

Individual/Family Plan 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	Copay 25	Active Choice
ANNUAL DEDUCTIBLE: Individual/Family	No Deductible	\$3,000 / \$5,000
ANNUAL OUT OF POCKET MAXIMUM: Individual/Family	\$3,500 / \$7,000	\$4,000 / \$6,000
LIFETIME MAXIMUM	No Limit	No Limit
PROFESSIONAL SERVICES		After Deductible
Primary and specialty care visits	\$25 copay per visit	\$30 copay per visit
Maternity / Prenatal Care	\$25 copay per visit	No Charge
Eye examinations	\$25 copay per visit	\$30 copay per visit
Hearing examinations	\$25 copay per visit	\$30 copay per visit
Physical Examinations:		Not Subject to Deductible
Preventive Services - Children	No Charge	No Charge
Preventive Services - Women	No Charge	No Charge
Preventive Services - All Adults	No Charge	No Charge
Immunizations	No Charge	No Charge
OUTPATIENT SERVICES		After Deductible
Lab test, X-rays	No Charge	\$10 copay per visit
MRI/CT/PET	No Charge	\$50 copay per visit
Allergy testing and serum	50% of cost	50% of cost
Allergy diagnosis and injection	50% of cost	\$30 per visit
Physical, speech, & occupational therapy	\$25 copay per visit	\$30 copay per visit
Outpatient surgery (Facility Charge)	\$100 copay per visit	\$250 copay per visit
HOSPITALIZATION SERVICES		After Deductible
Inpatient hospital services	\$250 copay per day (Limit of \$1,000 per admission)	\$500 copay per day
Skilled nursing facility care	No charge	\$50 copay per day
EMERGENCY SERVICES		After Deductible
EMERGENCY ROOM (waived if admitted to the hospital)	\$100 copay per visit	\$100 copay per visit
AMBULANCE	\$100 copay per trip	\$100 copay per trip
DURABLE MEDICAL EQUIPMENT		Not Subject To Deductible
Inpatient	No Charge	No Charge
Outpatient (not applicable to OOP Max)	50% of cost (Maximum annual benefit of \$2,000)	50% of cost (Maximum annual benefit of \$500)
PROSTHETICS		Not Subject To Deductible
Inpatient	No Charge	No Charge
Outpatient	\$25 per item	\$30 per item
MENTAL HEALTH & CHEMICAL DEPENDENCY		After Deductible
Outpatient Care	\$25 copay per visit	\$30 copay per visit
Inpatient Mental Health Services Inpatient Chemical Dependency - Detox Only	\$250 per Day (Limit of \$1,000 per admission)	\$500 copay per day
HOME HEALTH SERVICES	No Charge	No Charge
PRESCRIPTION DRUG COVERAGE (on CCHP formulary)		
Generic Drugs (up to a 30 days supply)	\$10 copay	\$10 copay
Brand-name Drugs* (up to a 30 days supply) (*\$250 Calendar Year Brand Name Drug Deductible)	\$30 copay	\$30 copay

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	Copay 25	Active Choice
年度累積扣除額 (個人 / 家庭)	沒有	\$3,000 / \$5,000
年度累積自付費 (個人 / 家庭)	\$3,500 / \$7,000	\$4,000 / \$6,000
一生累積保額限制	沒有限制	沒有限制
專業服務		扣除額達到後
家庭科及專科醫務所診症	每次\$25	每次\$30
婦產科檢查	每次\$25	不收費
視覺檢查	每次\$25	每次\$30
聽覺檢查	每次\$25	每次\$30
身體檢查		不計入扣除額
預防性檢查-兒童	不收費	不收費
預防性檢查-女仕	不收費	不收費
預防性檢查-成人	不收費	不收費
免疫注射	不收費	不收費
門診服務		扣除額達到後
化驗, X - 光	不收費	每次\$10
MRI磁共振 / CT掃描 / PET掃描	不收費	每次\$50
過敏症測試及血清	醫療費之 50%	醫療費之 50%
過敏症診斷及注射	醫療費之 50%	每次\$30
物理, 言語機能, 職業療法	每次\$25	每次\$30
門診手術 (手術室)	每次\$100	每次\$250
醫院服務		扣除額達到後
住院留醫	每日\$250 (最高每次入院 \$1,000)	每日\$500
特技專業護理院	不收費	每日\$50
急症服務		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
救護車服務	每程\$100	每程\$100
耐用醫療器材		不計入扣除額
住院期間	不收費	不收費
門診 (不計入每歷年度累積自付費)	醫療費之 50% (每年最高保障額為\$2,000)	醫療費之 50% (每年最高保障額為\$500)
義肢		不計入扣除額
住院期間	不收費	不收費
門診	每項\$25	每項\$30
精神科護理及解除毒素		扣除額達到後
門診	每次\$25	每次\$30
精神科住院服務 住院解除毒素	每日\$250 (最高每次\$1,000)	每日\$500
家居醫療護理	不收費	不收費
處方藥物保障 (按CCHP藥物目錄)		
非商標藥 (最高可配至30日藥量)	\$10	\$10
商標藥* (最高可配至30日藥量) *每年有\$250扣除額	\$30	\$30