

Employer Group Benefit Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

BENEFITS	CCHP Ruby 10	CCHP Ruby 20	CCHP Ruby 40	CCHP Opal 25	CCHP Opal 50
ANNUAL DEDUCTIBLE (PER CALENDAR YEAR)	No Deductible	No Deductible	No Deductible	\$1,500 / \$3,000	\$2,500 / \$5,000
ANNUAL OUT OF POCKET MAXIMUM Individual/Family per Calendar Year	\$2,000 / \$4,000	\$2,500 / \$5,000	\$3,000 / \$6,000	\$3,000 / \$6,000	\$4,000 / \$6,000
LIFETIME BENEFIT MAXIMUM	No Limit	No Limit	No Limit	No Limit	No Limit
PROFESSIONAL PREVENTIVE CARE SERVICES Preventive Services - Children	No Charge	No Charge	No Charge	No Charge	No Charge
Preventive Services - Women					
Preventive Services - All Adults					
PROFESSIONAL SERVICES Primary Care Provider (PCP) and Specialty Care Visits	\$10 copay / visit	\$20 copay / visit	\$40 copay / visit	First (3) PCP visits / year at no charge; Additional visits at \$25 copay after deductible	First (3) PCP visits / year at no charge; Additional visits at \$50 copay after deductible
Maternity Care	No Charge	No Charge	No Charge	After Deductible No Charge	After Deductible No Charge
Immunizations	No Charge	No Charge	No Charge	No Charge	No Charge
Allergy Testing, Diagnosis & Treatment	\$10 copay / visit	\$20 copay / visit	\$40 copay / visit	After Deductible \$25 copay / visit	After Deductible \$50 copay / visit
Vision Exam/Screening					
Hearing Exam/Screening					
Acupuncture					
Infertility Services (Does not apply to annual out of pocket maximum)	50% of covered charged	50% of covered charges	50% of covered charges	50% of covered charges	50% of covered charges
OUTPATIENT SERVICES Routine Lab Tests & X-Ray Diagnosis	No Charge	No Charge	No Charge	After Deductible No Charge	After Deductible No Charge
Diagnostic Services (e.g. CT, PET, MRI - see Evidence of Coverage for details)	\$100 copay	\$100 copay	\$100 copay	\$100 copay	\$100 copay
Physical Therapy, Outpatient Rehabilitation, Speech, and/or Occupational Therapy	\$10 copay / visit	\$20 copay / visit	\$40 copay / visit	\$25 copay / visit	\$25 copay / visit
HOSPITALIZATION SERVICES Inpatient Hospital Stays at Chinese Hospital	\$100 copay / day (Limit of \$400)	\$150 copay / day (Limit of \$600)	\$200 copay / day (Limit of \$800)	After Deductible \$150 copay / day	After Deductible \$200 copay / day
Inpatient Hospital Stays at other contracted facilities	\$200 copay / day (Limit of \$800)	\$250 copay / day (Limit of \$1,000)	\$300 copay / day (Limit of \$1,200)	\$250 copay / day	\$300 copay / day
Outpatient Services at Chinese Hospital facility	\$50 copay / visit	\$50 copay / visit	\$75 copay / visit	\$50 copay / visit	\$75 copay / visit
