



SECTION 3



PRODUCTS AND BENEFITS

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CCHP Programs and Products

CCHP offers a variety of commercial products for small and large group employers as well as products for individuals. In addition, CCHP offers Medicare Advantage Plans including Part D drug coverage. The following programs are offered by CCHP:

- **CCHP Commercial Products** for employer groups and individuals and families. CCHP offers several plans with different choices of copayments and optional dental, vision and chiropractic riders.
- **CCHP Senior Program HMO** is a Medicare Advantage plan for people with Medicare Parts A and B. This plan includes a Medicare Part D drug benefit and offers an optional dental rider.
- **CCHP Senior Select Program HMO Special Needs Plan (SNP)** is a Medicare Advantage plan for people with both Medicare Parts A and B and Medi-Cal. This plan includes a Medicare Part D drug benefit.

Benefits Summary/Matrix

A summary of benefits for each product and plan type can be found on CCHP's Web site at www.cchphmo.com/prospective_members. Benefits are subject to change. Providers must verify a member's benefits and eligibility prior to rendering services as well as having prior authorization when required by CCHP. Refer to Section 2 for information on Web access to verify eligibility and benefits and Section 5 for services requiring prior authorization. Samples of CCHP Benefit Matrices are included in this section beginning on page 11. However, please remember that benefits are subject to change and you should not rely on these samples but should verify benefits online or by calling CCHP Member Services.

Service Area

CCHP's Service Area is the City and County of San Francisco and northern San Mateo County for all programs and products, except for the CCHP Senior Select Program. The Service Area for CCHP Senior Select Program members is the City and County of San Francisco only. For details go to: http://www.cchphmo.com/CCHP_service_area.html

Primary Care Physicians

CCHP members must select a primary care physician to coordinate their care. The primary physician coordinates all care including referrals to specialists. The member must use plan physicians, providers and facilities except for emergencies. For services





not available from the CCHCA/CCHP physician panel, prior authorization must be sought from the Utilization Management Department. (See Section 7)

Chinese Community Health Care Association Medical Group

Chinese Community Health Plan contracts with one medical group – Chinese Community Health Care Association (CCHCA). CCHCA has a network of over 280 physicians available to provide care to CCHP members. CCHCA primary care and specialist physicians have offices throughout San Francisco County and northern San Mateo County. In addition to CCHCA's provider panel of physicians and other health care providers, CCHP contracts directly with other health care providers and facilities for the provision of care to its members. For a directory of CCHP providers, please go to www.cchphmo.com/cchp_physicians_hospitals

Member Copayments

Chinese Community Health Plan (CCHP) members are responsible for certain copayments. The amount of the copayment varies by the plan to which they belong. Office visit copayment amounts are listed on CCHP member ID cards. For copayment information specific to each patient, you can look it up on our Web site at http://www.cchphmo.com/eligibility_inquiry.html

Co-payments should be collected from the patient at the time of service, and are deducted from the allowable amount. Depending upon the CCHP plan and line of business, many CCHP members have a yearly maximum limit on the amount of copayments or out-of-pocket charges that they have to pay, before they hit what is called the Out-Of-Pocket-Maximum (OOPMAX). During each calendar year, once the member individually, (or if part of a couple or family) has met the respective OOPMAX, then for the remainder of the calendar year any copayment amount would not be due from the member, or as applicable, from other family members (if the couple, or family maximum has been reached).

Preventive Services Covered Without Copayments

CCHP's goal is to partner with providers to ensure that members receive preventive care services. CCHP provides most preventive services to members without any copayments or cost sharing. Over time this is expected to significantly improve health and reduce incidence of preventable conditions. Providers are expected to review a patient's chart to determine if and when they need these important services and encourage patients to participate in their health by getting preventive services.





Preventive guidelines are based on the recommendations of the United States Preventive Services Task Force (USPSTF). For the most up to date information, please go to:

<http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>

See the following page for a quick reference guide.



Summary of Preventive Services Covered Without Copayments

The following preventive services are covered without member co-payments or cost sharing. A member's plan may include other preventive services not listed here that are at no cost to the member. Please consult the member's benefit plan description or contact CCHP Member Services with questions.

