Employer Group Plans | 2023 Plan Benefit Highlights

FOR A COMPLETE LIST OF BENEFITS UNDER EACH PLAN, REFER TO THE HEALTH PLAN BENEFITS AND COVERAGE MATRIX.
PLEASE CALL 1-877-224-7918 TO REQUEST A COPY, OR VISIT: www.cchphealthplan.com/employer-member.

Plan Name	Ruby 10 Platinum HMO	Ruby 20 Platinum HMO	Ruby 40 Platinum HMO	Opal 25 HMO	Opal 50 HMO	Platinum 90 HMO	Gold 80 HMO	Silver 70 HMO	Bronze 60 HMO	Bronze 60 HDHP HMO
Metal Level / Actuarial Value %(1)	Platinum / 91.96%	Platinum / 91.07 %	Platinum / 88.55%	Gold / 81.98 %	Silver / 71.90%	Platinum / 88.80%	Gold / 80.50%	Silver / 71.46%	Bronze / 63.92%	Bronze / 64.60%
SERVICES AND FEATURES										
Annual Deductible	$0	$0	$0	Individual $2,100 / Family $4,200 (3)	Individual $3,800 / Family $7,600 (3)	$0	Individual $250 / Family $500	Individual $2,500 / Family $5,000 (3)	Individual $6,300 / Family $12,600 (3)	Individual $7,000/ Family $14,000 Combined Medical/Rx
Out–of–Pocket Limit on Expenses	Individual $2,600 / Family $5,200	Individual $2,500 / Family $5,000	Individual $3,000 / Family $6,000	Individual $5,800 / Family $11,600	Individual $9,100 / Family $18,200	Individual $4,500 / Family $9,000	Individual $7,800/ Family $15,600	Individual $8,750/ Family $17,500	Individual $8,200/ Family $16,400	Individual $7,000/ Family $14,000
LIFETIME MAXIMUMS	No Limit					No Limit				
PROFESSIONAL SERVICES	**Member Cost Share**					**Member Cost Share**				
Preventive Care/ Screening/Immunization	$0 Copay					$0 Copay				
Primary Care Physician (PCP) Visit to Treat an Injury or Illness	$10 Copay	$20 Copay	$40 Copay	$30 Copay	$50 Copay	$20 Copay	$35 Copay	$55 Copay	$65 Copay (Deductible Applies after First 3 Non-Preventive Visits)	Full Cost Until Out-of-Pocket is Met
Specialist Visit	$20 Copay	$20 Copay	$40 Copay	$30 Copay	$95 Copay	$30 Copay	$55 Copay	$90 Copay	$95 Copay (Deductible Applies after First 3 Non-Preventive Visits)	Full Cost Until Out-of-Pocket is Met
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 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)	$250 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 5 Days)	$600 per day (Up to the First 5 Days) (After Deductible)	40% Coinsurance (After Deductible)	40% 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	$0 Copay	$0 Copay	40% Coinsurance	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
OUTPATIENT SERVICES										
Laboratory Tests & X-Rays	$10 Copay	$10 Copay	$10 Copay	$25 Copay	Laboratory: $50 Copay X-Ray: $95 Copay	Laboratory: $20 Copay X-Ray: $30 Copay	Laboratory: $35 Copay X-Ray: $55 Copay	Laboratory: $55 Copay X-Ray: $90 Copay	Laboratory: $40 Copay X-Ray: 40% Coinsurance (After Deductible for X-Ray)	Full Cost Until Out-of-Pocket is Met
Imaging (CT/PET Scans, MRIs)	$150 Copay	$150 Copay	$150 Copay	$250 Copay	$285 Copay	$100 Copay	$250 Copay (After Deductible)	$300 Copay (After Deductible)	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$100 Copay (Chinese Hospital) / $300 Copay (Other Facilities)	$100 Copay (Chinese Hospital) / $300 Copay (Other Facilities)	$150 Copay (Chinese Hospital) / $450 Copay (Other Facilities)	$250 Copay (Chinese Hospital) / $750 Copay (Other Facilities) (After Deductible)	$300 Copay (Chinese Hospital) / $750 Copay (Other Facilities) (After Deductible)	$100 Copay	$300 Copay (After Deductible)	35% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
Physician/Surgeon Fees	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$25 Copay	$35 Copay	30% Coinsurance	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met

Footnotes: (1) Actuarial Value is the percentage of total average costs for covered benefits that a plan will cover.
(2) Medical / RX cost-sharing contributes toward annual deductible.
(3) 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 health plan benefit and coverage matrix 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 Facilities) (Up to First 5 Days)	$150 Copay Per Day (Chinese Hospital) / $450 Copay Per Day (Other Facilities) (Up to First 5 Days)	$250 Copay Per Day (Chinese Hospital) / $750 Copay Per Day (Other Facilities) (Up to First 5 Days)	$250 Copay Per Day (Chinese Hospital) / $750 Copay Per Day (Other Facilities) (Up to First 5 Days) (After Deductible)	$250 Copay Per Day (Chinese Hospital) / $750 Copay Per Day (Other Facilities) (Up to First 5 Days) (After Deductible)	$250 Per Day (Up to First 5 Days)	$600 Per Day (Up to First 5 Days) (After Deductible)	40% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
Physician/Surgeon Fees	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	40% Coinsurance	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
EMERGENCY HEALTH COVERAGE										
Emergency Room Services (waived if admitted)	$200 Copay	$200 Copay	$200 Copay	$250 Copay (After Deductible)	$300 Copay (After Deductible)	$150 Copay	$250 Copay (After Deductible)	30% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
Professional Services (waived if admitted)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	Full Cost Until Out-of-Pocket is Met
Urgent Care Center	$10 Copay	$20 Copay	$40 Copay	$25 Copay	$50 Copay	$20 Copay	$35 Copay	$55 Copay	$65 Copay (Deductible Applies After First (3) Non-Preventive Visits)	Full Cost Until Out-of-Pocket is Met
PRESCRIPTION DRUG COVERAGE										
Annual Rx Deductible	$0	$0	$0	Individual $250 / Family $500	Individual $700 / Family $1,400 (3)	$0	$0	Individual $300 / Family $600	Individual $500 / Family $1,000	Individual $7,000/ Family $14,000 Combined Medical/Rx
Tier 1: Generic Drugs (30-Day Supply)	$5 Copay	$5 Copay	$5 Copay	$10 Copay	$30 Copay (After Deductible)	$5 Copay	$15 Copay	$ 19 Copay	$18 Copay (After Rx Deductible)	Full Cost Per Prescription until Out-of-Pocket is Met
Tier 2: Preferred Brand Drugs (30-Day Supply)	$15 Copay	$15 Copay	$15 Copay	$30 Copay (After Rx Deductible)	$80 Copay (After Deductible)	$20 Copay	$40 Copay	$ 85 Copay (After Rx Deductible)	40% Coinsurance up to $500 Per Prescription (After Rx Deductible)	Full Cost Per Prescription until Out-of-Pocket is Met
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	$25 Copay	$25 Copay	$25 Copay	$60 Copay (After Rx Deductible)	$95 Copay (After Deductible)	$30 Copay	$70 Copay	$110 Copay (After Rx Deductible)	40% Coinsurance up to $500 Per Prescription (After Rx Deductible)	Full Cost Per Prescription until Out-of-Pocket is Met
Tier 4: Specialty 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	30% Coinsurance Up to $250 Per Prescription (After Rx Deductible)	40% Coinsurance up to $500 Per Prescription (After Rx Deductible)	Full Cost Per Prescription until Out-of-Pocket is Met
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.				