CCHP Health Plan

CCHP Senior Program (HMO)
2026 Summary of Benefits

SERVICE AREA: ALAMEDA COUNTY

This is a summary of drug and health services covered by CCHP Senior Program (HMO) from January 1, 2026 - December 31, 2026.

Premiums and Benefits	CCHP Senior Program (HMO)
Monthly Plan Premium	**$29*** You must continue to pay your Medicare Part B premium. *Premium may vary based on the level of Extra Help you receive. Please contact the plan for further details.
Annual Deductible	$0
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$3,000 annually Includes copays and other costs for medical services for the year.
Inpatient Hospital	Days 1-7: $100 copay per day** (at Chinese Hospital) Days 1-7: $200 copay per day** (at all other in-network hospitals) Days 8-90: $0 copay per day**
Outpatient Hospital	$100 copay** (at Chinese Hospital) $310 copay** (at all other in-network hospitals)
Ambulatory Surgery Center (ASC) Services	$300 copay**
Doctor Visits	PCP: $0 copay, Specialists: $0 copay**
Preventive Care (e.g. flu vaccine, diabetic screenings)	$0 copay** Other preventive services are available. There are some covered services that have a cost.
Emergency / Worldwide ER Care	$110 copay within the U.S. $90 copay outside the U.S. Within the US: Copay is waived if admitted within 24 hours to hospital. Outside the US: Copay is not waived if admitted to hospital ($25,000 maximum coverage amount)
Urgently Needed Services	$20 copay within the US $90 copay outside the US ($25,000 maximum coverage amount)
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services: $100 copay** X-Ray and Lab Services: $0 copay** Diagnostic Tests & Procedures: $0 copay**
Hearing Services	Diagnostic Hearing Exam: $20 copay**
Hearing Aids	Routine Hearing Exam: $0 copay through NationsHearing (one routine hearing exam allowed annually) $600 - $2,075 copay per hearing aid, limit two every year, through NationsBenefits
Preventive Dental Services	$0 copay (limit twice per year)
Optional Comprehensive Dental Coverage	$16.75 monthly premium (in addition to monthly plan premium)
Vision Services	Full-Service VSP Vision Plan Routine eye exam: $20 copay** (one exam allowed annually) Eyeglasses: $0 copay** for one pair of glasses every two years (maximum $150 allowance)

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	Contact lens: $0 copay** for contact lens services and materials up to $150 plan allowance every two years from a VSP provider.		
Mental Health Services	Inpatient Hospital: Days 1-7: $250 copay/day** Days 8-90: $0 copay/day**	Group and Individual Therapy Sessions: $15 copay**	
Skilled Nursing Facility (up to 100 days/benefit period)	Days 1-20: $0 copay/day** Days 21-100: $75 copay/day**		
Physical Therapy	$15 copay**		
Ambulance Services	$180 copay per trip		
Transportation	$0 copay per trip, *36 round trips (72 one-way trips)*		
Medicare Part B Drugs	Medicare Part B Insulin Drugs: $35 copay Chemotherapy: 20% coinsurance** Other Part B drugs: 20% coinsurance**		
Acupuncture	$0 copay**		
Over-the-Counter (OTC) Items	$30 allowance per month (allowance expires quarterly)		
Grocery Flex Card	One-time $100 allowance*** (allowance expires on March 31st, 2027)		
Special Supplemental Benefits for the Chronically Ill (SSBCI)	$20 allowance per month**** (allowance expires at the end of plan year)		
Part D: Prescription Drug Coverage (for Drugs on CCHP's Formulary)	**30-day Supply at Retail Pharmacy**		**90-day Supply by Mail Order and Preferred Cost-Share Pharmacies**[1]
	Preferred Pharmacy	**Standard Pharmacy**	
Yearly Deductible	$0		
Initial Coverage			
Tier 1: Preferred Generic (no deductible)	$0 copay	$3 copay	$6 copay
Tier 2: Generic (no deductible)	$0 copay	$7 copay	$14 copay
Tier 3: Preferred Brand (no deductible)	$45 copay		$90 copay
Tier 4: Non-preferred Brand (no deductible)	$100 copay		$200 copay
Tier 5: Specialty (no deductible)	33% coinsurance		Drugs in this tier are <u>not</u> available at this extended day supply.
Catastrophic Coverage: Costs after yearly out-of-pocket drug costs reach $2,100			
Generic	During this payment stage, the plan pays the full cost of your covered Part D drugs. You pay nothing		
Brand & Specialty			
*Premium may vary based on the level of Extra Help you receive. Please contact the plan for further details. **Prior authorization and referral rules may apply. ***Must qualify by completing Annual Wellness Visit. ****Must meet qualification and participation of CCHP Hypertension Management Program. [1] Cost share for 90-day supply may differ at non-preferred cost sharing pharmacies.			

This plan is available to anyone who is enrolled in Medicare Part A and Part B and resides in our service area. Chinese Community Health Plan (CCHP) is a Medicare Advantage HMO plan with a Medicare contract and a California Medicaid program contract for our HMO D-SNP Plan. Enrollment in CCHP depends on contract renewal. A complete list of services we cover can be found in the "Evidence of Coverage" on our website www.cchphealthplan.com/medicare or contact us for more information, 1-888-681-3888 (TTY 1-877-681-8898) from 8:00 a.m. to 8:00 p.m., Monday to Friday. Chinese Community Health Plan complies with applicable Federal

civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. For coverage and costs of Original Medicare, look in your current “Medicare & You” handbook. View it online at https://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. CCHP’s pharmacy network offers limited access to pharmacies with preferred cost sharing in San Francisco, San Mateo and Alameda Counties. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including pharmacies with preferred cost sharing, please call 1-888-775-7888 or consult the online provider/pharmacy directory at www.CCHPHealthPlan.com/medicare.