# Individual & Family Plans | 2017 Plan Benefit Highlights

FOR A COMPLETE LIST OF BENEFITS UNDER EACH PLAN, REFER TO THE HEALTH PLAN BENEFITS AND COVERAGE MATRIX.
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| | | | | | | *PLANS AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA* | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Plan Name** | **Jade** | **Copay 25** | **Amber** | ***ActiveChoice* PPO** | | **Platinum$^{90}$ HMO** | **Gold$^{80}$ HMO** | **Silver$^{70}$ HMO** | **Bronze$^{60}$ HMO** | **Minimum Coverage HMO** |
| | | | | **(In-Network)** | **(Out-of-Network)** | | | | | |
| **Metal Level / Actuarial Benefit Value %*** | Platinum / 91.65% | Platinum / 90.92% | Silver / 71.1% | Silver / 70.8% | | Platinum / 90.3% | Gold / 81.2% | Silver / 71.5% | Bronze / 61.9% | N/A |
| **SERVICES AND FEATURES** | | | | | | | | | | |
| Annual Deductible | $0 | $0 | Individual $2,500 / Family $5,000 (A) | Individual $2,000 / Family $4,000 (A) Medical / Rx (1) | | $0 | $0 | Individual $2,500 / Family $5,000 (A) | Individual $6,300 / Family $12,600(A) | Individual $7,150 / Family $$14,300 (A) Medical / Rx (1) |
| Out–of–Pocket Limit On Expenses | Individual $4,000 / Family $8,000 | Individual $4,000 / Family $8,000 | Individual $6,250 / Family $12,500 | Individual $6,250 / Family $12,500 | | Individual $4,000 / Family $8,000 | Individual $6,750 / Family $13,500 | Individual $6,800 / Family $13,600 | Individual $6,800 / Family $13,600 | Individual $7,150 / Family $14,300 |
| **LIFETIME MAXIMUMS** | No Limit | | | | | No Limit | | | | |
| **PROFESSIONAL SERVICES** | **Member Cost Share** | | | | | **Member Cost Share** | | | | |
| Preventive Care/ Screening/Immunization | Not Subject to Copay | | | | | Not Subject to Copay | | | | |
| Primary Care Visit to Treat an Injury or Illness | $30 Copay | $25 Copay | $0 Copay for 1st (3) Non-Preventive PCP Visits (Deductible Does Not Apply) Then $50 Copay (After Deductible) | $0 Copay for 1st (3) Non-Preventive PCP Visits (Deductible Does Not Apply) Then $50 Copay (After Deductible) | 50% Coinsurance (After Deductible) | $15 Copay | $30 Copay | $35 Copay | $75 Copay (Deductible Applies After 1st (3) Non-Preventive Visits) | 0% Coinsurance (Deductible Applies After 1st (3) Non-Preventive Visits) |
| Specialist Visit | $35 Copay | $25 Copay | $50 Copay (After Deductible) | $50 Copay (After Deductible) | 50% Coinsurance (After Deductible) | $40 Copay | $55 Copay | $70 Copay | $105 Copay (Deductible Applies After 1st (3) Non-Preventive Visits) | 0% Coinsurance (After Deductible) |
| Maternity Care - Preconception/ Prenatal/Postnatal Care | $0 Copay | $0 Copay | $0 Copay | $0 Copay | | $0 Copay | $0 Copay | $0 Copay | $0 Copay | 0% Coinsurance |
| Delivery and all Inpatient Services (Hospital Services) | $200 Copay Per Day (Up To First 5 Days) | $600 Copay Per Day (Up To First 5 Days) | $500 Copay Per Day (Up To First 5 Days) (After Deductible) | 20% Coinsurance (Up to First 5 Days) (After Deductible | 50% Coinsurance (Up to First 5 Days) (After Deductible | $250 Copay Per Day (Up To First 5 Days) | $600 Copay Per Day (Up To First 5 Days) | 20% Coinsurance (After Deductible) | Full Cost Until Out-of-Pocket is Met | 0% Coinsurance (After Deductible) |
| Delivery and all Inpatient Services (Professional Services) | | | | | | $40 Copay | $55 Copay | | | |
