




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 <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 href="#">deductible</a> .	For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services 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="#">deductibles</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</a> limit 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</a> limits until the overall family <a href="#">out-of-pocket</a> limit has been met."
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premium</a> , health care this <a href="#">plan</a> doesn't and out-of-network services.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket</a> limit.
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://www.cchphealthplan.com/cchp-doctors">https://www.cchphealthplan.com/cchp-doctors</a> or call 1-888-775-7888 for a list of <a href="#">network provider</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 plan 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 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 <a href="#">provider's</a> office or clinic	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.
If you have a test	<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
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.cchphealthplan.com/employer-member.com">www.cchphealthplan.com/employer-member.com</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 participation 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	
	<a href="#">Tier 4 (Specialty drugs)</a>	10% up to \$250/Prescription (Retail)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 <a href="#">Copay</a>	Not Covered	<a href="#">Preauthorization</a> required.
	Physician/surgeon fees	\$25 <a href="#">Copay</a>	Not Covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <a href="#">Copay</a>	\$150 <a href="#">Copay</a>	<a href="#">Copay</a> is waived if admitted to the hospital.
	<a href="#">Emergency medical transportation</a>	\$150 <a href="#">Copay</a>	\$150 <a href="#">Copay</a>	None

\* 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)	
	<a href="#">Urgent care</a>	\$15 <a href="#">Copay</a>	Not Covered	None
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> Other Outpatient Visits: \$15 <a href="#">Copay</a>	Not Covered	Other outpatient visits include: Intensive Outpatient Care, BHT for treatment of PDD or Autism, Partial Hospitalization, Psychological Testing.
	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 for preventative services. Depending on the type of service, a copayment may apply. Maternity care may include test
	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.
	<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 paid 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   | • Hearing Aids                                       | • Private-duty nursing     |
| • Cosmetic Surgery    | • Infertility treatment                              | • Routine eye care (Adult) |
| • Dental Care (Adult) | • Long-term care                                     | • Routine foot care        |
|                       | • Non-emergency care when traveling outside the U.S. | • 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](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 our member portal at <https://www.cchphealthplan.com/individual-family-plan-members>, or file your complaint in writing to, Chinese Community Health Plan, 445 Grant Avenue, Suite 700, San Francisco, ca 94108. You can also contact the California Department of Managed Care, at 1-800-HMO-2219 or <http://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

-----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](#) \$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	\$12,137
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$605
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$665

### 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](#) \$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	\$6,158
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,120
Coinsurance	\$173
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$1,348

### 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](#) \$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	\$1,328
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$730
Coinsurance	\$4
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$734