




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. 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> ?	\$ 0	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. All services are covered without meeting a <a href="#">deductible</a> .	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?	No. There are no other specific <a href="#">deductibles</a> .	You don't have to meet <a href="#">deductible</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$4,500 individual / \$9,000 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/">https://cchphealthplan.com/</a> employer-member 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 <a href="#">provider</a> '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	\$15 <a href="#">Copay</a> /Visit	Not Covered	None
	<a href="#">Specialist</a> visit	\$30 <a href="#">Copay</a> /Visit	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 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)	\$15 <a href="#">Copay</a> /Visit (Lab) \$30 <a href="#">Copay</a> /Visit (X-Ray)	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$75 <a href="#">Copay</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://www.cchphealthplan.com/employer-member">https://www.cchphealthplan.com/employer-member</a>	Tier 1 (Generic drugs )	\$5 <a href="#">Copay</a> /Prescription (Retail). \$10 <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 Costco pharmacies and 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)	\$15 <a href="#">Copay</a> /Prescription (Retail). \$30 <a href="#">Copay</a> /Prescription (Mail Order).	Not Covered	
	Tier 3 (Non-preferred brand drugs)	\$25 <a href="#">Copay</a> /Prescription (Retail). \$50 <a href="#">Copay</a> /Prescription (Mail Order).	Not Covered	
	Tier 4 (Specialty drugs)	10% <a href="#">Coinsurance</a> up to \$250/Prescription (Retail)	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$100 <a href="#">Copay</a> /Visit	Not Covered	<a href="#">Preauthorization</a> required.
	Physician/surgeon fees	\$25 <a href="#">Copay</a> /Visit	Not Covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150 <a href="#">Copay</a> /Visit	\$150 <a href="#">Copay</a> /Visit	<a href="#">Copay</a> is waived if admitted into the hospital.
	<a href="#">Emergency medical transportation</a>	\$150 <a href="#">Copay</a> /Trip	\$150 <a href="#">Copay</a> /Trip	None
	<a href="#">Urgent care</a>	\$15 <a href="#">Copay</a> /Visit	\$15 <a href="#">Copay</a> /Visit	None

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)	\$250 <a href="#">Copay</a> /Day up to first 5 days	Not Covered	<a href="#">Preauthorization</a> required.
	Physician/surgeon fees	No Charge	Not Covered	<a href="#">Preauthorization</a> required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient Office Visit: \$15 <a href="#">Copay</a> /Visit. Other Outpatient Visits: \$15 <a href="#">Copay</a> /Visit.	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	\$250 <a href="#">Copay</a> /Day up to first 5 days	Not Covered	<a href="#">Preauthorization</a> required.
If you are pregnant	Office visits	No Charge	Not Covered	<a href="#">Cost sharing</a> does not apply <a href="#">for preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	\$250 <a href="#">Copay</a> /Day up to first 5 days	Not Covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$20 <a href="#">Copay</a> /Visit	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Rehabilitation services</a>	\$15 <a href="#">Copay</a> /Visit	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Habilitation services</a>	\$15 <a href="#">Copay</a> /Visit	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Skilled nursing care</a>	\$150 <a href="#">Copay</a> /Day up to first 5 days	Not Covered	<a href="#">Preauthorization</a> required. Limited to 100 covered days every calendar year
	<a href="#">Durable medical equipment</a>	10% <a href="#">Coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Hospice services</a>	No Charge	Not Covered	<a href="#">Preauthorization</a> 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 contact lenses in lieu of glasses)
	Children's dental check-up	No Charge	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](#).)

- |                       |  |                            |
|-----------------------|--|----------------------------|
| • Chiropractic care   | • Infertility treatment                              | • Private-duty nursing     |
| • Cosmetic surgery    | • Long-term care                                     | • Routine eye care (Adult) |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Routine foot care        |
| • Hearing aids        |  | • Weight loss programs     |

**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://www.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 a grievance against Chinese Community Health Plan, you can also contact the California Department of Managed Health Care, at 1-800-HMO-2219 or <http://www.hmohelp.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](#) \$0
- [Specialist copayments](#) \$30
- Hospital (facility) [copayments](#) \$250/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	\$12,800
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$660</b>

### 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 copayments](#) \$30
- Hospital (facility) [copayments](#) \$250/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	\$7,500
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,060</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayments](#) \$30
- Hospital (facility) [copayments](#) \$250/day up to first 5 days
- Other [Coinsurance](#) 10%

#### This EXAMPLE event includes services like:

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

Total Example Cost	\$2,000
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$600</b>