| **OUTPATIENT SERVICES** | | | | | | | | | | |
| Laboratory Tests & X-Rays | $0 Copay | $0 Copay | $0 Copay (After Deductible) | $0 Copay (After Deductible) | 50% Coinsurance (After Deductible) | $20 Copay (Laboratory) / $40 Copay (X-Ray) | $35 Copay (Laboratory) / $55 Copay (X-Ray) | $35 Copay (Laboratory) / $70 Copay (X-Ray) | $40 Copay (Laboratory)/ Full Cost Until Out-of-Pocket is Met (X-Ray) | 0% Coinsurance (After Deductible) |
| Imaging (CT/PET Scans, MRIs) | $100 Copay | $300 Copay | $300 Copay (After Deductible) | $200 Copay (After Deductible) | 50% Coinsurance (After Deductible) | $150 Copay | $275 Copay | $300 Copay | Full Cost Until Out-of-Pocket is Met | 0% Coinsurance (After Deductible) |
| Surgery - Facility Fee (e.g., Ambulatory Surgery Center) | $200 Copay (Chinese Hospital) / $600 Copay (Other Contracted Facilities) | $250 Copay | $400 Copay (Chinese Hospital) / $1,200 Copay (Other Contracted Facilities) (After Deductible) | 20% Coinsurance (Chinese Hospital) / 40% Coinsurance (Other Contracted Facilities) (After Deductible) | 50% Coinsurance (After Deductible) | $250 Copay | $600 Copay | 20% Coinsurance | Full Cost Until Out-of-Pocket is Met | 0% Coinsurance (After Deductible) |
| Physician/Surgeon Fees | | | | | | $40 Copay | $55 Copay | | | |

**Footnotes:** * Actuarial Value is the percentage of total average costs for covered benefits that a plan will cover.
Preventive care are not subject to the deductible.
(1) Medical / RX cost-sharing contributes toward annual deductible.
(A) You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use, unless the service is not subject to the deductible. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st).

| Plan Name | Jade | Copay 25 | Amber | *ActiveChoice* PPO | | PLANS AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | (In-Network) | (Out-of-Network) | Platinum$^{90}$ HMO | Gold$^{80}$ HMO | Silver$^{70}$ HMO | Bronze$^{60}$ HMO | Minimum Coverage HMO |
| **HOSPITALIZATION SERVICES** | **Member Cost Share** | | | | | **Member Cost Share** | | | | |
| Facility Fee (e.g., Hospital Room) | $200 Copay Per Day (Chinese Hospital) / $600 Copay Per Day (Other Contracted Facilities) (Up To First 5 Days) | $600 Copay Per Day (Up To First 5 Days) | $500 Copay Per Day (Chinese Hospital) / $1,500 Copay Per Day (Other Contracted Facilities) (Up To First 5 Days) (After Deductible) | 20% Coinsurance (Chinese Hospital) / 40% Coinsurance (Other Contracted Facilities) (Up to First 5 Days) (After Deductible) | 50% Coinsurance (Up To First 5 Days) (After Deductible) | $250 Copay Per Day (Up To First 5 Days) | $600 Copay Per Day (Up To First 5 Days) | 20% Coinsurance (After Deductible) | Full Cost Until Out-of-Pocket is Met | 0% Coinsurance (After Deductible) |
| Physician/Surgeon Fees | | | | | | $40 Copay | $55 Copay | | | |
| **EMERGENCY HEALTH COVERAGE** | | | | | | | | | | |
| Emergency Room Services | $100 Copay | $250 Copay | $250 Copay (After Deductible) | $200 Copay (After Deductible) | | $150 Copay | $325 Copay | $350 Copay | Full Cost Until Out-of-Pocket is Met | 0% Coinsurance (After Deductible) |
| Professional Services | | | | | | | | | | |
| Urgent Care Center | $30 Copay | $25 Copay | $50 Copay (After Deductible) | $50 Copay (After Deductible) | | $15 Copay | $30 Copay | $35 Copay | $75 Copay (Deductible Applies After 1st (3) Non-Preventive Visits) | 0% Coinsurance (Deductible Applies After 1st (3) Non-Preventive Visits) |