Service	USPSTF Grade	Adults		Special Population	
		Men	Women	Pregnant Woman	Children
Abdominal Aortic Aneurysm, Screening ¹	B	x			
Alcohol Misuse Screening and Behavioral Counseling Interventions by PCP	B	x	x	x	
Anemia, Prevention – Counseling by PCP ²	B				x
Anemia, Screening ³	B			x	
Anemia, Screening– Hemoglobin/Hematocrit in Childhood ⁴	B				x
Annual Well Visits for children ⁵	-				x
Annual Women's Well Visits ⁶	-		x		
Aspirin for the Prevention of Cardiovascular Disease, Counseling by PCP(Aspirin is Over the Counter and Not Covered) ⁷	A	x	x		
Asymptomatic Bacteriuria in Adults, Screening ⁸	A			x	
Breast Cancer,Screening ⁹	B		x		
Chemoprevention for Breast Cancer for High Risk Women Discussion with PCP ³⁵	B		x		
Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment and BRCA MutationTesting ¹⁰	B		x		
Breastfeeding, Counseling by PCP Regarding Behavioral Interventions ¹¹	B		X	x	
Cervical Cancer Screenig ¹²	B		X		
Chlamydial Infection,Screening ¹³	A		X	x	
Colorectal Cancer,Screeniogn ¹⁴	A	x	X		
Congenital Hypothyroidism, Screenign ¹⁵	A				x
Dental Caries in Preschool Children, Prevention and fluoride Prescription ¹⁶	B				x
Depression (Adults),Screening ¹⁷	B	x	x		
Diet, Behavioral Counseling By PCP to Promote a Healthy Diet ¹⁸	B	x	x		
Folic Acid Supplementation, Generic Prescription Folic Acid (Brand Name and Over the counter are Not Covered) ¹⁹	A			x	
Gonorrhea, Screening ²⁰	B		x	x	
Gonorrhea, Prophylactic Medicarion ²¹	A				x
Hearing Loss in Newborns,Screenig ¹⁵	B				x
Hepatitis B Virus Infection, Screenig ²²	A			x	
High Blood Pressure,Screening ³⁴	A	x	x		
HIV, Screening ²³	A	x	x	x	x



Service	USPSTF Grade	Adults		Special Population	
		Men	Women	Pregnant Woman	Children
Inmunizations ³⁷	-	x	x	x	x
Lead Screening up to Age 73 ⁶	I				x
Lipid Disorders in Adults, Screening ²⁴	A&B	x	x		
Major Depressive Disorder in Children and Adults, Screening ²⁴	B				x
Obesity in Adults, Screening ²⁶	B	x	x		
Osteoporosis in Postmenopausal Women, Screening ²⁷	B		x		
Phenylketonuria, Screening ¹⁵	A				x
Rh (D) Incompatibility, Screening ²⁸	A			x	
Sexually Transmitted Infections, counseling By PCP or OB/GYN ²⁹	B	x	x		x
Sickle Cell Disease, Screening ¹⁵	A				x
Syphilis Infection, Screening ³⁰	A	x	x	x	
TB Skin Test ³⁸	-				X
Tobacco Use and Caused Disease, Counseling by PCP and Generi ^{8c} Prescription Medications (Brand Name and Over the Counter Medications Not Covered) ³¹	A	x	x	x	
Type 2 Diabetes Mellitus in Adults, Screening ³²	B	x	x		
Visual Impairment in Children Younger than Age 5 Years, Screening ³³	I				x

This document includes the evidence-based items or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved

(<http://www.ahrq.gov/clinic/pocketgd90/gcp09sl.htm>) and, with respect to infants, children, and adolescents, evidence informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources Services Administration. In order for an office visit to be considered “preventive”, the service must have been provided or ordered by the PCP, or an OB/GYN who is a CCHCA/CCHP Participating Physician within the CCHCA medical group. CCHP does not cover any medications or supplements that are generally available over the counter (OTC), even if the member has received a prescription for the medications or supplements.

Footnotes:

1. One-time screening by ultrasonography in men aged 65 to 75 who have ever smoked.
2. Counseling regarding routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia. Iron supplements are available over the counter and are not covered.
3. Routine screening in asymptomatic pregnant women.
4. Screening for anemia in children under age 18.
5. Children under age 18.
6. Women of all ages.





- 7**When the potential harm of an increase in gastrointestinal hemorrhage is outweighed by a potential benefit of a reduction in myocardial infarctions (men aged 45-79 years) or in ischemic strokes (women aged 55-79 years).
- 8**Pregnant women at 12-16 weeks gestation or at first prenatal visit, if later.
- 9**Mammography every 1-2 years for women 40 and older.
- 10**Referral for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes for genetic counseling and evaluation for BRCA testing.
- 11**Interventions during pregnancy and after birth to promote and support breastfeeding.
- 12**Women aged 21-65 who have been sexually active and have a cervix.
- 13**Sexually active women 24 and younger and other asymptomatic women at increased risk for infection. Asymptomatic pregnant women 24 and younger and others at increased risk.
- 14**Adults aged 50-75 using fecal occult blood testing, sigmoidoscopy, or colonoscopy. Procedures to treat any abnormalities will require a co-payment, even if performed at the same time as the screening.
- 15**Newborns.
- 16**Prescription of oral fluoride supplementation at currently recommended doses to preschool children older than 6 months whose primary water source is deficient in fluoride.
- 17**In clinical practices with systems to assure accurate diagnoses, effective treatment, and follow-up.
- 18**Adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease.
- 19**Recommendation that women pregnant or planning on pregnancy have folic acid supplement.
- 20**Sexually active women, including pregnant women 25 and younger, or at increased risk for infection.
- 21**Prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.
- 22**Pregnant women at first prenatal visit.
- 23**All adolescents and adults at increased risk for HIV infection and all pregnant women.
- 24**Men aged 20-35 and women over age 20 that are at increased risk for coronary heart disease; all men aged 35 and older.
- 25**Adolescents (age 12-18) when systems are in place to ensure accurate diagnosis, psychotherapy, and follow-up.
- 26**Discussion/counseling about intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.
- 27**Women 65 and older and women 60 and older at increased risk for osteoporotic fractures.
- 28**Blood typing and antibody testing at first pregnancy-related visit. Repeated antibody testing for unsensitized Rh (D) –negative women at 24-28 weeks gestation unless biological father is known to be Rh (D)negative.
- 29**All sexually active adolescents and adults at increased risk for sexually transmitted infections.
- 30**Persons at increased risk and all pregnant women.
- 31**Discussion/counseling about tobacco cessation interventions for those who use tobacco. Augmented pregnancy-tailored counseling to pregnant women who smoke. Generic prescription medications are covered.
- 32**Asymptomatic adults with sustained blood pressure greater than 135/80 mm Hg.
- 33**To detect amblyopia, strabismus, and defects in visual acuity; part of well-child.
- 34**Screening for high blood pressure in adults ages 18 and older without known hypertension.
- 35**Discussion/counseling about chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.
- 36**Children ages 1-5 at increased risk for lead poisoning.
- 37**Refer to recommendations made by the CDC and ACIP for immunization of children and adults,
- 38**Refer to CDC guidelines.





