CCHP Health Plan

Individual & Family Plans
2019 Plan Benefit Highlights

	PLAN AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA
Plan Name	**Bronze 60 HDHP HMO**
SERVICES AND FEATURES	
Annual Deductible	Individual $6,000/ Family $12,000 (Combined
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	$0 Copay
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/Surgery 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	40% coinsurance (After Deductible)
Urgent Care Center	40% coinsurance (After Deductible)
PRESCRIPTION DRUG COVERAGE	
Annual Drug Deductible	Individual $6,000/ Family $12,000 (Combined
Tier 1 Drugs (30-Day Supply)	40% coinsurance up to $500 per prescription
Tier 2 Drugs (30-Day Supply)	40% coinsurance up to $500 per prescription
Tier 3 Drugs (30-Day Supply)	40% coinsurance up to $500 per prescription
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 No Cost Share
Eyewear (Contact Lenses)	$0 Copay
Pediatric Dental (Ages 0-18)	**SEE DELTA DEMTAL EOC**

Footnotes: (A) 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).