
 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, call 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> ?	\$4,750/individual or \$9,500/family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , office visits, outpatient services, medical supplies, and most home health services.	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="#">copaymen</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="#">deductibles</a> . See a list of covered <a href="#">preventive 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. \$85/individual or \$170/family for Tier 1, 2,3 and 4 <a href="#">prescription drugs</a> . 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> ?	\$8,750 individual / \$17,500 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 own <a href="#">out-of-pocket limits</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="#">Premium</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	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/family-member">https://cchphealthplan.com/family-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 <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 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	\$45 <a href="#">Copay</a> /Visit. <a href="#">Deductible</a> does not apply.	Not Covered	None
	<a href="#">Specialist</a> visit	\$85 <a href="#">Copay</a> /Visit. <a href="#">Deductible</a> does not apply.	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Preventive care/screening/immunization</a>	No Charge. <a href="#">Deductible</a> does not apply.	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed 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)	\$50 <a href="#">Copay</a> /Visit (Lab). <a href="#">Deductible</a> does not apply. \$95 <a href="#">Copay</a> /Visit (X-Ray). <a href="#">Deductible</a> does not apply.	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$325 <a href="#">Copay</a> /Visit. <a href="#">Deductible</a> does not apply.	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/family-member">https://cchphealthplan.com/family-member</a>	Tier 1 - Generic drugs	\$16 <a href="#">Copay</a> /Prescription (Retail). \$32 <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 Chinese Hospital Pharmacy. Mail order is not available for Tier 4 - <a href="#">Specialty drugs</a> .  We will cover prescription filled out-of-network if they are related to care for a medical emergency or urgently needed care.  If your prescription is not listed on the formulary, you can request for <a href="#">Preauthorization</a> .
	Tier 2 - Preferred brand drugs	\$60 <a href="#">Copay</a> /Prescription (Retail). \$120 <a href="#">Copay</a> /Prescription (Mail Order).	Not Covered	
	Tier 3 - Non-preferred brand drugs	\$90 <a href="#">Copay</a> /Prescription (Retail). \$180 <a href="#">Copay</a> /Prescription (Mail Order).	Not Covered	

\* 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)	
	<u>Tier 4 - Specialty drugs</u>	20% <u>Coinsurance</u> up to \$250/Prescription (Retail).	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>Coinsurance/Visit. Deductible</u> does not apply.	Not Covered	<u>Preauthorization</u> required.
	Physician/surgeon fees	20% <u>Coinsurance/Visit. Deductible</u> does not apply.	Not Covered	<u>Preauthorization</u> required.
If you need immediate medical attention	<u>Emergency room care</u>	\$400 <u>Copay/Visit. Deductible</u> does not apply.	\$400 <u>Copay/Visit. Deductible</u> does not apply.	<u>Copay</u> is waived if admitted into the hospital.
	<u>Emergency medical transportation</u>	\$250 <u>Copay/Trip. Deductible</u> does not apply.	\$250 <u>Copay/Trip. Deductible</u> does not apply.	None
	<u>Urgent care</u>	\$45 <u>Copay/Visit. Deductible</u> does not apply.	\$45 <u>Copay/Visit. Deductible</u> does not apply.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>Coinsurance/Visit</u>	Not Covered	<u>Preauthorization</u> required.
	Physician/surgeon fees	30% <u>Coinsurance/Visit. Deductible</u> does not apply.	Not Covered	<u>Preauthorization</u> required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient Office Visit: \$45 <u>Copay/Visit. Deductible</u> does not apply. Other Outpatient Visits: \$45 <u>Copay. Deductible</u> does not apply	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	30% <u>Coinsurance/Visit</u>	Not Covered	<u>Preauthorization</u> required.
If you are pregnant	Office visits	No Charge. <u>Deductible</u> does not apply.	Not Covered	<u>Cost sharing</u> does not apply <u>for preventive services</u> . Depending on the type of services, a <u>copayment</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	30% <u>Coinsurance/Visit. Deductible</u> does not apply.	Not Covered	

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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	30% <a href="#">Coinsurance/Visit</a>	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$45 <a href="#">Copay/Visit</a> . <a href="#">Deductible</a> does not apply.	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Rehabilitation services</a>	\$45 <a href="#">Copay/Visit</a> . <a href="#">Deductible</a> does not apply.	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Habilitation services</a>	\$45 <a href="#">Copay/Visit</a> . <a href="#">Deductible</a> does not apply.	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Skilled nursing care</a>	30% <a href="#">Coinsurance/Visit</a>	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> . <a href="#">Deductible</a> does not apply.	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 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. <a href="#">Deductible</a> does not apply.	Not Covered	1 covered exam every 6 months

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<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 programs</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.)**

- 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 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 at 1-888-775-7888, submit a grievance form through <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 Health 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

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 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](#) \$4,750
- [Specialist copayments](#) \$85
- Hospital (facility) [coinsurance](#) 30%
- 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>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$4,800
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$1,100
What isn't covered	
Limits or exclusions	\$2,700
<b>The total Peg would pay is</b>	<b>\$9,300</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$4,750
- [Specialist copayments](#) \$85
- Hospital (facility) [coinsurance](#) 30%
- 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>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$85
<a href="#">Copayments</a>	\$1,900
<a href="#">Coinsurance</a>	\$200
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,205</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$4,750
- [Specialist copayments](#) \$85
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$10
<a href="#">Copayments</a>	\$1,300
<a href="#">Coinsurance</a>	\$50
What isn't covered	
Limits or exclusions	\$40
<b>The total Mia would pay is</b>	<b>\$1,400</b>