Member Entitlement to Copayment Parity for Services Not Available at Chinese Hospital

Chinese Community Health Plan (CCHP) has some benefit plans where the copayment for services rendered at Chinese Hospital is lower than the copayment rendered at other hospitals. It is the policy of CCHP that in the event a member's benefit plan has a lower copayment for services rendered at Chinese Hospital, and the member requires and is authorized for healthcare services at a facility other than Chinese Hospital, or its outpatient facilities for reasons beyond the member's control and care must be obtained at an outside facility, the member's copayment for the services rendered at a facility other than Chinese Hospital will not exceed that which would have been applicable, if the services could have been have obtained at Chinese Hospital. In addition, this policy is also applicable if Chinese Hospital is not within the required mandated standards of being within 15 miles from the member's residence, as long as the member obtains prior authorization for services from a contracted CCHP facility.

In regard to specialty services not provided by Chinese Hospital (such as Inpatient Mental Health, Substance Abuse, or OB-Labor & Delivery), members will be responsible for copayments that are no more than would be required for similar treatment or stays at Chinese Hospital for commensurate care for inpatient or outpatient services.

See the following page for a copy of this policy.





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TITLE: Member Copayment Parity for Necessary Utilization Other than Chinese Hospital for Services

PURPOSE:

To establish the requirement to ensure when members are 'required' or 'need' to receive their specific covered and authorized Chinese Community Health Plan (CCHP) healthcare services at a hospital other than Chinese Hospital (CH).

SUPPORTIVE DATA:

Within the Combined Evidence of Coverage and Disclosure Form(s), the Summary of Benefits, and /or within the Benefits Matrix for certain CCHP covered benefits, there are specific tables and/or descriptions of specific health care benefits and covered services, against which is listed the applicable member responsibility and/or benefit amount by category of benefits. Some categories such as hospital stays and outpatient facilities, the copayments and charges reflect different member copayment amounts if the member receives services at CH or not.

POLICY:

1. It is the policy of CCHP that in the event a commercial member requires and is authorized for health care services, other than at CH for reasons beyond the member's control and must be obtained at a outside facility, and/or if CH is not within the required California mandated standard of being 15 miles or less from the member's official residence, and so long as member obtains services from preauthorized and contracted CCHP facility that is within the 15 mile standard, the member's copayment amount due and payable for the services will not exceed that



which would have been applicable, if the services could have been or might have been obtainable at CH.

2. In specific regard to Mental Health Services and or Substance Abuse benefits, since CH does not offer specialized inpatient, partial hospitalization or day treatment programs for substance abuse, that the member's copayment amount due and payable for the services will not exceed that which would have been applicable if the services could have been or might have been obtained at CH. Due to legal requirements for parity between categories of service and reimbursement between 'medical physical health' and 'mental health' and 'substance abuse', the member shall not be charged the lower of the near 'equivalent' for the 'medical' benefits and copayments whether at CH or a non-CH facility.
3. In regard to Obstetrical, Pediatric, or other inpatient services not provided by CH, or the intensity or specialty of which has been determined by CCHP's Medical Director to be medically necessary to be obtained from a facility other than CH; or in the event that CH does not have available capacity or cannot accommodate member in a timely manner; the member's copayment amount due and payable for the services will not exceed that which would have been applicable if the services could have been or might have been obtainable at CH.
4. Other reasons the member's copayment amount due and payable for the services will not exceed that which would have been applicable if the services could have been or might have been obtainable at CH, if as preauthorized by the CCHP Medical Management as being medically necessary, prudent, and or required by law or regulation in order to assist the member to obtain crucial and specialized treatment.
5. This policy and procedure does not apply to emergency or emergent services for which no authorization is required and before medical stabilization has been achieved.

