Amber

Individual & Family Plan
Summary of Benefits and Coverage

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華人健保計劃 CCHP Health Plan

CCHP Amber HMO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2016

Coverage for: Individual and Family | **Plan Type: HMO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.cchphealthplan.com or by calling 1-888-681-3888.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$2,500 (Individual)/ $5,000 (Family) Medical.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st).See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes. $250 (Individual)/ $500 (Family) Tier 2- Tier 4 Pharmacy.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $6,250 (Individual) / $12,500 (Family) Medical / $250 (30-day-supply) tier 4 Pharmacy	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, and health care this plan doesn't cover. If you are enrolled in adult vision or dental, these expenses do not count towards the out-of-pocket limit.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit** on your expenses
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.cchphealthplan.com or call 1-888-681-3888	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. You do need a referral to see a specialist.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5 or 6. See your policy or plan document for additional information about excluded services."

Questions: Call 1-888-681-3888 or visit us at www.cchphealthplan.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cchphealthplan.com or call 1-888-681-3888 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 copay for 1st 3 non-preventive visits (Deductible does not apply) Then $50 copay (Deductible applies)	Not-covered	Services a Member receives from a non-plan physician are not covered, except for covered urgently-needed or emergency services.
	Specialist visit	After dedutible $50 copay / visit	Not-covered	
	Other practitioner office visit	After deductible $50 copay/ visit	Not-covered	
	Preventive care/ screening/immunization	$0 copay / visit	Not-covered	None
If you have a test	Diagnostic test (x-ray, blood work)	After dedutible $0 copay (Laboratory) / $0 copay (x-ray) / visit	Not-covered	None
	Imaging (CT/PET scans, MRIs)	After dedutible $300 copay / visit	Not-covered	Requires prior-authorization

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cchphealthplan.com.	Tier 1	$15 copay (30-day supply - retail) $30 copay (90-day supply – Mail Order, Costco Pharmacy or Chinese Hospital Pharmacy)	Not-covered	Up to $250 (30-day-supply per script tier 4 Rx) and up to $750 (90-day-supply per script tier 4 Rx) after Pharmacy Deductible. We will cover prescriptions that are filled at an Out-of-Network Pharmacy if the prescriptions 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 prior authorization.
	Tier 2	After deductible $50 copay (30-day supply – retail) After deductible $100 copay (90-day supply – Mail Order, Costco Pharmacy or Chinese Hospital Pharmacy)	Not-covered	
	Tier 3	After deductible $70 copay (30-day supply – retail) After deductible $140 copay (90-day supply – Mail Order, Costco Pharmacy or Chinese Hospital Pharmacy)	Not-covered	
	Tier 4	After deductible 20% coinsurance (30-day supply – Retail) After deductible 20% coinsurance (90-day supply – Mail Order, Costco Pharmacy or Chinese Hospital Pharmacy)	Not-covered	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	After deductible $400 copay (Chinese Hospital)/ $1,200 copay (Other Contracted Facilities)	Not-covered	Requires prior-authorization
	Physician/surgeon fees		Not-covered	Requires prior-authorization
If you need immediate medical attention	Emergency room services for	After deductible $250 copay / visit	After deductible $250 copay / visit	Copay waived if admitted to the hospital
	Emergency medical transportation	After deductible $100 copay / trip	After deductible $100 copay / trip	None
	Urgent care	After deductible $50 copay / visit	After deductible $50 copay / visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	After deductible $500 per day (Chinese Hospital)/ $1,500 per day (Other Contracted Facilities) (Up to the first 5 days)	Not-covered	Requires prior-authorization
	Physician/surgeon fee			Requires prior-authorization
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$0 copay for 1st 3 (Individual) Mental/ Behavioral Health visits (Deductible does not apply). Then $50 copay (Individual office visit and other outpatient services)/ $25 copay (Group office visit and other outpatient services) (Deductible applies)	Not-covered	Other outpatient services include: Mental health partial hospitalization, Mental health intensive outpatient treatment, Mental health monitoring of drug therapy, Substance use disorder day treatment, Substance use disorder intensive outpatient treatment, Substance use disorder medication treatment withdrawal.
	Mental/Behavioral health inpatient services	After deductible $500 per day (Up to first 5 days)	Not-covered	Requires prior-authorization

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Substance use disorder outpatient services	$0 copay for 1st 3 (Individual) Substance use disorder visits (Deductible does not apply). Then $50 copay (Individual office visit and other outpatient services)/ $25 copay (Group office visit and other outpatient services) (Deductible applies)	Not-covered	Other outpatient services include: Mental health partial hospitalization, Mental health intensive outpatient treatment, Mental health monitoring of drug therapy, Substance use disorder day treatment, Substance use disorder intensive outpatient treatment, Substance use disorder medication treatment withdrawal
	Substance use disorder inpatient services	After deductible $500 per day (Up to first 5 days)	Not-covered	Requires prior-authorization
If you are pregnant	Prenatal and postnatal care	$0 copay	Not-covered	None
	Delivery and all inpatient services	After deductible $500 per day (Up to first 5 days)	Not-covered	Requires prior-authorization
If you need help recovering or have other special health needs	Home health care	After deductible $0 copay / visit	Not-covered	Requires prior-authorization
	Rehabilitation services	After deducitble $50 copay / visit	Not-covered	None
	Habilitation services	After deductible $50 copay / visit	Not-covered	None
	Skilled nursing care	1st 10 days at no cost share (Deductible does not apply). Then $100 copay per day (Deductible applies)	Not-covered	Requires prior-authoriztion Limited to 100 days per benefit period
	Durable medical equipment	After deductible $0 copay (Inpatient)/ 50% coinsurance (Outpatient)	Not-covered	Requires prior-authorization
	Hospice service	$0 copay	Not-covered	Requires prior-authorization
	Eye exam	$0 copay	Not-covered	1 exam every calendar year

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	$0 copay	Not-covered	1 exam every calendar year
	Glasses	$0 copay	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)
	Dental check-up	$0 copay	Not-covered	2 dental check-up(s) every 12 months

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Chiropractic care
- Cosmetic Surgery
- Dental care (Adult)
- Hearing aids
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside U.S.
- Private duty nursing
- Routine Eye Care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric Surgery

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-415-834-2118. You may also contract your state insurance department at 1-888-466-2219 (California Department of Managed Health Care).

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: California Department of Managed Health Care at 1-888-466-2219.

Additionally, a consumer assistance program can help you file your appeal. Contact California Department of Managed Health Care at 1-888-466-2219.

Does this Coverage Satisfy the Individual Responsibility Requirement and Meet the Minimum Value Standard?

Yes. This coverage constitutes minimum essential coverage under the Affordable Care Act, so enrolling in this coverage satisfies your obligations under the individual responsibility requirement. In addition, this coverage provides a level of benefits specified in the Affordable Care Act as "minimum value."

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-415-955-8800.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-415-955-8800.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-415-955-8800.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-415-955-8800.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4432
- **Patient pays** $3108

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$2000
Copays	$1000
Coinsurance	$0
Limits or exclusions	$2500
Total	$3000

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $1690
- **Patient pays** $3710

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$2750
Copays	$960
Coinsurance	$0
Limits or exclusions	None
Total	$3710

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.