Balance by CCHP

Benefit Chart	Ruby 10 HMO Platinum
Covered Services	**2023**
DEDUCTIBLES	
Annual Deductible	Medical: $0 Drug: $0
Out–of–Pocket Limit On Expenses	Individual $2,600 / Family $5,200
PROFESSIONAL SERVICES	**Member Cost Share**
Visit to a Health Care Provider's Office or Clinic	
Preventive Care/ Screening/ Immunization	$0 Copay
Family Planning (Consultation and Contraceptive Services	$0 Copay
Prenatal Care and Preconception Visits	$0 Copay
Diabetes Care Management	$0 Copay
Diabetes Education	$0 Copay
Primary Care Visit to Treat an Injury or Illness	$10 Copay
Specialist Visit	$20 Copay
Acupuncture	$10 Copay
Allergy Visit (Testing and Treatment)	$20 Copay
Other Practitioner Office Visit	$10 Copay
Outpatient Services	**Member Cost Share**
Tests	
Laboratory Tests	$10 Copay
X-Rays	$10 Copay
Imaging (CT/PET scans, MRIs)	$150 Copay
Outpatient Surgery	
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$100 (Chinese Hospital) / $300 (Other Facilities)
Physician/Surgeon Fees	$0 Copay
Outpatient Visit	$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)
Physician/Surgeon Fees	$0 Copay
Delivery and All Inpatient Services (Hospital Services)	$150 copay per day (Up to the first 5 days)
Delivery and All Inpatient Services (Professional Services)	$0 Copay
Emergency Health Coverage	
Emergency Room Services	$200 Copay
Emergency Room Physician Fee	$0 Copay
Urgent Care	$10 Copay
Ambulance Services	
Medical Transportation (Including Emergency and Non-	$100 Copay

Benefit Chart	Ruby 10 HMO Platinum
Covered Services	**2023**
emergency)	
Prescription Drug Coverage	
Tier 1:Generic Drugs (30-Day Supply)	$5 Copay
Tier 1:Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$10 Copay
Tier 2: Preferred Brand Drugs (30-Day Supply)	$ 15 Copay
Tier 2: Preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$ 30 Copay
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	$25 Copay
Tier 3: Non-preferred Brand Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$50 Copay
Tier 4: Specialty Drugs (30-Day Supply)	10% Coinsurance Up to $250 Per Prescription
Medical Supplies/ Durable Medical Equipment	
Medical Supplies	20% Coinsurance
Prosthetic Devices	20% Coinsurance
Durable Medical Equipment (Outpatient)	20% Coinsurance
Mental Health Services	
Mental/Behavioral Health Outpatient Office Visits	$10 Copay
Mental/ Behavioral Health Other Outpatient Items and Services	$10 Copay
Mental/Behavioral Health Inpatient Facility Fee	$150 copay/day (Up to the first 5 days)
Mental/Behavioral Health Inpatient Professional Fee	$0 Copay
Chemical Dependency Services	
Substance Use Disorder Outpatient Office Visits	$10 Copay
Substance Use Disorder Other Outpatient Items and Services	$10 Copay
Substance Use Disorder Inpatient Facility Services	$150 copay/day (Up to the first 5 days)
Substance Use Disorder Inpatient Professional Fee	$0 Copay
Home Health Services	
Home Health Care	$0 Copay
Rehabilitation Services	$10 Copay
Habilitation Services	$10 Copay
Skilled Nursing Care	1st 10 days at no charge; then $100 copay per day.
Hospice Services	$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
1 Pair of Glasses Per Year (or Contact Lenses in Lieu of	$0 Copay

Benefit Chart	Ruby 10 HMO Platinum
Covered Services	**2023**
Glasses) Calendar Year	
Pediatric Dental (Ages 0-18) **Administered by Delta Dental**	
Child Dental Diagnostic and Preventive Services	No Charge