健華計人劃保 CCHP Health Plan

Individual & Family Plans
2017 Plan Benefit Highlights

	PLAN AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA
Plan Name	**Minimum Coverage HMO**
SERVICES AND FEATURES	
Annual Deductible	Individual $7,150 / Family $14,300 (A) Medical / RX (1)
Out–of–Pocket Limit On Expenses	Individual $7,150 / Family $14,300
LIFETIME MAXIMUMS	No Limit
PROFESSIONAL SERVICES	**Member Cost Share**
Preventive Care/Screening/Immunization	$0 Copay
Primary Care Visit to Treat an Injury or Illness	0% Coinsurance (Deductible Applies After 1st (3) Non-Preventive Visits)
Specialist Visit	0% Coinsurance (After Deductible)
Maternity Care - Preconception/Prenatal/Postnatal Care	$0 Copay
Delivery and all Inpatient Services (Hospital Services)	0% Coinsurance (After Deductible)
Delivery and all Inpatient Services (Professional Services)	0% Coinsurance (After Deductible)
OUTPATIENT SERVICES	
Laboratory Tests & X-Rays	0% Coinsurance (After Deductible)
Imaging (CT/PET Scans, MRIs)	0% Coinsurance (After Deductible)
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	0% Coinsurance (After Deductible)
Physician/Surgeon Fees	0% Coinsurance (After Deductible)
HOSPITALIZATION SERVICES	
Facility Fee (e.g., Hospital Room)	0% Coinsurance (After Deductible)
Physician/Surgeon Fees	0% Coinsurance (After Deductible)
EMERGENCY HEALTH COVERAGE	
Emergency Room Services	0% Coinsurance (After Deductible)
Professional Services	0% Coinsurance (After Deductible)
Urgent Care Center	0% Coinsurance (Deductible Applies After 1st (3) Non-Preventive Visits)
PRESCRIPTION DRUG COVERAGE	
Annual Rx Deductible	Individual $7,150 / Family $14,300 (A) Medical / RX (1)
Tier 1 Drugs (30-Day Supply)	0% Coinsurance (After Deductible)
Tier 2 Drugs (30-Day Supply)	0% Coinsurance (After Deductible)
Tier 3 Drugs (30-Day Supply)	0% Coinsurance (After Deductible)
Tier 4 Drugs (30-Day Supply)	0% Coinsurance (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 (After Deductible)
Eyewear (Lenses) (1 Pair Per Calendar Year) (Contact Lenses Provided in Lieu of Glasses)	Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share (After Deductible)
Eyewear (Contact Lenses)	$0 Copay (After Deductible)
Pediatric Dental (Ages 0-18)	Included in Plan. See Dental Summary Page.

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

(1) Medical / RX cost-sharing contributes toward annual 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).