



Employer Group Plans | 2017 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

Plan Name	Ruby 10	Ruby 20	Ruby 40	Opal 25	Opal 50	PLANS AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA			
						Platinum ⁹⁰ HMO	Gold ⁸⁰ HMO	Silver ⁷⁰ HMO*	Bronze ⁶⁰ HMO*
Metal Level / Actuarial Benefit Value %*	Platinum / 91.89%	Platinum / 90.74%	Platinum / 88.9%	Gold / 78.1%	Silver / 71.1%	Platinum / 90.3%	Gold / 81.2%	Silver / 71.3%	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⁾	\$0	\$0	Individual \$2,000 / Family \$4,000 ^(A)	Individual \$6,300 / Family \$12,600 ^(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 \$4,000 / Family \$8,000	Individual \$6,750 / Family \$13,500	Individual \$6,800 / Family \$13,600	Individual \$6,800 / Family \$13,600
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)	\$15 Copay	\$30 Copay	\$45 Copay	\$75 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)	\$40 Copay	\$55 Copay	\$75 Copay	\$105 Copay (Deductible Applies After 1st (3) Non-Preventive Visits)
Maternity Care - Preconception/ Prenatal/Postnatal Care	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
Delivery and all Inpatient Services (Hospital Services)	\$150 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)	\$250 Copay Per Day (Up to First 5 Days)	\$600 Copay Per Day (Up to First 5 Days)	20% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
Delivery and all Inpatient Services (Professional Services)	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$40 Copay	\$55 Copay	20% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
OUTPATIENT SERVICES									
Laboratory Tests & X-Rays	\$10 Copay	\$10 Copay	\$10 Copay	\$0 Copay (After Deductible)	\$0 Copay (After Deductible)	\$20 Copay (Laboratory) / \$40 Copay (X-Ray)	\$35 Copay (Laboratory) / \$55 Copay (X-Ray)	\$40 Copay (Laboratory) / \$70 Copay (X-Ray)	\$40 Copay (Laboratory)/ Full Cost Until Out-of-Pocket is Met (X-Ray)
Imaging (CT/PET Scans, MRIs)	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay (After Deductible)	\$250 Copay (After Deductible)	\$150 Copay	\$275 Copay	\$300 Copay	Full Cost Until Out-of-Pocket is Met
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)	\$250 Copay	\$600 Copay	20% Coinsurance	Full Cost Until Out-of-Pocket is Met
Physician/Surgeon Fees	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$40 Copay	\$55 Copay	\$0 Copay	Full Cost Until Out-of-Pocket is Met

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).

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						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)	\$150 Copay Per Day (Chinese Hospital) / \$450 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)	\$250 Copay Per Day (Up to First 5 days)	\$600 Copay Per Day (Up to First 5 days)	20% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
Physician/Surgeon Fees	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$40 Copay	\$55 Copay	\$0 Copay	Full Cost Until Out-of-Pocket is Met
EMERGENCY HEALTH COVERAGE									
Emergency Room Services	\$150 Copay	\$150 Copay	\$150 Copay	\$100 Copay (After Deductible)	\$250 Copay (After Deductible)	\$150 Copay	\$325 Copay	\$350 Copay	Full Cost Until Out-of-Pocket is Met
Professional Services	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
Urgent Care Center	\$10 Copay	\$20 Copay	\$40 Copay	\$25 Copay (After Deductible)	\$50 Copay (After Deductible)	\$15 Copay	\$30 Copay	\$45 Copay	\$75 Copay (Deductible Applies After 1st (3) Non-Preventive Visits)
PRESCRIPTION DRUG COVERAGE									
Annual Rx Deductible	\$0	\$0	\$0	Individual \$250 / Family \$500 Tier 2/Tier 3/ Tier 4 Rx ^(A)	Individual \$2,000 / Family \$4,000 ^(A) Medical / Rx ⁽¹⁾	\$0	\$0	Individual \$250 / Family \$500 Tier 2/Tier 3/ Tier 4 Rx ^(A)	Individual \$500 / Family \$1,000 All Tiers Rx ^(A)
Tier 1 Drugs (30-Day Supply)	\$5 Copay	\$5 Copay	\$5 Copay	\$15 Copay	\$15 Copay	\$5 Copay	\$15 Copay	\$15 Copay	Full Cost up to \$500 per Prescription Until Out-of-Pocket is Met (After Rx Deductible)
Tier 2 Drugs (30-Day Supply)	\$15 Copay	\$15 Copay	\$15 Copay	\$50 Copay (After Rx Deductible)	\$50 Copay (After Deductible)	\$15 Copay	\$55 Copay	\$55 Copay (After Rx Deductible)	Full Cost up to \$500 per Prescription Until Out-of-Pocket is Met (After Rx Deductible)
Tier 3 Drugs (30-Day Supply)	\$25 Copay	\$25 Copay	\$25 Copay	\$70 Copay (After Rx Deductible)	\$70 Copay (After Deductible)	\$25 Copay	\$75 Copay	\$85 Copay (After Rx Deductible)	Full Cost up to \$500 per Prescription Until Out-of-Pocket is Met (After Rx Deductible)
Tier 4 Drugs (30-Day Supply)	10% Coinsurance up to \$250 per Prescription	10% Coinsurance up to \$250 per Prescription	10% Coinsurance up to \$250 per Prescription	20% Coinsurance up to \$250 per Prescription (After Rx Deductible)	20% Coinsurance up to \$250 per Prescription (After Deductible)	10% Coinsurance up to \$250 per Prescription	20% Coinsurance up to \$250 per Prescription	20% Coinsurance up to \$250 per Prescription (After Rx Deductible)	Full Cost up to \$500 per Prescription Until Out-of-Pocket is Met (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					\$0 Copay			
Eyewear (Frames) (1 Pair Per Calendar Year)	\$0 Copay					\$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					Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share			
Eyewear (Contact Lenses)	\$0 Copay					\$0 Copay			
Pediatric Dental (Ages 0-18)	Included in Plan. See Dental Summary Page.					Included in Plan. See Dental Summary Page.			