華人保健計劃 CCHP Health Plan

Senior Program (HMO)

2019 | 2020

Welcome!

This is our Summary of Benefits document.

They give you a good summary of the benefits and features of our health plan. Included are:

2020 Summary of Benefits

for people looking for coverage between January through December 2020

2019 Summary of Benefits

for people looking for coverage until the end of 2019. Must qualify.
(Please remember you must sign up by October 25th for November coverage and by November 25 for December coverage)

CCHP Senior Program (HMO)
2019 Summary of Benefits
Service Area: San Francisco & San Mateo County

This is a summary of drug and health services covered by CCHP Senior Program (HMO) January 1, 2019 - December 31, 2019.

Premiums and Benefits	CCHP Senior Program (HMO)	
Monthly Plan Premium	**$42** You must continue to pay your Medicare Part B premium.	
Deductible	$0	
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$6,700 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: $280 copay per day** (at all other hospitals) Days 8+: $0 copay per day**	
Outpatient Hospital	$100 copay** (at Chinese Hospital) $295 copay** (at all other hospitals)	
Doctor Visits	PCP: $10 copay Specialists: $20 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 Care (Worldwide coverage)	$90 copay If you are admitted to the hospital within 24 hours, then you do not have to pay $90.	
Urgently Needed Services	$35 copay	
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services: $0 - $200 copay** X-Ray and Lab Services: $0 copay**	
Hearing Services	Routine Hearing Exam: $35 copay** (one routine hearing exam allowed annually)	
Dental Services	Not Covered	
Vision Services	$20 copay for refraction** $0 copay for one pair of glasses every two years (maximum $150 allowance)	
Mental Health Services	Inpatient Hospital: Days 1-7: $225 copay/day** Days 8-90: $0 copay/day**	Group and Individual Therapy Sessions: $35 copay**
Skilled Nursing Facility (up to 100 days/benefit period)	Days 1-20: $0 copay/day** Days 21-100: $135 copay/day**	
Physical Therapy	$25 copay**	

Premiums and Benefits	CCHP Senior Program (HMO)	
Ambulance Services	$225 copay per trip	
Transportation	$0 copay per trip, 8 one-way trips per year**	
Medicare Part B Drugs	$0 copay**	
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***
Initial Coverage: Costs for Brand and Specialty drugs after the $100 yearly deductible.		
Tier 1: Preferred Generic (no deductible)	$3 copay	$6 copay
Tier 2: Non-preferred Generic (no deductible)	$7 copay	$14 copay
Tier 3: Preferred Brand	$40 copay	$80 copay
Tier 4: Non-preferred Brand	$60 copay	$120 copay
Tier 5: Specialty	30% coinsurance	Drugs in this tier are not available at this extended day supply.
Coverage Gap: Costs after your total yearly drug costs reach $3,820		
Generic	37% coinsurance	
Brand & Specialty	25% coinsurance	
Catastrophic Coverage: Costs after yearly out-of-pocket drug costs reach $5,100		
Generic	You pay the greater of 5% or $3.40 copay.	
Brand & Specialty	You pay the greater of 5% or $8.50 copay.	
*Cost share for 90-day supply may differ at non-preferred cost sharing pharmacies.		
Optional Dental Coverage	$18 per month (in addition to monthly plan premium)	

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 SNP. This information is not a complete description of benefits. 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, 1-888-371-3060 (TTY 1-877-681-8898) from 8:00 a.m. to 8:00 p.m., seven days a week. 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 and San Mateo 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 pharmacy directory at www.CCHPHealthPlan.com/medicare. ATTENTION: This information is available for free in other languages. Please contact our Member Services Department at <1-888-775-7888> (TTY 1-877-681-8898) from 8:00 a.m. to 8:00 p.m., seven days a week. ATENCIÓN: Esta información está disponible gratuitamente en otros idiomas. Por favor póngase en contacto con nuestro departamento de servicio de miembro al 1-888-775-7888 (TTY 1-877-681-8898) de 8:00 a.m. a 8:00 p.m., siete días a la semana. 此文件有其它的語言版本免費提供。了解詳情請致電 1-888-775-7888 與會員服務中心聯絡（聽力殘障人仕請電 TTY 1-877-681-8898），每週 7 天，上午 8 時至晚上 8 時。

***Prior authorization and referral rules apply.*

CCHP Senior Program (HMO)
2020 Summary of Benefits
Service Area: San Francisco & San Mateo County

This is a summary of drug and health services covered by CCHP Senior Program (HMO) January 1, 2020- December 31, 2020.

Premiums and Benefits	CCHP Senior Program (HMO)
Monthly Plan Premium	**$42** You must continue to pay your Medicare Part B premium.
Deductible	$0
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$6,700 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: $305 copay per day** (at all other hospitals) Days 8+: $0 copay per day**
Outpatient Hospital	$100 copay** (at Chinese Hospital) $300 copay** (at all other hospitals)
Ambulatory Surgery Center (ASC) Services	$300 copay**
Doctor Visits	PCP: $10 copay Specialists: $20 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 Care (Worldwide coverage)	$90 copay If you are admitted to the hospital within 24 hours, then you do not have to pay $90.
Urgently Needed Services (Worldwide coverage)	$45 copay
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services: $200 copay** X-Ray and Lab Services: $0 copay** Diagnostic Tests & Procedures: $0 copay**
Hearing Services **Hearing Aids**	Routine Hearing Exam: $35 copay** (one routine hearing exam allowed annually) $600 - $2,075 copay/ear, limit two per year
Dental Services	Not Covered
Vision Services	$20 copay for refraction** (one exam allowed annually) $0 copay for one pair of glasses every two years (maximum $150 allowance)

Premiums and Benefits	CCHP Senior Program (HMO)	
Mental Health Services	Inpatient Hospital: Days 1-7: $250 copay/day** Days 8-90: $0 copay/day**	Group and Individual Therapy Sessions: $35 copay**
Skilled Nursing Facility (up to 100 days/benefit period)	Days 1-20: $0 copay/day** Days 21-100: $150 copay/day**	
Physical Therapy	$20 copay**	
Ambulance Services	$225 copay per trip	
Transportation	$0 copay per trip, 8 one-way trips per year**	
Medicare Part B Drugs	$0 copay**	
Acupuncture	$20 copay**	
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***
Tier 1: Preferred Generic (no deductible)	$3 copay	$6 copay
Tier 2: Non-preferred Generic (no deductible)	$7 copay	$14 copay
Tier 3: Preferred Brand (no deductible)	$40 copay	$80 copay
Tier 4: Non-preferred Brand (no deductible)	$60 copay	$120 copay
Tier 5: Specialty (no deductible)	30% coinsurance	Drugs in this tier are <u>not</u> available at this extended day supply.
Coverage Gap: Costs after your total yearly drug costs reach $4,020		
Generic	25% coinsurance	
Brand & Specialty	25% coinsurance	
Catastrophic Coverage: Costs after yearly out-of-pocket drug costs reach $6,350		
Generic	You pay the greater of 5% or $3.60 copay.	
Brand & Specialty	You pay the greater of 5% or $8.95 copay.	
*Cost share for 90-day supply may differ at non-preferred cost sharing pharmacies.		
Optional Dental Coverage	$20 per month (in addition to monthly plan premium)	

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