PROCEDURE:

1. CCHP's Utilization Management department shall provide the member receiving any authorization to a non CH facility that appears to fit within the guidelines of this Policy and Procedure, with a letter confirming that the authorized services apply to the benefit, and that the member's copayment shall be at parity to CH level, and they shall update the file to indicate the Member's reduced copayment.
2. Until and unless CH inaugurates a newly licensed and operating Psychiatric, Substance Abuse-Detoxification or Rehabilitation, Pediatric Unit, and or an Obstetrical-Labor & Delivery Units, then UM shall notify all members of the applicability of the CCHP Parity Benefit and shall inform them in writing as to the applicable CH copayments that will apply to their required non-CH services and/or





stay. They shall then update the members billing file to indicate the applicable copayment that shall apply and be collected from the member.

3. In the event that the Utilization Management department has made a determination, that the request and authorized services to a non-CH facility have been voluntary; or do not apply to a service related to Mental Health, Substance Abuse, or Obstetrical Labor & Delivery Services; or do not result from the closure, full census, or inability to accommodate a specific member due to a unique disability or individually unique treatment requirement, then it may determine this policy does not apply. In this case, they shall inform the member by mail and include the reason it does not apply, as well as provide CCHP appeal, grievance and DMHC rights and notification letters to the member.





Employer Group Benefit Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

BENEFITS	Ruby 10	Ruby 20	Ruby 40	Opal 25	Opal 50
ANNUAL DEDUCTIBLE (PER CALENDAR YEAR)	No Deductible	No Deductible	No Deductible	\$1,500 / \$3,000	\$2,500 / \$5,000
ANNUAL OUT OF POCKET MAXIMUM					
Individual/Family per Calendar Year	\$2,000 / \$4,000	\$2,500 / \$5,000	\$3,000 / \$6,000	\$3,000 / \$6,000	\$4,000 / \$6,000
LIFETIME BENEFIT MAXIMUM	No Limit	No Limit	No Limit	No Limit	No Limit
PROFESSIONAL PREVENTIVE CARE SERVICES					
Preventive Services - Children					
Preventive Services - Women	No Charge	No Charge	No Charge	No Charge	No Charge
Preventive Services - All Adults					
PROFESSIONAL SERVICES					
Primary Care Provider (PCP) and Specialty Care Visits	\$10 copay / visit	\$20 copay / visit	\$40 copay / visit	First (3) PCP visits / year at no charge; Additional visits at \$25 copay after deductible	First (3) PCP visits / year at no charge; Additional visits at \$50 copay after deductible
Maternity Care	No Charge	No Charge	No Charge	After Deductible No Charge	After Deductible No Charge
Immunizations	No Charge	No Charge	No Charge	No Charge	No Charge
Allergy Testing, Diagnosis & Treatment					
Vision Exam/Screening	\$10 copay / visit	\$20 copay / visit	\$40 copay / visit	After Deductible \$25 copay / visit	After Deductible \$50 copay / visit
Hearing Exam/Screening					
Acupuncture					
Infertility Services (Does not apply to annual out of pocket maximum)	50% of covered charges	50% of covered charges	50% of covered charges	50% of covered charges	50% of covered charges
OUTPATIENT SERVICES				After Deductible	After Deductible
Routine Lab Tests & X-Ray Diagnosis	No Charge	No Charge	No Charge	No Charge	No Charge
Diagnostic Services (e.g. CT, PET, MRI - see Evidence of Coverage for details)	\$100 copay	\$100 copay	\$100 copay	\$100 copay	\$100 copay
Physical Therapy, Outpatient Rehabilitation, Speech, and/or Occupational Therapy	\$10 copay / visit	\$20 copay / visit	\$40 copay / visit	\$25 copay / visit	\$25 copay / visit
HOSPITALIZATION SERVICES				After Deductible	After Deductible
Inpatient Hospital Stays at Chinese Hospital (Limit of \$400)	\$100 copay / day	\$150 copay / day (Limit of \$600)	\$200 copay / day (Limit of \$800)	\$150 copay / day	\$200 copay / day
Inpatient Hospital Stays at other contracted facilities (Limit of \$800)	\$200 copay / day	\$250 copay / day (Limit of \$1,000)	\$300 copay / day (Limit of \$1,200)	\$250 copay / day	\$300 copay / day
Outpatient Services at Chinese Hospital facility	\$50 copay / visit	\$50 copay / visit	\$75 copay / visit	\$50 copay / visit	\$75 copay / visit
Outpatient Services at other contracted facilities & ambulatory surgical centers	\$75 copay / visit	\$75 copay / visit	\$100 copay / visit	\$75 copay / visit	\$100 copay / visit
Skilled Nursing Care	First 10 days at no charge; then \$100 copay / day	First 10 days at no charge; then \$100 copay / day	First 10 days at no charge; then \$100 copay / day	First 10 days at no charge after deductible; then \$100 copay / day	First 10 days at no charge after deductible; then \$100 copay / day
EMERGENCY SERVICES				After Deductible	After Deductible
Emergency Room Services (copay waived if admitted)	\$100 copay / visit	\$100 copay / visit	\$100 copay / visit	\$100 copay / visit	\$100 copay / visit
Ambulance (Medical Transportation)	\$100 copay / trip	\$100 copay / trip	\$100 copay / trip	\$100 copay / trip	\$100 copay / trip
HOME HEALTH & HOSPICE SERVICES				After Deductible	After Deductible
Home Health Services					
Hospice Care (refer to the Evidence of Coverage for more information)	No Charge	No Charge	No Charge	No Charge	No Charge

