Employer Group Plans | 2018 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				
Plan Name	**Ruby 10 HMO Platinum**	**Ruby 20 HMO Platinum**	**Ruby 40 HMO Platinum**	**Opal 25 HMO Gold**	**Opal 50 HMO Silver**	**Platinum^{90} HMO**	**Gold^{80} HMO**	**Silver^{70} HMO**	**Bronze^{60} HMO**	**Bronze 60 HDHP HMO**
Metal Level / Actuarial Value %*	Platinum / 91.96%	Platinum / 90.72%	Platinum / 88.81%	Gold / 78.54%	Silver / 71.46%	Platinum / 88.1%	Gold / 78.4%	Silver / 71.4%	Bronze / 60.8%	Bronze / 61.4%
SERVICES AND FEATURES										
Annual Deductible	$0	$0	$0	Individual $1,500 / Family $3,000 (A)	Individual $2,000 / Family $4,000 (A) Combined Medical / Rx (1)	$0	$0	Individual $2,000 / Family $4,000 (A)	Individual $6,300 / Family $12,600 (A)	Individual $4,800/ Family $9,600 Combined Medical/Rx
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 $3,350 / Family $6,700	Individual $6,000/ Family $12,000	Individual $7,000/ Family $14,000	Individual $7,000/ Family$14,000	Individual $6,550/ Family $13,100
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	$25 Copay	$45 Copay	$75 Copay (Deductible Applies after 1st 3 non-preventive visits)*	40% Coinsurance (After Deductible)
Specialist Visit	$35 Copay	$40 Copay	$50 Copay	$25 Copay (After Deductible)	$50 Copay (After Deductible)	$30 Copay	$55 Copay	$75 Copay	$105 Copay (Deductible Applies after 1st 3 non-preventive visits)*	40% Coinsurance (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	No Charge
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 per day (Up to the first Five Days)	$600 per day (Up to the first Five Days)	20% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)
Delivery and all Inpatient Services (Professional Services)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	20% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)
OUTPATIENT SERVICES										
Laboratory Tests & X-Rays	$10 Copay	$10 Copay	$10 Copay	$0 Copay (After Deductible)	$0 Copay (After Deductible)	$15 Copay (Laboratory) / $30 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)	40% Coinsurance (After Deductible)
Imaging (CT/PET Scans, MRIs)	$150 Copay	$150 Copay	$150 Copay	$150 Copay (After Deductible)	$250 Copay (After Deductible)	$75 Copay	$275 Copay	$300 Copay	Full Cost Until Out-of-Pocket is Met	40% 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)	$100 Copay	$300 Copay	20% Coinsurance	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)
Physician/Surgeon Fees	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$25 Copay	$40 Copay	20% Coinsurance	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)

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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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 Per Day (Up To First 5 Days)	$600 Per Day (Up To First 5 Days)	20% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)
Physician/Surgeon Fees	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	20% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)
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	40% Coinsurance (After Deductible)
Professional Services	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	No Charge
Urgent Care Center	$10 Copay	$20 Copay	$40 Copay	$25 Copay (After Deductible)	$50 Copay (After Deductible)	$15 Copay	$25 Copay	$45 Copay	$75 Copay (Deductible Applies After 1st (3) Non-Preventive Visits)	40% Coinsurance (After Deductible)
PRESCRIPTION DRUG COVERAGE										
Annual Rx Deductible	$0	$0	$0	Individual $250 / Family $500	Individual $2,000 / Family $4,000 (A) Combined Medical / Rx (1)	$0	$0	Individual $125 / Family $250	Individual $500 / Family $1,000	Individual $4,800/ Family $9,600 Combined Medical/Rx
Tier 1 Drugs (30-Day Supply)	$5 Copay	$5 Copay	$5 Copay	$15 Copay	$15 Copay	$5 Copay	$ 15 Copay	$ 15 Copay (After Rx Deductible)	Full Cost up to $500 per Prescription Until Out-of-Pocket is Met (After Rx Deductible)	40% Coinsurance up to $500 per Prescription (After 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)	40% Coinsurance up to $500 per Prescription (After 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)	40% Coinsurance up to $500 per Prescription (After 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)	40% Coinsurance up to $500 per Prescription (After 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.				