Employer Group Plans | 2016 Plan Benefit Highlights

FOR A COMPLETE LIST OF BENEFITS UNDER EACH PLAN, REFER TO THE HEALTH PLAN BENEFITS AND COVERAGE MATRIX.
PLEASE CALL 1-888-681-3888 TO REQUEST A COPY, OR VISIT: WWW.CCHPHEALTHPLAN.COM/EGP

								PLANS AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA (SHOP)			
PLAN NAME	**Ruby 10**	**Ruby 20**	**Ruby 40**	**Opal 25**	**Opal 50**	***ActiveChoice* PPO**		**Platinum^{90} HMO**	**Gold^{80} HMO**	**Silver^{70} HMO**	**Bronze^{60} HMO**
						(In-Network)	**(Out-of-Network)**				
Metal Level / Actuarial Value %*	Platinum / 91.39%	Platinum / 90.61%	Platinum / 88.24%	Gold / 79.76%	Silver / 71.3%	Silver 70.8%		Platinum / 89.91%	Gold / 81.05%	Silver / 71.45%	Bronze / 61.9%
SERVICES AND FEATURES											
Annual Deductible	$0	$0	$0	Individual $1,500 / Family $3,000 [A]	Individual $2,000 / Family $4,000 [A] Medical / Rx [1]	Individual $2,000 / Family $4,000 [A] Medical / Rx [1]		$0	$0	Individual $1,500 / Family $3,000 [A]	Individual $6,000 / Family $12,000 [A]
Out–of–Pocket Limit On Expenses	Individual $4,000 / Family $8,000	Individual $4,000 / Family $8,000	Individual $6,850 / Family $13,700	Individual $4,000 / Family $8,000	Individual $6,250 / Family $12,500	Individual $6,250 / Family $12,500		Individual $4,000 / Family $8,000	Individual $6,200 / Family $12,400	Individual $6,250 / Family $12,500	Individual $6,500 / Family $13,000
LIFETIME MAXIMUMS	No Limit							No Limit			
PROFESSIONAL SERVICES	**Member Cost Share**							**Member Cost Share**			
Preventive Care/Screening/ Immunization	$0 Copay							$0 Copay			
Primary Care Visit to Treat an Injury or Illness	$10 Copay	$20 Copay	$40 Copay	$0 Copay for 1st (3) Non-Preventive PCP Visits (Deductible Does Not Apply) Then $25 Copay (After Deductible)	$0 Copay for 1st (3) Non-Preventive PCP Visits (Deductible Does Not Apply) Then $50 Copay (After Deductible)	$0 Copay for 1st (3) Non-Preventive PCP Visits (Deductible Does Not Apply) Then $50 Copay (After Deductible)	50% Coinsurance (After Deductible)	$20 Copay	$35 Copay	$45 Copay	$70 Copay (Deductible Applies After 1st (3) Non-Preventive Visits)
Specialist Visit	$35 Copay	$40 Copay	$50 Copay	$25 Copay (After Deductible)	$50 Copay (After Deductible)	$50 Copay (After Deductible)	50% Coinsurance (After Deductible)	$40 Copay	$55 Copay	$70 Copay	$90 Copay (After Deductible)
Maternity Care - Preconception/ Prenatal/Postnatal Care	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay		$0 Copay	$0 Copay	$0 Copay	$0 Copay
Delivery and Inpatient Services (Hospital Services)	$100 Copay Per Day (Up to First 5 Days)	$150 Copay Per Day (Up to First 5 Days)	$250 Copay Per Day (Up to First 5 Days)	$150 Copay Per Day (Up to First 5 Days) (After Deductible)	$250 Copay Per Day (Up to First 5 Days) (After Deductible)	20% Coinsurance (Up to First 5 Days) (After Deductible)	50% Coinsurance (Up to First 5 Days) (After Deductible	$250 Copay Per Day (Up to First 5 Days)	$600 Copay Per Day (Up to First 5 Days)	20% Coninsurance (After Deductible)	100% Coinsurance (After Deductible)
Delivery and Inpatient Services (Professional Services)								$40 Copay	$55 Copay		
OUTPATIENT SERVICES											
Laboratory Tests & X-Rays	$10 Copay	$10 Copay	$10 Copay	$0 Copay (After Deductible)	$0 Copay (After Deductible)	$0 Copay (After Deductible)	50% Coinsurance (After Deductible)	$20 Copay (Laboratory) / $40 Copay (X-Ray)	$35 Copay (Laboratory) / $50 Copay (X-Ray)	$35 Copay (Laboratory) / $65 Copay (X-Ray)	$40 Copay (Laboratory) (Deductible Does Not Apply)/ 100% Coinsurance (X-Ray) (After Deductible)
Imaging (CT/PET Scans, MRIs)	$150 Copay	$150 Copay	$150 Copay	$150 Copay (After Deductible)	$250 Copay (After Deductible)	$200 Copay (After Deductible)	50% Coinsurance (After Deductible)	$150 Copay	$250 Copay	$250 Copay	100% Coinsurance (After Deductible)
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$75 Copay (Chinese Hospital) / $225 Copay (Other Contracted Facilities)	$75 Copay (Chinese Hospital) / $225 Copay (Other Contracted Facilities)	$200 Copay (Chinese Hospital) / $600 Copay (Other Contracted Facilities)	$50 Copay (Chinese Hospital) / $150 Copay (Other Contracted Facilities) (After Deductible)	$75 Copay (Chinese Hospital) / $225 Copay (Other Contracted Facilities) (After Deductible)	20% Coinsurance (Chinese Hospital) / 40% Coinsurance (Other Contracted Facilities) (After Deductible)	50% Coinsurance (After Deductible)	$250 Copay	$600 Copay	20% Coinsurance	100% Coinsurance (After Deductible)
Physician/Surgeon Fees								$40 Copay	$55 Copay		