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Employer Group Benefit Matrix

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BENEFITS	Ruby 10	Ruby 20	Ruby 40	Opal 25	Opal 50
MENTAL HEALTH & CHEMICAL DEPENDENCY				After Deductible	After Deductible
Inpatient Mental Health Services					
Inpatient Chemical Dependency - Detoxification Only	\$100 copay / day (Limit of \$400)	\$150 copay / day (Limit of \$600)	\$200 copay / day (Limit of \$800)	\$150 copay / day	\$200 copay / day
Outpatient Care (Individual/Group Treatment)	\$10 copay / \$5 copay	\$20 copay / \$10 copay	\$40 copay / \$20 copay	\$25 copay / \$12.50 copay	\$50 copay / \$25 copay
DURABLE MEDICAL EQUIPMENT				After Deductible	After Deductible
Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient (Maximum annual benefit of \$2,000)	50% of cost	50% of cost	50% of cost	50% of cost	50% of cost
PROSTHETICS				After Deductible	After Deductible
Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient	\$10 copay / item	\$20 copay / item	\$40 copay / item	\$25 copay / item	\$50 copay / item
PRESCRIPTION DRUG COVERAGE					
Annual Brand Name Drug Deductible	\$250 copay / person	\$250 copay / person	\$250 copay / person	\$250 copay / person	\$250 copay / person
Generic Drugs (up to 30 days supply)	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay
Brand-name Drugs on Formulary (up to 30 days supply)	After Deductible \$30 copay	After Deductible \$30 copay	After Deductible \$30 copay	After Deductible \$30 copay	After Deductible \$30 copay
Prescription Drugs filled at Chinese Hospital Pharmacy (up to 90 days supply)	Generic: \$20 copay	Generic: \$20 copay	Generic: \$20 copay	Generic: \$20 copay	Generic: \$20 copay
Mail Order (up to 90 days supply)	After Deductible Brand-name Drugs: \$60 copay	After Deductible Brand-name Drugs: \$60 copay	After Deductible Brand-name Drugs: \$60 copay	After Deductible Brand-name Drugs: \$60 copay	After Deductible Brand-name Drugs: \$60 copay



Employer Group Benefit Matrix

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BENEFITS	PLAN A	PLAN B	PLAN C	PLAN D	PLAN E	Active Choice
ANNUAL DEDUCTIBLE (PER CALENDAR YEAR)	No Deductible	No Deductible	No Deductible	No Deductible	No Deductible	\$3,000 / \$5,000
ANNUAL OUT OF POCKET-MAXIMUM						
Individual/Family	\$2,000 / \$4,000	\$2,000 / \$4,000	\$2,500 / \$5,000	\$3,000 / \$6,000	\$3,500 / \$7,000	\$4,000 / \$6,000
LIFETIME MAXIMUM	No Limit	No Limit	No Limit	No Limit	No Limit	No Limit
PROFESSIONAL SERVICES						After Deductible
Primary and specialty care visits	\$5 per visit	\$10 per visit	\$15 per visit	\$20 per visit	\$45 per visit	\$30 per visit
Maternity / Prenatal Care	\$5 per visit	\$10 per visit	\$10 per visit	\$10 per visit	\$10 per visit	No Charge
Eye examinations	\$5 per visit	\$10 per visit	\$15 per visit	\$20 per visit	\$45 per visit	\$30 per visit
Hearing examinations	\$5 per visit	\$10 per visit	\$15 per visit	\$20 per visit	\$45 per visit	\$30 per visit
Physical Examinations:						Not Subject To Deductible
Preventive Services - Children	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Preventive Services - Women	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Preventive Services - All Adults	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Immunizations	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
OUTPATIENT SERVICES						After Deductible
Lab test, X-rays	No Charge	No Charge	No Charge	No Charge	No Charge	\$10 per visit
MR/CT/PET	No Charge	No Charge	No Charge	No Charge	No Charge	\$50 per visit
Allergy testing and serum	50% of cost	50% of cost	50% of cost	50% of cost	50% of cost	50% of cost
Allergy diagnosis and injection	50% of cost	50% of cost	50% of cost	50% of cost	50% of cost	\$30 per visit
Infertility Services	50% of cost	50% of cost	50% of cost	50% of cost	50% of cost	50% of cost
Physical, speech, & occupational therapy	\$5 per visit	\$10 per visit	\$15 per visit	\$20 per visit	\$45 per visit	\$30 per visit
Outpatient surgery (Facility Charge)	No Charge	\$100 per visit	\$100 per visit	\$200 per visit	\$200 per visit	\$250 per visit
HOSPITALIZATION SERVICES						After Deductible
Inpatient hospital services	No Charge	\$200 per admission	\$500 per admission	\$250 per day; limit of \$1000	\$500 per day	\$500 per day
Skilled nursing facility care	No Charge	No Charge	No Charge	\$100 per day	\$100 per day	\$50 per day
EMERGENCY ROOM						After Deductible
(waived if admitted to the hospital)	\$50 per visit	\$50 per visit	\$50 per visit	\$100 per visit	\$100 per visit	\$100 per visit
AMBULANCE	\$100 per trip	\$100 per trip	\$100 per trip	\$100 per trip	\$100 per trip	\$100 per trip
DURABLE MEDICAL EQUIPMENT						Not Subject To Deductible
Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient	50% of cost (Maximum annual benefit of \$2000)	50% of cost (Maximum annual benefit of \$2000)	50% of cost (Maximum annual benefit of \$2000)	50% of cost (Maximum annual benefit of \$2000)	50% of cost (Maximum annual benefit of \$2000)	50% of cost (not applicable to OOP Max) (Maximum annual benefit of \$500)
PROSTHETICS						Not Subject To Deductible
Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient	\$5 per item	\$10 per item	\$15 per item	\$20 per item	\$45 per item	\$30 per item
MENTAL HEALTH & CHEMICAL DEPENDENCY						After Deductible
Outpatient Care	\$5 per visit	\$10 per visit	\$15 per visit	\$20 per visit	\$45 per visit	\$30 copay per visit
Inpatient Mental Health Services		\$200 per admission	\$500 per admission	\$250 per day; limit of \$1000	\$500 per day	\$500 per day
Inpatient Chemical Dependency - Detox Only	No Charge	\$200 per admission	\$500 per admission	\$250 per day; limit of \$1000	\$500 per day	\$500 per day
HOME HEALTH SERVICES	No Charge	No Charge	No Charge	No Charge	No Charge	Not Subject To Deductible No Charge
PRESCRIPTION DRUG COVERAGE (on CCHP formulary)						
Generic Drugs Up to 30 Days Supply	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay
Brand-name Drugs* Up to 30 Days Supply (*\$250 Calendar Year Brand Name Drug Deductible)	\$30 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay

