Balance by CCHP

For your review, this is a side-by-side comparison of benefits from 2024 to 2025.

Benefit Comparison Chart	Gold 80 HMO 2024 Employer Group	Gold 80 HMO 2025 Employer Group
Deductibles		
Annual Medical Deductible	Individual $250 / Family $500	Individual $250 / Family $500
Annual Drug Deductible	$0	$0
Maximum Out of Pocket	Individual $7,800 Family $15,600	Individual $7,800 Family $15,600
Professional Services		
Provider's Office or Clinic Visit		
Preventive Care / Screening / Immunization	$0 Copay	$0 Copay
Family Planning (Consultation and Contraceptive Services)	$0 Copay	$0 Copay
Preconception and Prenatal Visits	$0 Copay	$0 Copay
Diabetes Care Management	$0 Copay	$0 Copay
Diabetes Education	$0 Copay	$0 Copay
Primary Care Visit to Treat an Injury or Illness	$35 Copay	$35 Copay
Specialist Visit	$55 Copay	$55 Copay
Acupuncture	$35 Copay	$35 Copay
Allergy Visit (Testing and Treatment)	$55 Copay	$55 Copay
Other Practitioner Office Visit	$35 Copay	$35 Copay
Outpatient Services		
Tests		
Laboratory Tests	$35 Copay	$35 Copay
X-Rays	$55 Copay	$55 Copay
Imaging (CT/PET Scans, MRIs)	After Medical Deductible, $250 Copay	After Medical Deductible, $250 Copay
Outpatient Surgery		
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	After Medical Deductible, $300 Copay	After Medical Deductible, $300 Copay
Outpatient Physician/Surgeon Fees	$35 Copay	$35 Copay
Outpatient Visit	20% Coinsurance	20% Coinsurance

Benefit Comparison Chart	Gold 80 HMO 2024 Employer Group	Gold 80 HMO 2025 Employer Group
Hospitalization Services		
Facility Fee (e.g., Hospital Room)	After Medical Deductible, $600 per Day (up to the First 5 Days)	After Medical Deductible, $600 per Day (up to the First 5 Days)
Inpatient Physician/Surgeon Fees	$0 Copay	$0 Copay
Delivery and All Inpatient Services (Hospital Services)	After Medical Deductible, $600 per Day (up to the First 5 Days)	After Medical Deductible, $600 per Day (up to the First 5 Days)
Delivery and All Inpatient Services (Professional Services)	$0 Copay	$0 Copay
Emergency Health Coverage		
Emergency Room Services	After Medical Deductible, $250 Copay	After Medical Deductible, $250 Copay
Emergency Room Physician Fee	$0 Copay	$0 Copay
Urgent Care	$35 Copay	$35 Copay
Ambulance Services		
Medical Transportation (Including Emergency and Non-emergency)	After Medical Deductible, $250 Copay	After Medical Deductible, $250 Copay
Prescription Drug Coverage		
Tier 1: Generic Drugs (30-Day Supply)	$15 Copay	$15 Copay
Tier 1: Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$30 Copay	$30 Copay
Tier 2: Preferred Brand Drugs (30-Day Supply)	$40 Copay	$40 Copay
Tier 2: Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$80 Copay	$80 Copay
Tier 3: Non-Preferred Brand Drugs (30-Day Supply)	$70 Copay	$70 Copay
Tier 3: Generic Drugs (90-Day Supply) Chinese Hospital Pharmacy, or Mail Order	$140 Copay	$140 Copay
Tier 4: Specialty Drugs (30-Day Supply)	20% Coinsurance, up to $250 per Prescription	20% Coinsurance, up to $250 per Prescription
Medical Supplies / Durable Medical Equipment		
Medical Supplies	20% Coinsurance	20% Coinsurance
Prosthetic Devices	20% Coinsurance	20% Coinsurance
Durable Medical Equipment	20% Coinsurance	20% Coinsurance
Mental Health Services		
Mental/Behavioral Health Outpatient Office Visits	$0 Copay	$0 Copay

Benefit Comparison Chart	Gold 80 HMO 2024 Employer Group	Gold 80 HMO 2025 Employer Group
Mental/Behavioral Health Other Outpatient Items and Services	$35 Copay	$35 Copay
Mental/Behavioral Health Inpatient Facility Fee	After Medical Deductible, $600 per Day (up to the First 5 Days)	After Medical Deductible, $600 per Day (up to the First 5 Days)
Mental/Behavioral Health Inpatient Professional Fee	$0 Copay	$0 Copay
Chemical Dependency Services		
Substance Use Disorder Outpatient Office Visits	$0 Copay	$0 Copay
Substance Use Disorder Other Outpatient Items and Services	$35 Copay	$35 Copay
Substance Use Disorder Inpatient Facility Services	After Medical Deductible, $600 per Day (up to the First 5 Days)	After Medical Deductible, $600 per Day (up to the First 5 Days)
Substance Use Disorder Inpatient Professional Fee	$0 Copay	$0 Copay
Home Health Services		
Home Health Care	$30 Copay	$30 Copay
Rehabilitation Services	$35 Copay	$35 Copay
Habilitation Services	$35 Copay	$35 Copay
Skilled Nursing Care	After Medical Deductible, $300 per Day (up to the First 5 Days)	After Medical Deductible, $300 per Day (up to the First 5 Days)
Hospice Services	$0 Copay	$0 Copay
Pediatric (Ages 0-18) Vision and Dental, Included in Plan		
Pediatric Vision - Administered by VSP		
Annual Eye Exam	$0 Copay	$0 Copay
Contact Lenses in Lieu of Glasses	$0 Copay	$0 Copay
Pediatric Dental - Administered by Delta Dental		
See Delta Dental Evidence of Coverage (EOC)		

Footnotes:

Preventive care services are not subject to the deductible.
(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 policy or plan document to see when the deductible starts over (usually, but not always, January 1).