | Not Covered | None |
| | Specialist visit | \$30 Copay / Visit | Not Covered | Preauthorization required. |
| | Preventive care/screening/immunization | No Charge | Not Covered | You may to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | \$5 Copay / Visit (Lab) \$5 Copay / Visit (X-Ray) | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | \$100 Copay / Visit | Not Covered | None |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.cchphealthplan.com/family-member | Tier 1 - Generic drugs | \$5 Copay /Prescription (Retail) \$10 Copay /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 - Specialty drugs . We will cover prescription filled out-of-network if they are related to care for a medical emergency or urgently needed care. If you prescription is not listed on the formulary, you can request for Preauthorization . |
| | Tier 2 - Preferred brand drugs | \$15 Copay /Prescription (Retail) \$30 Copay /Prescription (Mail Order) | Not Covered | |
| | Tier 3 - Non-preferred brand drugs | \$25 Copay /Prescription (Retail) \$50 Copay /Prescription (Mail Order) | Not Covered | |
| | Tier 4 - Specialty drugs | 10% coinsurance up to \$250/ Prescription(Retail) | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$250 Copay / Visit | Not Covered | Preauthorization required. |
| | Physician/surgeon fees | No Charge | Not Covered | |
| If you need immediate medical attention | Emergency room care | \$100 Copay / Visit | \$100 Copay / Visit | Copay is waived if admitted into the hospital. |
| | Emergency medical transportation | \$100 Copay / Trip | \$100 Copay / Trip | None |
| | Urgent care | \$50 Copay / Visit | \$50 Copay / Visit | None |

* For more information about limitations and exceptions, see the plan or policy document at 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) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$150 Copay (Chinese Hospital)/ \$450 Copay (Other Facilities) | Not Covered | Preauthorization required. |
| | Physician/surgeon fees | No Charge | Not Covered | Preauthorization required. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$15 Copay / Visit | Not Covered | Other outpatient services include: Mental health partial hospitalization, Mental health intensive outpatient disorder, Substance use disorder day treatment and Substance use disorder intensive outpatient treatment. |
| | Inpatient services | \$150 Copay / Day up to first 5 days | Not Covered | Preauthorization required. |
| If you are pregnant | Office visits | No Charge | Not Covered | Cost Sharing does not apply for preventive services. Depending on the type of service, a copayment may apply. Maternity care may include tests and services described elsewhere in this document. (i.e. ultrasound) |
| | Childbirth/delivery professional services | No Charge | Not Covered | |
| | Childbirth/delivery facility services | \$150 Copay / Day up to first 5 days | Not Covered | |
| If you need help recovering or have other special health needs | Home health care | No Charge | Not Covered | Preauthorization required. |
| | Rehabilitation services | \$15 Copay / Visit | Not Covered | Preauthorization required. |
| | Habilitation services | \$15 Copay / Visit | Not Covered | Preauthorization required. |
| | Skilled nursing care | No Charge | Not Covered | Preauthorization required. Limited to 100 covered days every calendar year. |
| | Durable medical equipment | 50% Coinsurance | Not Covered | Preauthorization required. |
| | Hospice services | No Charge | Not Covered | Preauthorization 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 contacts 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.

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](#).)

- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss program

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

- Acupuncture
- Bariatric Surgery

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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 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/family-member>, or file your complaint in writing to, 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 Care, at 1-888-466-2219 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

—————*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](#) \$0
- [Specialist copayment](#) \$30
- Hospital (facility) [copayment](#) \$150/Day up to first 5 days
- Other [Coinsurance](#) 10%

This EXAMPLE event includes services like:

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

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$200 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$2,700 |
| The total Peg would pay is | \$2,900 |

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 copayment](#) \$30
- Hospital (facility) [copayment](#) \$150/Day up to first 5 days
- Other [Coinsurance](#) 10%

This EXAMPLE event includes services like:

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

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$700 |
| Coinsurance | \$400 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,120 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$30
- Hospital (facility) [copayment](#) \$150/Day up to first 5 days
- Other [Coinsurance](#) 10%

This EXAMPLE event includes services like:

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

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$500 |
| Coinsurance | \$100 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$600 |