April 2011

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Individual/Family Plan Benefit Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

BENEFITS	Jade	Amber
ANNUAL DEDUCTIBLE: Individual/Family	No Deductible	\$3,000 / \$5,000
ANNUAL OUT OF POCKET MAXIMUM: Individual/Family	\$2,500 / \$5,000	\$4,000 / \$8,000
LIFETIME MAXIMUM	No Limit	No Limit
PROFESSIONAL PREVENTIVE CARE SERVICES		
Preventive Services - Children	No Charge	No Charge
Preventive Services - Women		
Preventive Services - All Adults		
PROFESSIONAL SERVICES		
Primary Care Provider (PCP) and Specialty Care Visits	\$30 copay / visit	First (3) PCP visits / year at no charge; Additional visits at \$50 copay / year after deductible
Maternity Care	No Charge	No Charge
Immunizations		
Allergy Testing, Diagnosis & Treatment		After Deductible
Vision Exam/Screening	\$30 copay / visit	\$50 copay / visit
Hearing Exam/Screening		
Acupuncture		
OUTPATIENT SERVICES		After Deductible
Routine Lab Tests & X-Ray Diagnosis	No Charge	No Charge
Diagnostic Services (e.g. CT, PET, MRI - see Evidence of Coverage for details)	\$100 copay / visit	\$100 copay / visit
Physical Therapy, Outpatient, Rehabilitation, Speech, and/or Occupational	\$30 copay / visit	\$50 copay / visit
HOSPITALIZATION SERVICES		After Deductible
Inpatient Hospital Stays at Chinese Hospital	\$200 copay / day (Limit of \$1,000)	\$250 copay / day
Inpatient Hospital Stays at other contracted Facilities	\$300 copay / day (Limit of \$1,500)	\$500 copay / day
Outpatient Facility Services at Chinese Hospital Facilities	\$75 copay / visit	\$75 copay / visit
Outpatient Facility Services at other contracted Facilities & Ambulatory Surgical Centers	\$100 copay / visit	\$100 copay / visit
Skilled Nursing Care	First 10 Days at no charge; then \$100 copay / day	First 10 days at no charge; then \$100 copay / day
EMERGENCY SERVICES		After Deductible
Emergency Room Services (copay waived if admitted)	\$100 copay / visit	\$100 copay / visit
Ambulance (Medical Transportation)	\$100 copay / trip	\$100 copay / trip
HOME HEALTH & HOSPICE SERVICES		After Deductible
Home Health Services	No Charge	No Charge
Hospice Care		



