健華
計人
劃保 CCHP Health Plan

Employer Group Plans
2018 Plan Benefit Highlights

	PLAN AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA
Plan Name	**Bronze 60 HDHP HMO**
SERVICES AND FEATURES	
Annual Deductible	Individual $4,800 / Family $9,600 Integrated Medical/Rx Deductible
Out–of–Pocket Limit On Expenses	Individual $6,550 / Family $13,100
LIFETIME MAXIMUMS	No Limit
PROFESSIONAL SERVICES	**Member Cost Share**
Preventive Care/Screening/Immunization	No Charge
Primary Care Visit to Treat an Injury or Illness	40% Coinsurance (After Deductible)
Specialist Visit	40% Coinsurance (After Deductible)
Maternity Care - Preconception/Prenatal/Postnatal Care	No Charge
Delivery and all Inpatient Services (Hospital Services)	40% Coinsurance (After Deductible)
Delivery and all Inpatient Services (Professional Services)	40% Coinsurance (After Deductible)
OUTPATIENT SERVICES	
Laboratory Tests & X-Rays	40% Coinsurance (After Deductible)
Imaging (CT/PET Scans, MRIs)	40% Coinsurance (After Deductible)
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	40% Coinsurance (After Deductible)
Physician/Surgeon Fees	40% Coinsurance (After Deductible)
HOSPITALIZATION SERVICES	
Facility Fee (e.g., Hospital Room)	40% Coinsurance (After Deductible)
Physician/Surgeon Fees	40% Coinsurance (After Deductible)
EMERGENCY HEALTH COVERAGE	
Emergency Room Services	40% Coinsurance (After Deductible)
Professional Services	No Charge
Urgent Care Center	40% Coinsurance (After Deductible)
PRESCRIPTION DRUG COVERAGE	
Annual Rx Deductible	Individual $4,800 / Family $9,600 Integrated Medical/Rx Deductible
Tier 1 Drugs (30-Day Supply)	40% Coinsurance up to $500 per Prescription (After Deductible)
Tier 2 Drugs (30-Day Supply)	40% Coinsurance up to $500 per Prescription (After Deductible)
Tier 3 Drugs (30-Day Supply)	40% Coinsurance up to $500 per Prescription (After Deductible)
Tier 4 Drugs (30-Day Supply)	40% Coinsurance up to $500 per Prescription (After Deductible)
PEDIATRIC VISION AND DENTAL (Included in Plan)	
Child Needs Eye Care (Ages 0-18)	
Eye Exam (1 Per Calendar Year)	No Charge
Eyewear (Frames) (1 Pair Per Calendar Year)	No Charge
Eyewear (Lenses) (1 Pair Per Calendar Year) (Contact Lenses Provided in Lieu of Glasses)	Single Vision / Bi-focal / Tri-focal / Lenticular No Charge
Eyewear (Contact Lenses)	No Charge
Pediatric Dental (Ages 0-18)	Included in Plan. See Dental Summary Page.