CCHP Health Plan

Individual & Family Plans
2019 Plan Benefit Highlights

Plan Name	Amber 50 HMO Silver
SERVICES AND FEATURES	
Annual Deductible	Individual $2,500 /Family $5,000
Out–of–Pocket Limit On Expenses	Individual $7,500/ Family $15,000
LIFETIME MAXIMUMS	None
PROFESSIONAL SERVICES	
Preventive Care/Screening/Immunization	$0 Copay
Primary Care Visit to Treat an Injury or Illness	$0 Copay for 1st (3) PCP Visits (Deductible does not apply), Then $50 Copay (After Deductible)
Specialist Visit	$50 Copay
Maternity Care - Preconception/Prenatal/Postnatal Care	$0 Copay
Delivery and all Inpatient Services (Hospital Services)	$500 Copay per day (Up to the first 5 days) (After Deductible)
Delivery and all Inpatient Services (Professional Services)	$0 Copay
Outpatient Services	
Laboratory Tests & X-Rays	Lab: $25 Copay (After Deductible)
Imaging (CT/PET Scans, MRIs)	$350 Copay
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$400 (Chinese Hospital) / $1,200 (Other Contracted Facilities) (After Medical Deductible)
Physician/Surgeon Fees	$0 Copay
Hospitalization Services	
Facility Fee (e.g., Hospital Room)	$500 Copay (Chinese Hospital) $1,500 Copay (Other Contracted Facilities) (Up To First 5 Days) (After Medical Deductible)
Physician/Surgeon Fees	$0 Copay
Emergency Health Coverage	
Emergency Room Services	$300 Copay
Professional Services	$0 Copay
Urgent Care Center	$50 Copay
Prescription Drug Coverage	
Annual Drug Deductible	Individual $275/ Family $550
Tier 1 Drugs (30-Day Supply)	$15 Copay
Tier 2 Drugs (30-Day Supply)	$ 50 Copay (After Drug Deductible)
Tier 3 Drugs (30-Day Supply)	$ 70 Copay (After Drug Deductible)
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**

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).