Footnotes: * Actuarial Value is the percentage of total average costs for covered benefits that a plan will cover.
Preventive care are not subject to the deductible.
(1) Medical / RX cost-sharing contributes toward annual deductible.
(A) You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use, unless the service is not subject to the deductible. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st).
(D1) For Tier 2, Tier 3 and Tier 4 prescription drugs only.
The benefit information provided is a brief summary. For a complete list of benefits under each plan, please call 1-888-681-3888 to request a copy of the plan Evidence of Coverage.

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PLAN NAME	Ruby 10	Ruby 20	Ruby 40	Opal 25	Opal 50	*ActiveChoice* PPO (In-Network)	*ActiveChoice* PPO (Out-of-Network)	PLANS AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA (SHOP) Platinum^{90} HMO	Gold^{80} HMO	Silver^{70} HMO	Bronze^{60} HMO
HOSPITALIZATION SERVICES	Member Cost Share							Member Cost Share			
Facility Fee (e.g., Hospital Room)	$100 Copay Per Day (Chinese Hospital) / $300 Copay Per Day (Other Contracted Facilities) (Up to First 5 days)	$150 Copay Per Day (Chinese Hospital) / $450 Copay Per Day (Other Contracted Facilities) (Up to First 5 days)	$250 Copay Per Day (Chinese Hospital) / $750 Copay Per Day (Other Contracted Facilities) (Up to First 5 days)	$150 Copay Per Day (Chinese Hospital) / $450 Copay Per Day (Other Contracted Facilities) (Up to First 5 days) (After Deductible)	$250 Copay Per Day (Chinese Hospital) / $750 Copay Per Day (Other Contracted Facilities) (Up to First 5 days) (After Deductible)	20% Coinsurance (Chinese Hospital) / 40% Coinsurance (Other Contracted Facilities) (Up to First 5 days) (After Deductible)	50% Coinsurance (Up to First 5 days) (After Deductible)	$250 Copay Per Day (Up to First 5 days)	$600 Copay Per Day (Up to First 5 days)	20% Coinsurance (After Deductible)	100% Coinsurance (After Deductible)
Physician/Surgeon Fees								$40 Copay	$55 Copay		
EMERGENCY HEALTH COVERAGE											
Emergency Room Services	$150 Copay	$150 Copay	$150 Copay	$100 Copay (After Deductible)	$250 Copay (After Deductible)	$200 Copay (After Deductible)		$150 Copay	$250 Copay	$250 Copay (After Deductible)	100% Coinsurance (After Deductible)
Professional Services										$50 Copay (After Deductible)	
Urgent Care Center	$10 Copay	$20 Copay	$40 Copay	$25 Copay (After Deductible)	$50 Copay (After Deductible)	$50 Copay (After Deductible)		$40 Copay	$60 Copay	$90 Copay	$120 Copay (Deductible Applies After 1st (3) Non-Preventive Visits)
PRESCRIPTION DRUG COVERAGE											