Outpatient Services at other contracted facilities & ambulatory surgical centers	\$75 copay / visit	\$75 copay / visit	\$100 copay / visit	\$75 copay / visit	\$100 copay / visit
Skilled Nursing Care	First 10 days at no charge; then \$100 copay / day	First 10 days at no charge; then \$100 copay / day	First 10 days at no charge; then \$100 copay / day	First 10 days at no charge after deductible; then \$100 copay / day	First 10 days at no charge after deductible; then \$100 copay / day
EMERGENCY SERVICES Emergency Room Services (copay waived if admitted)	\$100 copay / visit	\$100 copay / visit	\$100 copay / visit	After Deductible \$100 copay / visit	After Deductible \$100 copay / visit
Ambulance (Medical Transportation)	\$100 copay / trip	\$100 copay / trip	\$100 copay / trip	\$100 copay / trip	\$100 copay / trip
HOME HEALTH & HOSPICE SERVICES Home Health Services	No Charge	No Charge	No Charge	After Deductible	After Deductible
Hospice Care (refer to the Evidence of Coverage for more information)				No Charge	No Charge
MENTAL HEALTH & CHEMICAL DEPENDENCY Inpatient Mental Health Services	\$100 copay / day (Limit of \$400)	\$100 copay / day (Limit of \$400)	\$100 copay / day (Limit of \$400)	After Deductible	After Deductible
Inpatient Chemical Dependency - Detoxification Only				\$150 copay / day	\$200 copay / day
Outpatient Care (Individual/Group Treatment)				\$10 copay/\$5 copay	\$20 copay/\$10 copay
DURABLE MEDICAL EQUIPMENT Inpatient	No Charge	No Charge	No Charge	After Deductible No Charge	After Deductible No Charge
Outpatient (Maximum annual benefit of \$2,000)	50% of cost	50% of cost	50% of cost	50% of cost	50% of cost
PROSTHETICS Inpatient	No Charge	No Charge	No Charge	After Deductible No Charge	After Deductible No Charge
Outpatient	\$10 copay / item	\$20 copay / item	\$40 copay / item	\$25 copay / item	\$50 copay / item
PRESCRIPTION DRUG COVERAGE Annual Brand Name Drug Deductible	\$250 copay / person	\$250 copay / person	\$250 copay / person	\$250 copay / person	\$250 copay / person
Generic Drugs (up to 30 days supply)	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay
Brand-name Drugs on Formulary (up to 30 days supply)	After Deductible \$30 copay	After Deductible \$30 copay	After Deductible \$30 copay	After Deductible \$30 copay	After Deductible \$30 copay
Prescription Drugs filled at Chinese Hospital Pharmacy (up to 90 days supply)	Generic: \$20 copay	Generic: \$20 copay	Generic: \$20 copay	Generic: \$20 copay	Generic: \$20 copay
Mail Order (up to 90 days supply)	After Deductible Brand-name Drugs: \$60 copay	After Deductible Brand-name Drugs: \$60 copay	After Deductible Brand-name Drugs: \$60 copay	After Deductible Brand-name Drugs: \$60 copay	After Deductible Brand-name Drugs: \$60 copay

