CCHP Health Plan

Employer Group Plans
2019 Plan Benefit Highlights

Plan Name	Ruby 10 HMO Platinum
SERVICES AND FEATURES	
Annual Deductible	$0
Out–of–Pocket Limit On Expenses	Individual $4,250/Family $8,500
LIFETIME MAXIMUMS	None
PROFESSIONAL SERVICES	
Preventive Care/Screening/Immunization	$0 Copay
Primary Care Visit to Treat an Injury or Illness	$10 Copay
Specialist Visit	$35 copay
Maternity Care - Preconception/Prenatal/Postnatal Care	$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
OUTPATIENT SERVICES	
Laboratory Tests & X-Rays	$10 Copay
Imaging (CT/PET Scans, MRIs)	$150 Copay
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$75 (Chinese Hospital) / $225 (Other Contracted Facilities)
Physician/Surgeon Fees	$0 Copay
HOSPITALIZATION SERVICES	
Facility Fee (e.g., Hospital Room)	$150 Copay / Day (Chinese Hospital) $450 Copay / Day (Other Contracted Facilities) (Up to First 5 Days)
Physician/Surgeon Fees	$0 Copay
EMERGENCY HEALTH COVERAGE	
Emergency Room Services	$150 Copay
Professional Services	$0 Copay
Urgent Care Center	$10 Copay
PRESCRIPTION DRUG COVERAGE	
Annual Rx Deductible	None
Tier 1 Drugs (30-Day Supply)	$5 Copay
Tier 2 Drugs (30-Day Supply)	$15 Copay
Tier 3 Drugs (30-Day Supply)	$25 Copay
Tier 4 Drugs (30-Day Supply)	10% Coinsurance Up to $250 Per Prescription
PEDIATRIC VISION AND DENTAL (Included in Plan)	
Child Needs Eye Care (Ages 0-18)	
Eye Exam (1 Per Calendar Year)	$0 Copay
Eyewear (Frames) (1 Pair Per Calendar Year)	$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
Eyewear (Contact Lenses)	$0 Copay
Pediatric Dental (Ages 0-18)	**SEE DELTA DENTAL EOC**