CCHP Health Plan

Individual & Family Plans
2017 Plan Benefit Highlights

	PLAN AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA
Plan Name	**Gold[80]**
SERVICES AND FEATURES	
Annual Deductible	$0
Out–of–Pocket Limit On Expenses	Individual $6,750 / Family $13,500
LIFETIME MAXIMUMS	No Limit
PROFESSIONAL SERVICES	**Member Cost Share**
Preventive Care/Screening/Immunization	Not Subject to Copay
Primary Care Visit to Treat an Injury or Illness	$30 Copay
Specialist Visit	$55 Copay
Maternity Care - Preconception/Prenatal/Postnatal Care	$0 Copay
Delivery and all Inpatient Services (Hospital Services)	$600 Copay Per Day (Up to First 5 days)
Delivery and all Inpatient Services (Professional Services)	$55 Copay
OUTPATIENT SERVICES	
Laboratory Tests & X-Rays	$35 Copay (Laboratory) / $55 Copay (X-Ray)
Imaging (CT/PET Scans, MRIs)	$275 Copay
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$600 Copay
Physician/Surgeon Fees	$55 Copay
HOSPITALIZATION SERVICES	
Facility Fee (e.g., Hospital Room)	$600 Copay Per Day (Up To First 5 Days)
Physician/Surgeon Fees	$55 Copay
EMERGENCY HEALTH COVERAGE	
Emergency Room Services	$325 Copay
Professional Services	$0 Copay
Urgent Care Center	$30 Copay
PRESCRIPTION DRUG COVERAGE	
Annual Tier 2/Tier 3/Tier 4 Rx Deductible	$0
Tier 1 Drugs (30-Day Supply)	$15 Copay
Tier 2 Drugs (30-Day Supply)	$55 Copay
Tier 3 Drugs (30-Day Supply)	$75 Copay
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)	Included in Plan. See Dental Summary Page.

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