CCHP Health Plan

# Employer Group Plans
# 2019 Plan Benefit Highlights

| | *PLAN AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA* |
|---|---|
| **Plan Name** | **Bronze 60 HMO 6300/75 + Child Dental** |
| **SERVICES AND FEATURES** | |
| Annual Deductible | Individual $6,300/ Family $12,600 |
| 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 | $75 Copay (Deductible Applies after 1st 3 non-preventive visits)* |
| Specialist Visit | $105 Copay (Deductible Applies after 1st 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 (After Deductible) |
| Delivery and all Inpatient Services (Professional Services) | Full Cost Until Out of Pocket is Met (After |
| **OUTPATIENT SERVICES** | |
| Laboratory Tests & X-Rays | Laboratory: $40 copay<br>X-Ray: Full Cost Until Out of Pocket is Met (After Deductible) |
| Imaging (CT/PET Scans, MRIs) | Full Cost Until Out of Pocket is Met (After Deductible) |
| Surgery - Facility Fee (e.g., Ambulatory Surgery Center) | Full Cost Until Out of Pocket is Met (After Deductible) |
| Physician/Surgeon Fees | Full Cost Until Out of Pocket is Met (After Deductible) |
| **HOSPITALIZATION SERVICES** | |
| Facility Fee (e.g., Hospital Room) | Full Cost Until Out of Pocket is Met (After Deductible) |
| Physician/Surgeon Fees | Full Cost Until Out of Pocket is Met (After Deductible) |
| **EMERGENCY HEALTH COVERAGE** | |
| Emergency Room Services | Full Cost Until Out of Pocket is Met (After Deductible) |
| Professional Services | $0 Copay |
| Urgent Care Center | $75 Copay, (Deductible Applies after 1st 3 non-preventive visits) |
| **PRESCRIPTION DRUG COVERAGE** | |
| Annual Rx Deductible | Individual $500/ Family $1,000 |
| Tier 1 Drugs (30-Day Supply) | Full Cost Until Out of Pocket is Met up to $500 per |
| Tier 2 Drugs (30-Day Supply) | Full Cost Until Out of Pocket is Met up to $500 per |
| Tier 3 Drugs (30-Day Supply) | Full Cost Until Out of Pocket is Met up to $500 per |
| Tier 4 Drugs (30-Day Supply) | Full Cost Until Out of Pocket is Met up to $500 per |
| **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% Coinsurance |
| Eyewear (Lenses) (1 Pair Per Calendar Year) (Contact Lenses Provided in Lieu of Glasses) | Single Vision/Bi-focal/Tri-focal/Lenticular<br>0% Coinsurance |
| Eyewear (Contact Lenses) | 0% Coinsurance |
| Pediatric Dental (Ages 0-18) | **SEE DELTA DENTAL EOC** |