



CCHP Senior Select Program (HMO D-SNP) 2026 Summary of Benefits

SERVICE AREA: SAN FRANCISCO COUNTY

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

Premiums and Benefits	CCHP Senior Select Program (HMO D-SNP)
Monthly Plan Premium	\$0 You must continue to pay your Medicare Part B premium.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	\$3,400 annually Includes copays AND other costs for medical services for the year.
Inpatient Hospital	Days 1-7: \$0 copay per day**, Days 8-90: \$0 copay per day**
Outpatient Hospital	\$0 copay**
Ambulatory Surgery Center (ASC) Services	\$0 copay**
Doctor Visits	PCP: \$0 copay Specialists: \$0 copay**
Preventive Care (e.g. flu vaccine, diabetic screenings)	\$0 copay**
Emergency / Worldwide ER Care	\$0 copay within the U.S. \$90 copay outside the US (\$25,000 maximum coverage amount). Copay is not waived if admitted into hospital.
Urgently Needed Services	\$0 copay within the US \$90 copay outside the US (\$25,000 maximum coverage amount)
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services: \$0 copay** X-Ray and Lab Services: \$0 copay** Diagnostic Tests and Procedures: \$0 copay**
Hearing Services	Diagnostic Hearing Exam: \$0 copay** (Up to one hearing exam each year)
Hearing Aids	Routine Hearing Exam: \$0 copay through NationsHearing (Up to one Routine hearing exam each year) \$1,000 annual allowance may be applied towards the purchase price of up to two Entry Level hearing aids each year. Purchases must be made through NationsHearing.
Dental Services	\$1,000 allowance for Dental Services beyond those covered by Medi-Cal Dental Program.
Vision Services	Full-Service VSP Vision Plan Routine eye exam: \$0 copay** (one exam allowed annually) Eyeglasses: \$0 copay for one pair of glasses every two years (maximum \$150 allowance) Contact lens: \$0 copay** for contact lens services and materials up to \$150 allowance every two years from a VSP provider.

Premiums and Benefits		CCHP Senior Select Program (HMO D-SNP)	
Mental Health Services	Inpatient Hospital: Days 1-90: \$0 copay per day**	Group and Individual Therapy Sessions: \$0 copay**	
Skilled Nursing Facility (up to 100 days/benefit period)	Days 1-100: \$0 copay per day**		
Physical Therapy	\$0 copay**		
Ambulance Services	\$0 copay per trip		
Transportation	\$0 copay per trip, 48 one-way trips per year**		
Medicare Part B Drugs	\$0 copay**		
Acupuncture	\$0 copay**		
Over-the-Counter (OTC) Items	\$15 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)****	\$45 allowance per month**** (allowance expires at the end of plan year)		
	Hypertension Management Program: \$10 allowance per month**** (allowance expires at the end of plan year)		
Prescription Drug Coverage (for Drugs on CCHP's Formulary)	Drug Tier	Copay* (may vary based on the level of Extra Help eligibility)	
Yearly Deductible	\$0 if you receive Extra Help, \$615 if you receive no Extra Help		
Initial Coverage	Cost-Sharing Tier 1: Preferred Generic	\$0 Does not apply to deductible	
	Cost-Sharing Tier 2: Generic	25% coinsurance and applies to deductible	
	Cost-Sharing Tier 3: Preferred Brand	25% coinsurance and applies to deductible	
	Cost-Sharing Tier 4: Non-preferred Brand	25% coinsurance and applies to deductible	
	Cost-Sharing Tier 5: Specialty	25% coinsurance and applies to deductible	
Catastrophic Coverage: Costs after yearly out-of-pocket drug costs reach \$2,100.	Generic (including brand drugs treated as generic)	During this payment stage, the plan pays the full cost of your covered Part D drugs. You pay nothing.	
	All Other Drugs	During this payment stage, the plan pays the full cost of your covered Part D drugs. You pay nothing.	
<p>*Premiums, co-pays, co-insurance, and deductibles 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 rules.</p>			

The following services are not covered by CCHP Senior Select Program (HMO D-SNP) but may be available through Medi-Cal (Medicaid):

- Long term care in a facility longer than the month of admission plus one month

- Routine foot care
- Incontinence supplies
- Certain drugs excluded by Medicare, check the Medi-Cal (Medicaid) formulary for more details
- Certain dental services

This plan is available to anyone who is enrolled in Medicare Part A and Part B, receives Medi-Cal (Medicaid) benefits, and resides in San Francisco County. 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.