CCHP Health Plan

Employer Group Plans
2017 Plan Benefit Highlights

Plan Name	Opal 25
SERVICES AND FEATURES	
Annual Deductible	Individual $1,500 / Family $3,000 (A)
Out–of–Pocket Limit On Expenses	Individual $4,000 / Family $8,000
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 $25 Copay (After Deductible)
Specialist Visit	$25 Copay (After Deductible)
Maternity Care - Preconception/Prenatal/Postnatal Care	$0 Copay
Delivery and all Inpatient Services (Hospital Services)	$150 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)	$150 Copay (After Deductible)
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$50 Copay (Chinese Hospital) / $150 Copay (Other Contracted Facilities) (After Deductible)
Physician/Surgeon Fees	
HOSPITALIZATION SERVICES	
Facility Fee (e.g., Hospital Room)	$150 Copay Per Day (Chinese Hospital) / $450 Copay Per Day (Other Contracted Facilities) (Up to First 5 Days) (After Deductible)
Physician/Surgeon Fees	
EMERGENCY HEALTH COVERAGE	
Emergency Room Services	$100 Copay (After Deductible)
Professional Services	
Urgent Care Center	$25 Copay (After Deductible)
PRESCRIPTION DRUG COVERAGE	
Annual Tier 2/Tier 3/Tier 4 Rx Deductible	Individual $250 / Family $500 Tier 2/Tier 3/Tier 4 Rx
Tier 1 Drugs (30-Day Supply)	$15 Copay
Tier 2 Drugs (30-Day Supply)	$50 Copay (After Rx Deductible)
Tier 3 Drugs (30-Day Supply)	$70 Copay (After Rx Deductible)
Tier 4 Drugs (30-Day Supply)	20% Coinsurance Up to $250 Per Prescription (After
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.

(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).