



Individual & Family 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 1-877-256-2477 TO REQUEST A COPY, OR VISIT: WWW.CCHPHEALTHPLAN.COM.

Plan Name	PLANS AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA					Platinum 90 HMO	Gold 80 HMO	Silver 70* HMO	Bronze 60 HMO	Bronze 60 HDHP HMO	Minimum Coverage HMO
	Jade 15 Platinum HMO	Silver 70 Off-Exchange HMO	Amber 50 Silver HMO	ActiveChoice PPO Silver							
Metal Level / Actuarial Benefit Value %**	Platinum / 91.2%	Silver / 71.6%	Silver / 69.98%	Silver / 71.99 %		Platinum / 89.8%	Gold / 80.1 %	Silver / 71.6 %	Bronze / 64.5%	Bronze / 64.2%	N/A
SERVICES AND FEATURES											
Annual Deductible	\$0	Individual \$4,750 / Family \$9,500 ^(A)	Individual \$2,750 / Family \$5,500 ^(A)	Individual \$2,500 / Family \$5,000 ^(A) Medical/ Rx ⁽¹⁾		\$0	\$0	Individual \$4,750 / Family \$9,500 ^(A)	Individual \$6,300 / Family \$12,600 ^(A)	Individual \$7,000/ Family \$14,000 ^(A) Medical/ Rx ⁽¹⁾	Individual \$9,100 / Family \$18,200 ^(A) Medical / Rx ⁽¹⁾
Out-of-Pocket Limit on Expenses	Individual \$3,000/ Family \$6,000	Individual \$8,750 / Family \$17,500	Individual \$7,500 / Family \$15,000	Individual \$7,700 / Family \$15,400		Individual \$4,500 / Family \$9,000	Individual \$8,550/ Family \$17,100	Individual \$8,750/ Family \$17,500	Individual \$8,200/ Family \$16,400	Individual \$7,000/ Family \$14,000	Individual \$9,100 / Family \$18,200
LIFETIME MAXIMUMS	No Limit					No Limit					
PROFESSIONAL SERVICES	Member Cost Share					Member Cost Share					
Preventive Care/ Screening/Immunization	Not Subject to Copay					Not Subject to Copay					
Primary Care Visit to Treat an Injury or Illness	\$15 Copay	\$45 Copay	\$0 Copay for First (3) PCP Visits (Deductible does not apply), Then \$50 Copay (After Deductible)	\$0 Copay for First (3) PCP Visits (Deductible does not apply), Then \$50 Copay (After Deductible)	50% Coinsurance (After Deductible)	\$15 Copay	\$35 Copay	\$45 Copay	\$65 Copay (Deductible Applies After First (3) Non-Preventive Visits)	Full Cost Until Out-of-Pocket is Met	\$0 Copay for First (3) Non-Preventive Visits, then Full Cost Until Out-of-Pocket is Met
Specialist Visit	\$30 Copay	\$85 Copay	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)	50% Coinsurance (After Deductible)	\$30 Copay	\$65 Copay	\$85 Copay	\$95 Copay (Deductible Applies After First (3) Non-Preventive Visits)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
Prenatal and Preconception Visits	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	50% Coinsurance (After Deductible)	\$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)	30% Coinsurance (After Deductible)	\$500 Copay Per Day (Up to First 5 Days) (After Deductible)	20% Coinsurance (Up to First 5 Days) (After Deductible)	50% Coinsurance (After Deductible)	\$250 Per day (Up to First 5 Days)	\$350 Per day (Up to First 5 Days)	30% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
Delivery and All Inpatient Services (Professional Services)	\$0 Copay	30% Coinsurance (After Deductible)	\$0 Copay	\$0 Copay	50% Coinsurance (After Deductible)	\$0 Copay	\$0 Copay	30% Coinsurance	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
OUTPATIENT SERVICES											
Laboratory Tests	\$5 Copay	\$50 Copay	\$25 Copay (After Deductible)	\$10 Copay (After Deductible)	50% Coinsurance (After Deductible)	\$15 Copay	\$40 Copay	\$50 Copay	\$40 Copay	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
X-Rays	\$5 Copay	\$95 Copay	\$50 Copay (After Deductible)	\$50 Copay (After Deductible)	50% Coinsurance (After Deductible)	\$30 Copay	\$75 Copay	\$95 Copay	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
Imaging (CT/PET Scans, MRIs)	\$100 Copay	\$325 Copay	\$350 Copay (After Deductible)	\$200 Copay (After Deductible)	50% Coinsurance (After Deductible)	\$75 Copay	\$75 Copay	\$325 Copay	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	\$250 Copay	20% Coinsurance	\$400 Copay Chinese Hospital / \$1,200 Copay Other Facilities (After Deductible)	20% Coinsurance Chinese Hospital / 40% Coinsurance Other Facilities (After Deductible)	50% Coinsurance (After Deductible)	\$100 Copay	\$150 Copay	20% Coinsurance	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
Physician/Surgeon Fees	\$0 Copay	20% Coinsurance	\$0 Copay (After Deductible)	20% Coinsurance Chinese Hospital / 40% Coinsurance Other Facilities (After Deductible)	50% Coinsurance (After Deductible)	\$25 Copay	\$40 Copay	20% Coinsurance	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met

Footnotes: * Available in Covered California only.

Actuarial Value is the Percentage of total average costs for covered benefits that a plan will cover.

Preventive care is 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).