Individual/Family Plan Benefit Matrix

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BENEFITS	Jade	Amber
MENTAL HEALTH & CHEMICAL DEPENDENCY		After Deductible
Inpatient Mental Health Services	\$200 copay / day (Limit of \$1,000)	\$250 copay / day
Inpatient Chemical Dependency - Detoxification Only		
Outpatient Care (Individual/Group Treatment)	\$30 copay / \$15 copay	\$50 copay / \$25 copay
DURABLE MEDICAL EQUIPMENT		After Deductible
Inpatient	No Charge	No Charge
Outpatient	50% of cost (Maximum annual benefit of \$2,000)	50% of cost (Maximum annual benefit of \$500)
PROSTHETICS & ORTHOTICS DEVICE		After Deductible
Inpatient	No Charge	No Charge
Outpatient	\$30 copay / item	\$50 copay / item
PRESCRIPTION DRUG COVERAGE		
Annual Brand Name Drug Deductible	\$250 / person	\$250 / person
Generic Drugs (up to 30 days supply)	\$10 copay	\$10 copay
Brand-name Drugs (on formulary) (up to 30 days supply)	After Deductible \$30 copay	After Deductible \$30 copay
Prescription Drugs filled at Chinese Hospital Pharmacy (up to 90 days supply)	Generic: \$20 copay	Generic: \$20 copay
Mail Order (up to 90 days supply)	After Deductible Brand-name on Formulary: \$60 copay	After Deductible Brand-name on Formulary: \$60 copay



Individual/Family Plan Benefit Matrix

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BENEFITS	Copay 25	Active Choice
ANNUAL DEDUCTIBLE: Individual/Family	No Deductible	\$3,000 / \$5,000
ANNUAL OUT OF POCKET MAXIMUM: Individual/Family	\$3,500 / \$7,000	\$4,000 / \$8,000
LIFETIME MAXIMUM	No Limit	No Limit
PROFESSIONAL SERVICES		After Deductible
Primary and specialty care visits	\$25 copay per visit	\$30 copay per visit
Maternity / Prenatal Care	\$25 copay per visit	No Charge
Eye examinations	\$25 copay per visit	\$30 copay per visit
Hearing examinations	\$25 copay per visit	\$30 copay per visit
Physical Examinations:		Not Subject to Deductible
Preventive Services - Children	No Charge	No Charge
Preventive Services - Women	No Charge	No Charge
Preventive Services - All Adults	No Charge	No Charge
Immunizations	No Charge	No Charge
OUTPATIENT SERVICES		After Deductible
Lab test, X-rays	No Charge	\$10 copay per visit
MRI/CT/PET	No Charge	\$50 copay per visit
Allergy testing and serum	50% of cost	50% of cost
Allergy diagnosis and injection	50% of cost	\$30 per visit
Physical, speech, & occupational therapy	\$25 copay per visit	\$30 copay per visit
Outpatient surgery (Facility Charge)	\$100 copay per visit	\$250 copay per visit
HOSPITALIZATION SERVICES		After Deductible
Inpatient hospital services	\$250 copay per day (Limit of \$1,000 per admission)	\$500 copay per day
Skilled nursing facility care	No charge	\$50 copay per day
EMERGENCY SERVICES		After Deductible
EMERGENCY ROOM (waived if admitted to the hospital)	\$100 copay per visit	\$100 copay per visit
AMBULANCE	\$100 copay per trip	\$100 copay per trip
DURABLE MEDICAL EQUIPMENT		Not Subject To Deductible
Inpatient	No Charge	No Charge
Outpatient (not applicable to OOP Max)	50% of cost (Maximum annual benefit of \$2,000)	50% of cost (Maximum annual benefit of \$500)
PROSTHETICS		Not Subject To Deductible
Inpatient	No Charge	No Charge
Outpatient	\$25 per item	\$30 per item
MENTAL HEALTH & CHEMICAL DEPENDENCY		After Deductible
Outpatient Care	\$25 copay per visit	\$30 copay per visit
Inpatient Mental Health Services Inpatient Chemical Dependency - Detox Only	\$250 per Day (Limit of \$1,000 per admission)	\$500 copay per day
HOME HEALTH SERVICES	No Charge	No Charge
PRESCRIPTION DRUG COVERAGE (on CCHP formulary)		
Generic Drugs (up to a 30 days supply)	\$10 copay	\$10 copay
Brand-name Drugs* (up to a 30 days supply) (*\$250 Calendar Year Brand Name Drug Deductible)	\$30 copay	\$30 copay

April 2011

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2011 Benefit Summary
CCHP Senior Program (HMO)
 Service area: San Francisco & Northern San Mateo Counties



THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERED BENEFIT AND LIMITATION.