| **PRESCRIPTION DRUG COVERAGE** | | | | | | | | | | |
| Annual Rx Deductible | $0 | $0 | Individual $250 Tier 2/Tier 3/ Tier 4 Rx | Individual $2,000 / Family $4,000 [A] Medical / Rx [1] | | $0 | $0 | Individual $250 / Family $500 Tier 2/Tier 3/ Tier 4 Rx | Individual $500 / Family $1,000 All Tiers Rx [A] | Individual $7,150 / Family $$14,300 [A] Medical / Rx [1] |
| Tier 1 Drugs (30-Day Supply) | $5 Copay | $5 Copay | $15 Copay | $15 Copay | Not Covered | $5 Copay | $15 Copay | $15 Copay | Full Cost up to $500 Until Out-of-Pocket is Met per Prescription (After Rx Deductible) | 0% Coinsurance (After Deductible) |
| Tier 2 Drugs (30-Day Supply) | $15 Copay | $15 Copay | $50 Copay (After Rx Deductible) | $50 Copay (After Deductible) | Not Covered | $15 Copay | $55 Copay | $55 Copay (After Rx Deductible) | Full Cost up to $500 Until Out-of-Pocket is Met per Prescription (After Rx Deductible) | 0% Coinsurance (After Deductible) |
| Tier 3 Drugs (30-Day Supply) | $25 Copay | $25 Copay | $70 Copay (After Rx Deductible) | $70 Copay (After Deductible) | Not Covered | $25 Copay | $75 Copay | $80 Copay (After Rx Deductible) | Full Cost up to $500 Until Out-of-Pocket is Met (After Rx Deductible) | 0% Coinsurance (After Deductible) |
| Tier 4 Drugs (30-Day Supply) | 10% Coinsurance up to $250 per script | 10% Coinsurance up to $250 per script | 20% Coinsurance up to $250 per script (After Rx Deductible) | 20% Coinsurance up to $250 per script (After Deductible) | Not Covered | 10% Coinsurance up to $250 per Prescription | 20% Coinsurance up to $250 per Prescription | 20% Coinsurance up to $250 per Prescription (After Rx Deductible) | Full Cost up to $500 Until Out-of-Pocket is Met per Prescription (After Rx Deductible) | 0% Coinsurance (After Deductible) |
| **PEDIATRIC VISION AND DENTAL** (Included in Plan) | | | | | | | | | | |
| Child Needs Eye Care (Ages 0-18) | | | | | | | | | | |
| Eye Exam (1 Per Calendar Year) | $0 Copay | $0 Copay | $0 Copay | $0 Copay | Not Covered | $0 Copay | $0 Copay | $0 Copay | $0 Copay | $0 Copay |
| Eyewear (Frames) (1 Pair Per Calendar Year) | $0 Copay | $0 Copay | $0 Copay | $0 Copay | Not Covered | $0 Copay | $0 Copay | $0 Copay | $0 Copay | $0 Copay (After Deductible) |
| Eyewear (Lenses) (1 Pair Per Calendar Year) (Contact Lenses Provided in Lieu of Glasses) | Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share | Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share | Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share | Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share | Not Covered | Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share | Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share | Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share | Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share | Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share (After Deductible) |
| Eyewear (Contact Lenses) | $0 Copay | $0 Copay | $0 Copay | $0 Copay | Not Covered | $0 Copay | $0 Copay | $0 Copay | $0 Copay | $0 Copay (After Deductible) |
| Pediatric Dental (Ages 0-18) | Included in Plan. See Dental Summary Page. | | | | | Included in Plan. See Dental Summary Page. | | | | |