CCHP Health Plan

Employer Group Plans
2019 Plan Benefit Highlights

Plan Name	Opal 50 HMO Silver
SERVICES AND FEATURES	
Annual Deductible	Individual $3,000/ Family $6,000 (Combined Medical/Drug Deductible)
Out–of–Pocket Limit On Expenses	Individual $7,500/ Family $15,000
LIFETIME MAXIMUMS	None
PROFESSIONAL SERVICES	
Preventive Care/Screening/Immunization	$0 Copay
Primary Care Visit to Treat an Injury or Illness	$0 Copay for 1st (3) PCP 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 the first 5 days) (After Deductible)
Delivery and all Inpatient Services (Professional Services)	$0 Copay
OUTPATIENT SERVICES	
Laboratory Tests & X-Rays	Laboratory: $25 Copay (After Deductible) X-Ray: $40 Copay (After Deductible)
Imaging (CT/PET Scans, MRIs)	$250 Copay (After Deductible)
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$75 (Chinese Hospital) $225 (Other Contracted Facilities) (After Deductible)
Physician/Surgeon Fees	$0 Copay
HOSPITALIZATION SERVICES	
Facility Fee (e.g., Hospital Room)	$250 Copay/ Day (Chinese Hospital) $750 Copay/ Day (Other Contracted Facilities) (Up to First 5 Days) (After Deductible)
Physician/Surgeon Fees	$0 Copay
EMERGENCY HEALTH COVERAGE	
Emergency Room Services	$300 Copay (After Deductible)
Professional Services	$0 Copay
Urgent Care Center	$50 Copay (After Deductible)
PRESCRIPTION DRUG COVERAGE	
Annual Rx Deductible	Individual $3,000/ Family $6,000 (Combined Medical/Drug 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)
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)	**SEE DELTA DENTAL EOC**