CCHP Health Plan

Individual & Family Plans
2019 Plan Benefit Highlights

	PLAN AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA
Plan Name	**Silver 94 HMO**
SERVICES AND FEATURES	
Annual Deductible	Individual $75 / Family $150
Out–of–Pocket Limit On Expenses	Individual $1,000/ Family $2,000
LIFETIME MAXIMUMS	None
PROFESSIONAL SERVICES	
Preventive Care/Screening/Immunization	$0 copay
Primary Care Visit to Treat an Injury or Illness	$5 copay
Specialist Visit	$8 copay
Maternity Care - Preconception/Prenatal/Postnatal Care	$0 copay
Delivery and all Inpatient Services (Hospital Services)	10% coinsurance
Delivery and all Inpatient Services (Professional Services)	10% coinsurance
OUTPATIENT SERVICES	
Laboratory Tests & X-Rays	$8 copay
Imaging (CT/PET Scans, MRIs)	$50 copay
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	10% coinsurance
Physician/Surgery Fees	10% coinsurance
HOSPITALIZATION SERVICES	
Facility Fee (e.g., Hospital Room)	10% coinsurance
Physician/Surgeon Fees	10% coinsurance
EMERGENCY HEALTH COVERAGE	
Emergency Room Services	$50 Copay
Professional Services	10% coinsurance
Urgent Care Center	$5 copay
PRESCRIPTION DRUG COVERAGE	
Annual Drug Deductible	None
Tier 1 Drugs (30-Day Supply)	$3 copay
Tier 2 Drugs (30-Day Supply)	$10 copay
Tier 3 Drugs (30-Day Supply)	$15 copay
Tier 4 Drugs (30-Day Supply)	10% coinsurance up to $150 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**