Employer Group Plans | 2026 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.

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 / 91.80%	Platinum / 89.94%	Platinum / 89.49%	Gold / 81.73%	Silver / 70.37%	Platinum / 88.72%	Gold / 81.67%	Silver / 71.69%	Bronze / 64.14%	Bronze / 64.97%
SERVICES AND FEATURES										
Annual Deductible	$0	$0	$0	Individual $2,100 Family $4,200 (3)	Individual $2,500 Family $5,000 (3)	$0	Individual $250 Family $500	Individual $3,200 Family $6,400 (3)	Individual $6,300 Family $12,600 (3)	Individual $7,100 Family $14,200 (3) (Combined Medical/ Drug Deductible)
Out–of–Pocket Limit on Expenses	Individual $3,900 Family $7,800	Individual $3,700 Family $7,400	Individual $3,000 Family $6,000	Individual $6,100 Family $12,200	Individual $9,100 Family $18,200	Individual $4,500 Family $9,000	Individual $7,800 Family $15,600	Individual $9,500 Family $19,000	Individual $8,200 Family $16,400	Individual $7,100 Family $14,200
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	$15 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)	0% Coinsurance (After Deductible)
Specialist Visit	$30 Copay	$20 Copay	$40 Copay	$35 Copay	$100 Copay	$30 Copay	$55 Copay	$90 Copay	$95 Copay (Deductible Applies after First 3 Non-Preventive Visits)	0% Coinsurance (After Deductible)
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/Day (Up to First 5 Days)	$150 Copay/Day (Up to First 5 Days)	$250 Copay/Day (Up to First 5 Days)	$250 Copay/Day (Up to First 5 Days) (After Deductible)	$250 Copay/Day (Up to First 5 Days) (After Deductible)	$250/day (Up to the First 5 Days)	$600/day (Up to the First 5 Days) (After Deductible)	35% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	0% Coinsurance (After Deductible)
Delivery and all Inpatient Services (Professional Services)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	35% Coinsurance	40% Coinsurance (After Deductible)	0% Coinsurance (After Deductible)
OUTPATIENT SERVICES										
Laboratory Tests & X-Rays	Laboratory: $15 Copay X-Ray: $10 Copay	$10 Copay	$10 Copay	$25 Copay	Laboratory: $50 Copay X-Ray: $110 Copay	Laboratory: $20 Copay X-Ray: $30 Copay	Laboratory: $35 Copay X-Ray: $55 Copay	Laboratory: $60 Copay X-Ray: $150 Copay	Laboratory: $40 Copay X-Ray: 40% Coinsurance (After Deductible for X-Ray)	0% Coinsurance (After Deductible)
Imaging (CT/PET Scans, MRIs)	$180 Copay	$160 Copay	$150 Copay	$250 Copay	$285 Copay	$100 Copay	$250 Copay (After Deductible)	$300 Copay (After Deductible)	40% Coinsurance (After Deductible)	0% Coinsurance (After Deductible)
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)	0% Coinsurance (After Deductible)
Physician/Surgeon Fees	$0 Copay	$0 Copay	$0 Copay	$0 Copay	30% Coinsurance	$25 Copay	$35 Copay	35% Coinsurance	40% Coinsurance (After Deductible)	0% Coinsurance (After Deductible)

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).

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
HOSPITALIZATION SERVICES	**Member Cost Share**					**Member Cost Share**				
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)	$250 Copay/Day (Chinese Hospital) $750 Copay/Day (Other Facilities) (Up to First 5 Days)	$250 Copay/Day (Chinese Hospital) $750 Copay/Day (Other Facilities) (Up to First 5 Days) (After Deductible)	$250 Copay/Day (Chinese Hospital) $750 Copay/Day (Other Facilities) (Up to First 5 Days) (After Deductible)	$250/Day (Up to First 5 Days)	$600/Day (Up to First 5 Days) (After Deductible)	35% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	0% Coinsurance (After Deductible)
Physician/Surgeon Fees	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	35% Coinsurance	40% Coinsurance (After Deductible)	0% Coinsurance (After Deductible)
EMERGENCY HEALTH COVERAGE										
Emergency Room Services (waived if admitted)	$200 Copay	$230 Copay	$200 Copay	$250 Copay (After Deductible)	$300 Copay (After Deductible)	$150 Copay	$250 Copay (After Deductible)	35% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	0% Coinsurance (After Deductible)
Professional Services (waived if admitted)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	0% Coinsurance (After Deductible)
Urgent Care Center	$15 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)	0% Coinsurance (After Deductible)
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 $7,100 Family $14,200 (Combined Medical/ Drug Deductible)
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)	0% Coinsurance (After Deductible)
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/Prescription (After Rx Deductible)	0% Coinsurance (After Deductible)
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/Prescription (After Rx Deductible)	0% Coinsurance (After Deductible)
Tier 4: Specialty Drugs (30-Day Supply)	10% Coinsurance up to $250/Prescription	10% Coinsurance up to $250/Prescription	10% Coinsurance up to $250/Prescription	20% Coinsurance up to $250/Prescription (After Rx Deductible)	20% Coinsurance up to $250/Prescription (After Deductible)	10% Coinsurance up to $250/Prescription	20% Coinsurance up to $250/Prescription	30% Coinsurance Up to $250/Prescription (After Rx Deductible)	40% Coinsurance up to $500/Prescription (After Rx Deductible)	0% Coinsurance (After Deductible)
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, lined bifocal, and lined trifocal lenses No Cost Share					Single vision, lined bifocal, and lined trifocal lenses 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.				

How to Contact Us? Balance by CCHP Sales Department | 1-877-224-7918 | sales@balancebycchp.com | 445 Grant Avenue | San Francisco, CA 94108