CCHP Health Plan

Employer Group Plans
2019 Plan Benefit Highlights

	PLAN AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA
Plan Name	**Silver 70 HMO 2000/45 + Child Dental**
SERVICES AND FEATURES	
Annual Deductible	Individual $2,000/ Family $4,000
Out–of–Pocket Limit On Expenses	Individual $7,550/ Family $15,100
LIFETIME MAXIMUMS	None
PROFESSIONAL SERVICES	
Preventive Care/Screening/Immunization	$0 Copay
Primary Care Visit to Treat an Injury or Illness	$45 Copay
Specialist Visit	$80 Copay
Maternity Care - Preconception/Prenatal/Postnatal Care	$0 Copay
Delivery and all Inpatient Services (Hospital Services)	20% Coinsurance (After Deductible)
Delivery and all Inpatient Services (Professional Services)	20% Coinsurance
OUTPATIENT SERVICES	
Laboratory Tests & X-Rays	Laboratory: $40 Copay X-Ray: $75 Copay
Imaging (CT/PET Scans, MRIs)	$300 Copay
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	20% Coinsurance
Physician/Surgeon Fees	20% Coinsurance
HOSPITALIZATION SERVICES	
Facility Fee (e.g., Hospital Room)	20% Coinsurance (After Deductible)
Physician/Surgeon Fees	20% Coinsurance
EMERGENCY HEALTH COVERAGE	
Emergency Room Services	$350 Copay
Professional Services	$0 Copay
Urgent Care Center	$45 Copay
PRESCRIPTION DRUG COVERAGE	
Annual Rx Deductible	Individual $200/ Family $400
Tier 1 Drugs (30-Day Supply)	$15 Copay
Tier 2 Drugs (30-Day Supply)	$55 Copay
Tier 3 Drugs (30-Day Supply)	$85 Copay
Tier 4 Drugs (30-Day Supply)	20% Coinsurance Up to $250 Per Prescription
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 No Cost Share
Eyewear (Contact Lenses)	$0 Copay
Pediatric Dental (Ages 0-18)	**SEE DELTA DENTAL EOC**