CCHP Health Plan

Employer Group Plans
2018 Plan Benefit Highlights

	PLAN AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA
Plan Name	**Bronze 60 HMO**
SERVICES AND FEATURES	
Annual Deductible	Individual $6,300 / Family $12,600
Out–of–Pocket Limit On Expenses	Individual $7,000 / Family $14,000
LIFETIME MAXIMUMS	No Limit
PROFESSIONAL SERVICES	**Member Cost Share**
Preventive Care/Screening/Immunization	$0 Copay
Primary Care Visit to Treat an Injury or Illness	$75 Copay (Deductible Applies after First 3 Non-preventive Visits)
Specialist Visit	$105 Copay (Deductible Applies after First 3 Non-preventive Visits)
Maternity Care - Preconception/Prenatal/Postnatal Care	$0 Copay
Delivery and all Inpatient Services (Hospital Services)	Full Cost Until Out-of-Pocket is met
Delivery and all Inpatient Services (Professional	Full Cost Until Out-of-Pocket is met
OUTPATIENT SERVICES	
Laboratory Tests & X-Rays	$40 Copay (Laboratory) / Full Cost Until Out-of-Pocket is Met (X-Ray)
Imaging (CT/PET Scans, MRIs)	Full Cost Until Out-of-Pocket is Met
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	Full Cost Until Out-of-Pocket is Met
Physician/Surgeon Fees	Full Cost Until Out-of-Pocket is Met
HOSPITALIZATION SERVICES	
Facility Fee (e.g., Hospital Room)	Full Cost Until Out-of-Pocket is Met
Physician/Surgeon Fees	Full Cost Until Out-of-Pocket is met
EMERGENCY HEALTH COVERAGE	
Emergency Room Services	Full Cost Until Out-of-Pocket is Met
Professional Services	$0 Copay
Urgent Care Center	$75 Copay (Deductible Applies after First 3 Non-preventive Visits)
PRESCRIPTION DRUG COVERAGE	
Annual Rx Deductible	Individual $500 / Family $1,000
Tier 1 Drugs (30-Day Supply)	Full Cost up to $500 Per Prescription Until Out-of-Pocket is Met (After Rx Deductible)
Tier 2 Drugs (30-Day Supply)	Full Cost up to $500 Per Prescription Until Out-of-Pocket is Met (After Rx Deductible)
Tier 3 Drugs (30-Day Supply)	Full Cost up to $500 Per Prescription Until Out-of-Pocket is Met (After Rx Deductible)
Tier 4 Drugs (30-Day Supply)	Full Cost up to $500 Per Prescription Until Out-of-Pocket is Met (After Rx Deductible)
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 $0 Copay
Eyewear (Contact Lenses)	$0 Copay
Pediatric Dental (Ages 0-18)	Included in Plan. See Dental Summary Page.