Annual Tier 2/Tier 3/Tier 4 Rx Deductible	$0	$0	$0	Individual $250 / Family $500 Tier 2/Tier 3/ Tier 4 Rx [D1]	Individual $2,000 / Family $4,000 [A] Medical / Rx [1]	Individual $2,000 / Family $4,000 [A] Medical / Rx [1]		$0	$0	Individual $250 / Family $500 Tier 2/Tier 3/ Tier 4 Rx [D1]	Individual $500 / Family $1,000 Tier 2/Tier 3/ Tier 4 Rx [D1]
Rx Out-of-Pocket Maximum Expense	Up to $250 (30-Day Supply) Out-of-Pocket Maximum on Tier 4 Rx Per Prescription	Up to $250 (30-Day Supply) Out-of-Pocket Maximum on Tier 4 Rx Per Prescription	Up to $250 (30-Day Supply) Out-of-Pocket Maximum on Tier 4 Rx Per Prescription	Up to $250 (30-Day Supply) Out-of-Pocket Maximum on Tier 4 Rx Per Prescription	Up to $250 (30-Day Supply) Out-of-Pocket Maximum on Tier 4 Rx Per Prescription	Up to $250 (30-Day Supply) Out-of-Pocket Maximum on Tier 4 Rx Per Prescription		Up to $250 (30-Day Supply) Out-of-Pocket Maximum on Tier 4 Rx Per Prescription	Up to $250 (30-Day Supply) Out-of-Pocket Maximum on Tier 4 Rx Per Prescription	Up to $500 (30-Day Supply) Out-of-Pocket Maximum on Tier 4 Rx Per Prescription	Up to $500 (30-Day Supply) Out-of-Pocket Maximum on all Rx Per Prescription
Tier 1 Drugs (30-Day Supply)	$5 Copay	$5 Copay	$5 Copay	$15 Copay	$15 Copay	$15 Copay	Not Covered	$5 Copay	$15 Copay	$15 Copay	100% Coinsurance (After Rx Deductible)
Tier 2 Drugs (30-Day Supply)	$15 Copay	$15 Copay	$15 Copay	$50 Copay (After Rx Deductible)	$50 Copay (After Deductible)	$50 Copay (After Deductible)	Not Covered	$15 Copay	$50 Copay	$55 Copay (After Rx Deductible)	100% Coinsurance (After Rx Deductible)
Tier 3 Drugs (30-Day Supply)	$25 Copay	$25 Copay	$25 Copay	$70 Copay (After Rx Deductible)	$70 Copay (After Deductible)	$70 Copay (After Deductible)	Not Covered	$25 Copay	$70 Copay	$75 Copay (After Rx Deductible)	100% Coinsurance (After Rx Deductible)
Tier 4 Drugs (30-Day Supply)	10% Coinsurance	10% Coinsurance	10% Coinsurance	20% Coinsurance (After Rx Deductible)	20% Coinsurance (After Deductible)	20% Coinsurance (After Deductible)	Not Covered	10% Coinsurance	20% Coinsurance	20% Coinsurance (After Rx Deductible)	100% Coinsurance (After Rx Deductible)
PEDIATRIC VISION AND DENTAL (Included in Plan)											
Child Needs Eye Care (Ages 0-18)											
Eye Exam (1 Per Calendar Year)	$0 Copay						Not Covered	$0 Copay			
Eyewear (Frames) (1 Pair Per Calendar Year)	$0 Copay						Not Covered	$0 Copay			
Eyewear (Lenses) (1 Pair Per Calendar Year) (Contact Lenses Provided in Lieu of Glasses)	Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share						Not Covered	Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share			
Eyewear (Contact Lenses)	$0 Copay						Not Covered	$0 Copay			
Pediatric Dental (Ages 0-18)	Included in Plan. See Dental Summary Page.							Included in Plan. See Dental Summary Page.			

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