

Plan Name	Opal 50 HMO Silver
<b>SERVICES AND FEATURES</b>	
Annual Deductible	Individual \$2,000 / Family \$4,000 Integrated Medical/Rx Deductible
Out-of-Pocket Limit On Expenses	Individual \$6,250 / Family \$12,500
<b>LIFETIME MAXIMUMS</b>	
<b>PROFESSIONAL SERVICES</b>	
<b>Member Cost Share</b>	
Preventive Care/Screening/Immunization	\$0 Copay
Primary Care Visit to Treat an Injury or Illness	\$0 Copay for First 3 Non-Preventive Visits, 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)	\$0 Copay
<b>OUTPATIENT SERVICES</b>	
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 (Other Contracted Facilities) (After Deductible)
Physician/Surgeon Fees	\$0 Copay
<b>HOSPITALIZATION SERVICES</b>	
Facility Fee (e.g., Hospital Room)	\$250 Copay Per Day (Chinese Hospital)/ \$750 Per Day (Other Contracted Facilities) Up to First 5 Days (After Deductible)
Physician/Surgeon Fees	\$0 Copay
<b>EMERGENCY HEALTH COVERAGE</b>	
Emergency Room Services	\$250 Copay (After Deductible)
Professional Services	\$0 Copay
Urgent Care Center	\$50 Copay(After Deductible)
<b>PRESCRIPTION DRUG COVERAGE</b>	
Annual Rx Deductible	Individual \$2,000 / Family \$4,000 Integrated Medical/Rx Deductible
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 up to \$250 per Prescription (After Deductible)
<b>PEDIATRIC VISION AND DENTAL (Included in Plan)</b>	
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.