**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/ or call 1-888-775-7888 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $9,100/Individual or $18,200/Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care and outpatient services. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventative services without cost sharing and before you meet your deductible. See a list of covered preventative services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. There are no other specific deductibles. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | $9,100 Individual / $18,200 Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premium, balance billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See https://www.cchphealthplan.com/family-member or call 1-888-775-7888 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | Yes. | This plan 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. |

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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 provider's office or clinic** | Primary care visit to treat an injury or illness | 0% Coinsurance/Visit. Deductible applies after first 3 non-preventive visits. | Not Covered | None |
| | Specialist visit | 0% Coinsurance/Visit | Not Covered | Preauthorization required. |
| | Preventive care/screening/ immunization | No Charge. Deductible does not apply. | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 0% Coinsurance/Visit (Lab). 0% Coinsurance/Visit (X-Ray). | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | 0% Coinsurance/Visit | Not Covered | None |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at https://www.cchphealthplan.com/family-member | Tier 1 - Generic drugs | 0% Coinsurance (Retail). 0% Coinsurance (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 pharmacies and Chinese Hospital Pharmacy. Mail order is not available for Tier 4 - Specialty drugs.<br><br>We will cover prescription filled out-of-network if they are related to care for a medical emergency or urgently needed care.<br><br>If you prescription is not listed on the formulary, you can request for Preauthorization. |
| | Tier 2 - Preferred brand drugs | 0% Coinsurance (Retail). 0% Coinsurance (Mail Order). | Not Covered | |
| | Tier 3 - Non-preferred brand drugs | 0% Coinsurance (Retail). 0% Coinsurance (Mail Order). | Not Covered | |
| | Tier 4 - Specialty drugs | 0% Coinsurance (Retail). | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% Coinsurance/Visit | Not Covered | Preauthorization required. |
| | Physician/surgeon fees | 0% Coinsurance/Visit | Not Covered | Preauthorization required. |
| **If you need immediate medical attention** | Emergency room care | 0% Coinsurance/Visit | 0% Coinsurance/Visit | Coinsurance is waived if admitted into the hospital. |
| | Emergency medical | 0% Coinsurance/Trip | 0% Coinsurance/Trip | None |

* For more information about limitations and exceptions, see the plan or policy document at 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) | |
| | transportation | | | |
| | Urgent care | 0% Coinsurance/Visit. Deductible applies after first 3 non-preventive visits. | 0% Coinsurance/Visit. Deductible applies after first 3 non-preventive visits. | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% Coinsurance/Visit | Not Covered | Preauthorization required. |
| | Physician/surgeon fees | 0% Coinsurance/Visit | Not Covered | Preauthorization required. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Outpatient Office Visit: No Charge. Deductible does not apply. Other Outpatient Visits: No Charge. | 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 | No Charge. Deductible does not apply. | Not Covered | Preauthorization required. |
| **If you are pregnant** | Office visits | No Charge. Deductible does not apply. | Not Covered | Cost Sharing does not apply for preventive services. Depending on the type of services, a copayment may apply. Maternity care may include test and services described elsewhere in this document (i.e. ultrasound). |
| | Childbirth/delivery professional services | 0% Coinsurance/Visit | Not Covered | |
| | Childbirth/delivery facility services | 0% Coinsurance/Visit | Not Covered | |
| **If you need help recovering or have other special health needs** | Home health care | 0% Coinsurance/Visit | Not Covered | Preauthorization required. |
| | Rehabilitation services | 0% Coinsurance/Visit | Not Covered | Preauthorization required. |
| | Habilitation services | 0% Coinsurance/Visit | Not Covered | Preauthorization required. |
| | Skilled nursing care | 0% Coinsurance/Visit | Not Covered | Preauthorization required. Limited to 100 covered days every calendar year. |
| | Durable medical equipment | 0% Coinsurance | Not Covered | Preauthorization required. |
| | Hospice services | 0% Coinsurance/Visit | Not Covered | Preauthorization required. |
| **If your child needs dental or eye care** | Children's eye exam | No Charge. Deductible does not apply. | 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. Deductible does not apply. | Not Covered | 1 covered exam every 6 months |

* For more information about limitations and exceptions, see the plan or policy document at www.cchphealthplan.com.

## 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
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- 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 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://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 1-888-466-2219 or http://www.dmhc.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, kwiijigo holne' 1-415-834-2118

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

* For more information about limitations and exceptions, see the plan or policy document at www.cchphealthplan.com.

## 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 | $9,100 |
| Specialist coinsurance | 0% |
| Hospital Coinsurance | 0% |
| Other Coinsurance | 0% |

**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** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $9,100 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $2,700 |
| **The total Peg would pay is** | **$11,800** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $9,100 |
| Specialist coinsurance | 0% |
| Hospital Coinsurance | 0% |
| Other Coinsurance | 0% |

**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** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $5,400 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$5,420** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $9,100 |
| Specialist coinsurance | 0% |
| Hospital Coinsurance | 0% |
| Other Coinsurance | 0% |

**This EXAMPLE event includes services like:**
Emergency room care (*including medical supplies*)
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,400 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $40 |
| **The total Mia would pay is** | **$2,440** |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.