Monthly Plan Premium	\$35		
Dental Services (optional)	\$14.60 per month (in addition to the \$35 plan premium)		
Doctor Office Visits	\$0-15 co-pay / visit		
X-Rays, Lab	\$0 co-pay		
Diagnostic Radiology Services	\$0-\$100		
Emergency Care (worldwide)	\$50 co-pay		
Ambulance Services	\$150 co-pay		
Outpatient Surgery	\$195 co-pay (SF member using Chinese Hospital) \$270 co-pay – all other contracted hospitals		
Hospitalization Services	Day 1 – 6: \$195 co-pay/day (SF member using Chinese Hospital) Days 1 - 6: \$270 co-pay/day - all other contracted hospitals Days 7 - 90: \$0 co-pay/day \$0 copay for each additional hospital day		
Inpatient Mental Health Care (190 days in a lifetime)	Day 1 – 6: \$195 co-pay/day (SF member using Chinese Hospital) Days 1 - 6: \$270 co-pay/day - all other contracted hospitals Days 7 - 90: \$0 co-pay/day \$0 co-pay for each additional hospital day		
Skilled Nursing Facility (up to 100 days each benefit period)	Days 1 - 20: \$0 co-pay/day Days 21 - 100: \$135 co-pay/day		
Durable Medical Equipment	20% of the cost per item		
Home Health Care	\$0 co-pay		
Medicare Prescription Drugs Coverage (Part D)	<i>Initial Coverage</i>	30-day Supply	90-day Supply
	Tier 1 Generic	\$10	\$20 (mail order)
	Tier 2 Brand Name	\$35	\$70 (mail order)
	Tier 3 Specialty Drug - Injectables	\$100	\$200 (mail order)
	<i>Coverage Gap</i> After your total yearly drug costs reach \$2,840, you receive a discount on brand name drugs and pay 93% of the plan's costs for all generic drugs, until your yearly out-of-pocket drug costs reach \$4,550.		
	<i>Catastrophic Coverage</i> After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of: -either 5% coinsurance of the cost of the drug -or \$2.50 copayment for a Generic. Or a \$6.30 copayment for Brand Name.		
Vision Services	\$15 co-pay/visit ▪ One pair of eyeglasses or contact lenses after cataract surgery ▪ One pair of glasses every two years		
Annual Out-of-Pocket Maximum **	\$3,400		

** Excludes prescription drug costs, prosthetic devices and durable medical equipment.

This is a summary for a plan offered by Chinese Community Health Plan, a Medicare Advantage organization with a Medicare contract. CCHP's plans are open to all who are enrolled in Medicare Parts A and B and reside in the plan's service area. Copayments, limitations and restrictions may apply. You must continue to pay your Medicare Part B premium. Members may enroll during specific time of the year contact CCHP for more information. You must receive all routine care from plan providers except in emergency or urgent care situations or for out-of-area renal dialysis. If you obtain routine care from out-of-network providers neither Medicare nor CCHP will be responsible for the costs. Member must use network pharmacies to access their prescription drug benefit except under non-routine circumstances when you cannot reasonably use network pharmacies. Quantity, limitations & restrictions may apply. The benefit information provided herein is a brief summary, not a comprehensive description of benefits. Document is available in alternate formats or languages. For more information contact the plan 415-955-8800 x 3256, TTY/TDD 877-681-8898. 8:00am – 8:00pm, 7 days a week. This is an advertisement.

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2011 Benefit Summary
CCHP Senior Select Program (HMO SNP)
 Service area: City and County of San Francisco



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Monthly Plan Premium *	\$0				
Doctor Office Visits	\$0 co-pay				
Diagnostic Tests, X-Rays, Lab and Radiology Services	\$0 co-pay				
Emergency Care (Worldwide Coverage)	\$0 co-pay				
Ambulance Services	\$0 co-pay				
Transportation	\$0 co-pay (up to 36 free one-way trips / per year)				
Personal Care Coordinator	\$0 co-pay				
Outpatient Surgery	\$0 co-pay				
Hospitalization Services	\$0 co-pay				
Skilled Nursing Facility	\$0 co-pay				
Home Health Care	\$0 co-pay				
Durable Medical Equipment	\$0 co-pay				
Acupuncture	\$0 co-pay				
Medicare Prescription Drugs Coverage (Part D) **	<p><i>Initial Coverage</i></p> <table border="1"> <tr> <td>Generic **</td> <td>\$0 / \$1.10 / \$2.50</td> </tr> <tr> <td>Brand Name**</td> <td>\$0 / \$3.30 / \$6.30</td> </tr> </table> <p><i>Catastrophic Coverage</i> After your yearly out-of-pocket drug costs reach \$4,550 you pay \$0 copay.</p>	Generic **	\$0 / \$1.10 / \$2.50	Brand Name**	\$0 / \$3.30 / \$6.30
Generic **	\$0 / \$1.10 / \$2.50				
Brand Name**	\$0 / \$3.30 / \$6.30				
Vision Services	\$0 co-pay <ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses after cataract surgery • One pair of glasses every two years 				

* If you are eligible for this plan, Medicare will pay for your monthly plan premium.
 ** All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

This is a summary for a plan offered by Chinese Community Health Plan, a Medicare Advantage organization with a Medicare contract. CCHP's plans are open to all who are enrolled in Medicare Parts A and B, full Medi-Cal benefits and reside in San Francisco. Copayments, limitations and restrictions may apply. Members may enroll during specific time of the year contact CCHP for more information. You must receive all routine care from plan providers except in emergency or urgent care situations or for out-of-area renal dialysis. If you obtain routine care from out-of-network providers neither Medicare nor CCHP will be responsible for the costs. Member must use network pharmacies to access their prescription drug benefit except under non-routine circumstances when you cannot reasonably use network pharmacies. Quantity limitations & restrictions may apply. The benefit information provided herein is a brief summary, not a comprehensive description of benefit. Document is available in alternate formats or languages. For more information contact the plan 415-955-8800 x 3256, TTY/TDD 877-681-8898. 8:00am – 8:00pm 7 days a week. This is an advertisement.

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