公司團體計劃保障簡介

本簡介只是幫助閣下對保障的內容及細則作為參考，詳細的保障內容及限制，請參閱保障說明書及計劃合約。

保障簡要	CCHP Ruby 10	CCHP Ruby 20	CCHP Ruby 40	CCHP Opal 25	CCHP Opal 50
每曆年度累積扣除額 (個人 / 家庭)	沒有	沒有	沒有	\$1,500 / \$3,000	\$2,500 / \$5,000
每曆年度累積自付費 (個人 / 家庭)	\$2,000 / \$4,000	\$2,500 / \$5,000	\$3,000 / \$6,000	\$3,000 / \$6,000	\$4,000 / \$6,000
一生累積保額限制	沒有限制	沒有限制	沒有限制	沒有限制	沒有限制
身體檢查					
預防性檢查-兒童					
預防性檢查-女仕	不收費	不收費	不收費	不收費	不收費
預防性檢查-成人					
專業服務					
家庭科及專科醫務所診症	每次\$10	每次\$20	每次\$40	首3次家庭醫生診症:免費 當扣除額達到後: 每次\$25	首3次家庭醫生診症:免費 當扣除額達到後: 每次\$50
婦產科檢查	不收費	不收費	不收費	當扣除額達到後: 不收費	當扣除額達到後: 不收費
免疫注射	不收費	不收費	不收費	不收費	不收費
過敏症測試診斷及注射					
視覺檢查	每次\$10	每次\$20	每次\$40	當扣除額達到後:每 次\$25	當扣除額達到後:每 次\$50
聽覺檢查					
針灸					
不育症治療	醫療費之 50%	醫療費之 50%	醫療費之 50%	醫療費之 50%	醫療費之 50%
門診服務				當扣除額達到後	當扣除額達到後
化驗, X - 光	不收費	不收費	不收費	不收費	不收費
MRI磁共振 / CT掃描 / PET掃描	每次\$100	每次\$100	每次\$100	每次\$100	每次\$100
物理, 言語機能, 職業療法	每次\$10	每次\$20	每次\$40	每次\$25	每次\$25
醫院服務				當扣除額達到後	當扣除額達到後
住院留醫 - 東華醫院	每日\$100 (最高每次入院 \$400)	每日\$150 (最高每次入院 \$600)	每日\$200 (最高每次入院 \$800)	每日\$150	每日\$200
住院留醫 - 其他合約醫院	每日\$200 (最高每次入院 \$800)	每日\$250 (最高每次入院 \$1000)	每日\$300 (最高每次入院 \$1200)	每日\$250	每日\$300
門診服務 - 東華醫院	每次\$50	每次\$50	每次\$75	每次\$50	每次\$75
門診服務 - 其他合約醫院及急辦術室	每次\$75	每次\$75	每次\$100	每次\$75	每次\$100
特技專業護理院	第1-10天: 不收費 第11天起: 每日\$100	第1-10天: 不收費 第11天起: 每日\$100	第1-10天: 不收費 第11天起: 每日\$100	第1-10天: 不收費 第11天起: 每日\$100	第1-10天: 不收費 第11天起: 每日\$100
急症服務				當扣除額達到後	當扣除額達到後
急症室 (隨即住院留醫, 可豁免急症室自付費)	每次\$100	每次\$100	每次\$100	每次\$100	每次\$100
救護車服務	每程\$100	每程\$100	每程\$100	每程\$100	每程\$100
家居醫療護理及善終服務				當扣除額達到後	當扣除額達到後
家居醫療護理					
善終服務	不收費	不收費	不收費	不收費	不收費
精神科護理及解除毒素				當扣除額達到後	當扣除額達到後
精神科住院服務	每日\$100 (最高每次入院 \$400)	每日\$150 (最高每次入院 \$600)	每日\$200 (最高每次入院 \$800)	每日\$150	每日\$200
住院解除毒素					
門診 (個別治療 / 小組治療)	每次\$10/\$5	每次\$20/\$10	每次\$40/\$20	每次\$25/\$12.50	每次\$50/\$25
耐用醫療器材				當扣除額達到後	當扣除額達到後
住院期間	不收費	不收費	不收費	不收費	不收費
門診	醫療費之 50%	醫療費之 50%	醫療費之 50%	醫療費之 50%	醫療費之 50%
義肢				當扣除額達到後	當扣除額達到後
住院期間	不收費	不收費	不收費	不收費	不收費
門診	每項\$10	每項\$20	每項\$40	每項\$25	每項\$50
處方藥物保障 (按CCHP藥物目錄)					
曆年度累積商標藥扣除額	每人\$250	每人\$250	每人\$250	每人\$250	每人\$250
非商標藥 (最高可配至30日藥量)	\$10	\$10	\$10	\$10	\$10
商標藥 (最高可配至30日藥量)	扣除額達到後 \$30	扣除額達到後 \$30	扣除額達到後 \$30	扣除額達到後 \$30	扣除額達到後 \$30
在東華醫院藥房配購的處方藥物 (最高可配至90日藥量)	非商標藥: \$20	非商標藥: \$20	非商標藥: \$20	非商標藥: \$20	非商標藥: \$20
郵購處方藥物 (最高可配至90日藥量)	扣除額達到後 商標藥: \$60	扣除額達到後 商標藥: \$60	扣除額達到後 商標藥: \$60	扣除額達到後 商標藥: \$60	扣除額達到後 商標藥: \$60