




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> ?	\$3,700/individual or \$7,400/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="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventative services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventative 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?	Yes. \$275/individual or \$550/family for Tier 1, 2,3 and 4 <a href="#">prescription drugs</a> . There are no other specific <a href="#">deductible</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> ?	\$6,500 individual / \$13,000 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/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	\$35 <a href="#">Copay</a> /Visit. <a href="#">Deductible</a> does not apply.	Not Covered	None
	<a href="#">Specialist</a> visit	\$75 <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)	\$40 <a href="#">Copay</a> /Visit (Lab). <a href="#">Deductible</a> does not apply. \$85 <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://www.cchphealthplan.com/family-member">https://www.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 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
	Tier 2 - Preferred brand drugs	\$55 <a href="#">Copay</a> /Prescription (Retail). \$110 <a href="#">Copay</a> /Prescription (Mail Order).	Not Covered	
	Tier 3 - Non-preferred brand drugs	\$85 <a href="#">Copay</a> /Prescription (Retail). \$170 <a href="#">Copay</a> /Prescription (Mail	Not Covered	

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)	
		Order).		<a href="#">Preauthorization</a> .
	Tier 4 - <a href="#">Specialty drugs</a>	20% <a href="#">Coinsurance</a> up to \$250/Prescription (Retail)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">Coinsurance</a> /Visit. <a href="#">Deductible</a> does not apply.	Not Covered	<a href="#">Preauthorization</a> required.
	Physician/surgeon fees	20% <a href="#">Coinsurance</a> /Visit. <a href="#">Deductible</a> does not apply.	Not Covered	<a href="#">Preauthorization</a> required.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$400 <a href="#">Copay</a> /Visit. <a href="#">Deductible</a> does not apply.	\$400 <a href="#">Copay</a> /Visit. <a href="#">Deductible</a> does not apply.	<a href="#">Copay</a> is waived if admitted into the hospital.
	<a href="#">Emergency medical transportation</a>	\$250 <a href="#">Copay</a> /Trip. <a href="#">Deductible</a> does not apply.	\$250 <a href="#">Copay</a> /Trip. <a href="#">Deductible</a> does not apply.	None
	<a href="#">Urgent care</a>	\$35 <a href="#">Copay</a> /Visit. <a href="#">Deductible</a> does not apply.	\$35 <a href="#">Copay</a> /Visit. <a href="#">Deductible</a> does not apply.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">Coinsurance</a> /Visit	Not Covered	<a href="#">Preauthorization</a> required.
	Physician/surgeon fees	20% <a href="#">Coinsurance</a> /Visit. <a href="#">Deductible</a> does not apply.	Not Covered	<a href="#">Preauthorization</a> required.

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 need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Outpatient Office Visit: \$35 <a href="#">Copay</a> /Visit. <a href="#">Deductible</a> does not apply. Other Outpatient Visits: 20% <a href="#">Coinsurance</a> /Visit up to \$35 <a href="#">Copay</a> /Visit. <a href="#">Deductible</a> 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	20% <a href="#">Coinsurance</a> /Visit	Not Covered	<a href="#">Preauthorization</a> required.
<b>If you are pregnant</b>	Office visits	No Charge. <a href="#">Deductible</a> does not apply.	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	20% <a href="#">Coinsurance</a> /Visit. <a href="#">Deductible</a> does not apply.	Not Covered	
	Childbirth/delivery facility services	20% <a href="#">Coinsurance</a> /Visit	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$40 <a href="#">Copay</a> /Visit. <a href="#">Deductible</a> does not apply.	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Rehabilitation services</a>	\$35 <a href="#">Copay</a> /Visit. <a href="#">Deductible</a> does not apply.	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Habilitation services</a>	\$35 <a href="#">Copay</a> /Visit. <a href="#">Deductible</a> does not apply.	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Skilled nursing care</a>	20% <a href="#">Coinsurance</a> /Visit	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>	Not Covered	1 pair per calendar year - Frames will be

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)	
		does not apply.		covered in full from the VSP Pediatric Collection (or contact lenses in lieu of glasses)
	Children's dental check-up	No Charge. <u>Deductible</u> does not apply.	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.)**

- |  |   |   |
|--|---|---|
| <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> |
|--|---|---|

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- |               |                     |
|---------------|---------------------|
| • Acupuncture | • Bariatric Surgery |
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**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/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 1-800-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](#) \$3,700
- [Specialist copayments](#) \$75
- Hospital (facility) [coinsurance](#) 20%
- 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>\$13,100</b>
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**In this example, Peg would pay:**

Cost Sharing	
Deductibles	\$3,700
Copayments	\$900
Coinsurance	\$1,800
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,460</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$3,700
- [Specialist copayments](#) \$75
- Hospital (facility) [coinsurance](#) 20%
- 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>\$8,000</b>
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**In this example, Joe would pay:**

Cost Sharing	
Deductibles	\$300
Copayments	\$2,300
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2,960</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$3,700
- [Specialist copayments](#) \$75
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$2,200</b>
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**In this example, Mia would pay:**

Cost Sharing	
Deductibles	\$0
Copayments	\$1,200
Coinsurance	\$10
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,210</b>