Balance by CCHP

Changes we're making to your current health plan

The difference between your 2021 monthly rate and your current rate is due to:

- Costs associated with the administration and delivery of essential health benefits.
- Changes to your benefit design that include(s):

Benefit Comparison Chart	Ruby 10 HMO Platinum	
Covered Services	**2020**	**2021**
DEDUCTIBLES		
Annual Deductible	Medical: $0 Drug: $0	Medical: $0 Drug: $0
Out–of–Pocket Limit On Expenses	Individual $2,500/ Family $5,000	Individual $2,500/ Family $5,000
PROFESSIONAL SERVICES	**Member Cost Share**	
Visit to a Health Care Provider's Office or Clinic		
Preventive Care/ Screening/ Immunization	$0 Copay	$0 Copay
Family Planning (Consultation and Contraceptive Services	$0 Copay	$0 Copay
Prenatal Care and Preconception Visits	$0 Copay	$0 Copay
Diabetes Care Management	$0 Copay	$0 Copay
Diabetes Education	$0 Copay	$0 Copay
Primary Care Visit to Treat an Injury or Illness	$10 Copay	$10 Copay
Specialist Visit	$20 copay	$20 copay
Acupuncture	$10 copay	$10 copay
Allergy Visit (Testing and Treatment)	$20 copay	$20 copay
Other Practitioner Office Visit	$10 copay	$10 copay
Outpatient Services	**Member Cost Share**	
Tests		
Laboratory Tests	$10 Copay	$10 Copay
X-Rays	$10 Copay	$10 Copay
Imaging (CT/PET scans, MRIs)	$150 Copay	$150 Copay
Outpatient Surgery		
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$100 (Chinese Hospital) / $300 (Other Facilities)	$100 (Chinese Hospital) / $300 (Other Facilities)
Physician/Surgeon Fees	$0 Copay	$0 Copay
Outpatient Visit	$0 Copay	$0 Copay
Hospitalization Services		
Facility Fee (e.g., Hospital Room)	$150 Copay / Day (Chinese Hospital) $450 Copay / Day (Other Facilities) (Up to First 5 Days)	$150 Copay / Day (Chinese Hospital) $450 Copay / Day (Other Facilities) (Up to First 5 Days)
Physician/Surgeon Fees	$0 Copay	$0 Copay

Benefit Comparison Chart	Ruby 10 HMO Platinum	
Covered Services	**2020**	**2021**
Delivery and All Inpatient Services (Hospital Services)	$150 copay per day (Up to the first 5 days)	$150 copay per day (Up to the first 5 days)
Delivery and All Inpatient Services (Professional Services)	$0 Copay	$0 Copay
Emergency Health Coverage		
Emergency Room Services	$200 Copay	$200 Copay
Emergency Room Physician Fee	$0 Copay	$0 Copay
Urgent Care	$10 Copay	$10 Copay
Ambulance Services		
Medical Transportation (Including Emergency and Non-emergency)	$100 Copay	$100 copay
Prescription Drug Coverage		
Tier 1:Generic Drugs (30-Day Supply)	$5 Copay	$5 Copay
Tier 1:Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$10 Copay	$10 Copay
Tier 2: Preferred Brand Drugs (30-Day Supply)	$ 15 Copay	$ 15 Copay
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$ 30 Copay	$ 30 Copay
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	$25 Copay	$25 Copay
Tier 3: Non-preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$50 Copay	$50 Copay
Tier 4: Specialty Drugs (30-Day Supply)	10% Coinsurance Up to $250 Per Prescription	10% Coinsurance Up to $250 Per Prescription
Medical Supplies/ Durable Medical Equipment		
Medical Supplies	20% coinsurance	20% coinsurance
Prosthetic Devices	20% coinsurance	20% coinsurance
Durable Medical Equipment (Outpatient)	20% coinsurance	20% coinsurance
Mental Health Services		
Mental/Behavioral Health Outpatient Office Visits	$10 Copay	$10 Copay
Mental/ Behavioral Health Other Outpatient Items and Services	$10 Copay	$10 Copay
Mental/Behavioral Health Inpatient Facility Fee	$150 copay/day (Up to the first 5 days)	$150 copay/day (Up to the first 5 days)
Mental/Behavioral Health Inpatient Professional Fee	$0 Copay	$0 Copay
Chemical Dependency Services		
Substance Use Disorder Outpatient Office Visits	$10 Copay	$10 Copay

Benefit Comparison Chart	Ruby 10 HMO Platinum	
Covered Services	**2020**	**2021**
Substance Use Disorder Other Outpatient Items and Services	$10 Copay	$10 Copay
Substance Use Disorder Inpatient Facility Services	$150 copay/day (Up to the first 5 days)	$150 copay/day (Up to the first 5 days)
Substance Use Disorder Inpatient Professional Fee	$0 Copay	$0 Copay
Home Health Services		
Home Health Care	$0 copay	$0 copay
Rehabilitation Services	$10 copay	$10 copay
Habilitation Services	$10 copay	$10 copay
Skilled Nursing Care	1st 10 days at no charge; then $100 copay per day.	1st 10 days at no charge; then $100 copay per day.
Hospice Services	$0 copay	$0 copay
Pediatric Vision and Dental (Included in Plan)		
Pediatric Vision (Ages 0-18) Administered by VSP		
Eye Exam Including Refraction and Dilation Per Year	$0 Copay	$0 Copay
1 Pair of Glasses Per Year (or Contact Lenses in Lieu of Glasses) Calendar Year	$0 Copay	$0 Copay
Pediatric Dental (Ages 0-18) Administered by Delta Dental		
Child Dental Diagnostic and Preventive Services	See Delta Dental EOC	See Delta Dental EOC