健華計人劃保 CCHP Health Plan

Employer Group Plans
2016 Plan Benefit Highlights

Plan Name	Opal 50
SERVICES AND FEATURES	
Annual Deductible	Individual $2,000 / Family $4,000 [A] Medical / RX [1]
Out–of–Pocket Limit On Expenses	Individual $6,250 / Family $12,500
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 Copay for 1st (3) Non-Preventive PCP Visits (Deductible Does Not Apply) Then $50 Copay (After Deductible)
Specialist Visit	$50 Copay (After Deductible)
Maternity Care - Preconception/Prenatal/Postnatal Care	$0 Copay
Delivery and all Inpatient Services (Hospital Services)	$250 Copay Per Day (Up to First 5 days) (After Deductible)
Delivery and all Inpatient Services (Professional Services)	
OUTPATIENT SERVICES	
Laboratory Tests & X-Rays	$0 Copay (After Deductible)
Imaging (CT/PET Scans, MRIs)	$250 Copay (After Deductible)
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$75 Copay (Chinese Hospital) / $225 Copay (Other Contracted Facilities) (After Deductible)
Physician/Surgeon Fees	
HOSPITALIZATION SERVICES	
Facility Fee (e.g., Hospital Room)	$250 Copay Per Day (Chinese Hospital) / $750 Copay Per Day (Other Contracted Facilities) (Up to First 5 Days) (After Deductible)
Physician/Surgeon Fees	
EMERGENCY HEALTH COVERAGE	
Emergency Room Services	$250 Copay (After Deductible)
Professional Services	
Urgent Care Center	$50 Copay (After Deductible)
PRESCRIPTION DRUG COVERAGE	
Annual Tier 2/Tier 3/Tier 4 Rx Deductible	Individual $2,000 / Family $4,000 [A] Medical / RX [1]
Rx Out-of-Pocket Maximum Expense	Up to $250 (30-Day Supply) Out-of-Pocket Maximum on Tier 4 Rx Per Prescription
Tier 1 Drugs (30-Day Supply)	$15 Copay
Tier 2 Drugs (30-Day Supply)	$50 Copay (After Deductible)
Tier 3 Drugs (30-Day Supply)	$70 Copay (After Deductible)
Tier 4 Drugs (30-Day Supply)	20% 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
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 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).