CCHP Health Plan

Individual & Family Plans
2017 Plan Benefit Highlights

	PLAN AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA
Plan Name	**Bronze[60]**
SERVICES AND FEATURES	
Annual Deductible	Individual $6,300 / Family $12,600 (A)
Out–of–Pocket Limit On Expenses	Individual $6,800 / Family $13,600
LIFETIME MAXIMUMS	No Limit
PROFESSIONAL SERVICES	**Member Cost Share**
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)	$0 Copay
OUTPATIENT SERVICES	
Laboratory Tests & X-Rays	$40 Copay (Laboratory)/ Full Cost Until Out-of-Pocket is Met (X-Ray)
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/Surgeon Fees	$0 Copay
HOSPITALIZATION SERVICES	
Facility Fee (e.g., Hospital Room)	Full Cost Until Out-of-Pocket is Met
Physician/Surgeon Fees	$0 Copay
EMERGENCY HEALTH COVERAGE	
Emergency Room Services	Full Cost Until Out-of-Pocket is Met
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 (A)
Tier 1 Drugs (30-Day Supply)	Full Cost Up to $500 Per Prescription Until Out-of-Pocket is Met (After Rx Deductible)
Tier 2 Drugs (30-Day Supply)	Full Cost Up to $500 Per Prescription Until Out-of-Pocket is Met (After Rx Deductible)
Tier 3 Drugs (30-Day Supply)	Full Cost Up to $500 Per Prescription Until Out-of-Pocket is Met (After Rx Deductible)
Tier 4 Drugs (30-Day Supply)	Full Cost Up to $500 Per Prescription Until Out-of-Pocket is Met (After Rx 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)	Included in Plan. See Dental Summary Page.

Footnotes: Preventive care services are not subject to the deductible.

(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).