CCHP Health Plan

Individual & Family Plans
2019 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 $7,550/ 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
Delivery and all Inpatient Services (Professional Services)	Full Cost Until Out-of-Pocket is Met
OUTPATIENT SERVICES	
Laboratory Tests & X-Rays	Lab: $40 copay X-Ray: Full Cost Until Out-of-Pocket is Met
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/Surgery 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	Full Cost Until Out-of-Pocket is Met
Urgent Care Center	$75 Copay, (Deductible Applies after 1st 3 non-preventive visits)
PRESCRIPTION DRUG COVERAGE	
Annual Drug Deductible	Individual $500/ Family $1,000
Tier 1 Drugs (30-Day Supply)	Full Cost Until Out-of-Pocket is Met up to $500 per prescription (After Drug Deductible)
Tier 2 Drugs (30-Day Supply)	Full Cost Until Out-of-Pocket is Met up to $500 per prescription (After Drug Deductible)

Tier 3 Drugs (30-Day Supply)	Full Cost Until Out-of-Pocket is Met up to $500 per prescription
Tier 4 Drugs (30-Day Supply)	Full Cost Until Out-of-Pocket is Met up to $500 per prescription (After Drug 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 DEMTAL EOC**

Footnotes: You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use, unless the service is not subject to the deductible. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st).