CCHP Health Plan

Employer Group Plans
2019 Plan Benefit Highlights

	PLAN AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA
Plan Name	**Bronze 60 HDHP HMO 6000/40% + Child Dental**
SERVICES AND FEATURES	
Annual Deductible	Individual $6,000/ Family $12,000 (Combined Medical/Drug Deductible)
Out–of–Pocket Limit On Expenses	Individual $6,650/ Family $13,300
LIFETIME MAXIMUMS	None
PROFESSIONAL SERVICES	
Preventive Care/Screening/Immunization	$0 Copay
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	40% coinsurance (After Deductible)
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	$0 Copay
Urgent Care Center	40% coinsurance (After Deductible)
PRESCRIPTION DRUG COVERAGE	
Annual Rx Deductible	Individual $6,000/ Family $12,000 (Combined Medical/Drug 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)	$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)	**SEE DELTA DENTAL EOC**