CCHP Health Plan

Employer Group Plans
2016 Plan Benefit Highlights

Plan Name	Ruby 40
SERVICES AND FEATURES	
Annual Deductible	$0
Out–of–Pocket Limit On Expenses	Individual $6,850 / Family $13,700
LIFETIME MAXIMUMS	No Limit
PROFESSIONAL SERVICES	**Member Cost Share**
Preventive Care/Screening/Immunization	$0 Copay
Primary Care Visit to Treat an Injury or Illness	$40 Copay
Specialist Visit	$50 Copay
Maternity Care - Preconception/Prenatal/Postnatal Care	$0 Copay
Delivery and all Inpatient Services (Hospital Services)	$250 Copay Per Day (Up to First 5 days)
Delivery and all Inpatient Services (Professional Services)	
OUTPATIENT SERVICES	
Laboratory Tests & X-Rays	$10 Copay
Imaging (CT/PET Scans, MRIs)	$150 Copay
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$200 Copay (Chinese Hospital) / $600 Copay (Other Contracted Facilities)
Physician/Surgeon Fees	
HOSPITALIZATION SERVICES	
Facility Fee (e.g., Hospital Room)	$250 Copay Per Day (Chinese Hospital) / $750 Copay Per Day (Other Contracted Facilities) (Up to First 5 Days)
Physician/Surgeon Fees	
EMERGENCY HEALTH COVERAGE	
Emergency Room Services	$150 Copay
Professional Services	
Urgent Care Center	$40 Copay
PRESCRIPTION DRUG COVERAGE	
Annual Tier 2/Tier 3/Tier 4 Rx Deductible	$0
Rx Out-of-Pocket Maximum Expense	Up to $250 (30-Day Supply) Out-of-Pocket Maximum on Tier 4 Rx Per Prescription
Tier 1 Drugs (30-Day Supply)	$5 Copay
Tier 2 Drugs (30-Day Supply)	$15 Copay
Tier 3 Drugs (30-Day Supply)	$25 Copay
Tier 4 Drugs (30-Day Supply)	10% Coinsurance
PEDIATRIC VISION AND DENTAL (Included in Plan)	
Child Needs Eye Care (Ages 0-18)	
Eye Exam (1 Per Calendar Year)	$0 Copay
Eyewear (Frames) (1 Pair Per Calendar Year)	$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
Eyewear (Contact Lenses)	$0 Copay
Pediatric Dental (Ages 0-18)	Included in Plan. See Dental Summary Page.

Footnotes: Preventive care are not subject to the deductible.