健華
計人
劃保
CCHP
Health Plan

Employer Group Plans
2018 Plan Benefit Highlights

Plan Name	Opal 25 HMO Gold
SERVICES AND FEATURES	
Annual Deductible	Individual $1,500 / Family $3,000
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 First 3 Non-Preventive Visits, 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)	$0 Copay
OUTPATIENT SERVICES	
Laboratory Tests & X-Rays	$0 Copay (Laboratory) / $0 Copay (X-Ray) (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	$0 Copay
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	$0 Copay
EMERGENCY HEALTH COVERAGE	
Emergency Room Services	$100 Copay (After Deductible)
Professional Services	$0 Copay
Urgent Care Center	$25 Copay (After Deductible)
PRESCRIPTION DRUG COVERAGE	
Annual Rx Deductible	Individual $250 / Family $500
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 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 $0 Copay
Eyewear (Contact Lenses)	$0 Copay
Pediatric Dental (Ages 0-18)	Included in Plan. See Dental Summary Page.