Individual & Family Plans | 2018 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 15 HMO Platinum**	**Silver 70 Off Exchange HMO**	**Amber 50 HMO Silver**	***ActiveChoice* PPO Silver**		**Platinum 90 HMO**	**Gold 80 HMO**	**Silver 70 HMO**	**Bronze 60 HMO**	**Bronze 60 HDHP HMO**	**Minimum Coverage HMO**
				(In-Network)	**(Out-of-Network)**						
Metal Level / Actuarial Benefit Value %*	Platinum / 91.7%	Silver / 71.5%	Silver / 69.73%	Silver / 70.72%		Platinum / 88.1%	Gold / 78.4%	Silver / 71.5%	Bronze / 60.8%	Bronze / 61.4%	N/A
SERVICES AND FEATURES											
Annual Deductible	$0	Individual $2,500 / Family $5,000 (A)	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 $4,800/ Family $9,600 (A) Medical/ Rx(1)	Individual $7,350 / Family $$14,700 (A) Medical / Rx (1)
Out–of–Pocket Limit On Expenses	Individual $3,250/ Family $6,500	Individual $7,000 / Family $14,000	Individual $6,250 / Family $12,500	Individual $6,250 / Family $12,500		Individual $3,350 / Family $6,700	Individual $6,000/ Family $12,000	Individual $7,000/ Family $14,000	Individual $7,000/ Family $14,000	Individual $6,550/ Family $13,100	Individual $7,350 / Family $14,700
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	$15 Copay	$35 Copay	$0 Copay for 1st (3) PCP Visits (Deductible does not apply), Then $50 Copay (After Deductible)	$0 Copay for 1st (3) PCP Visits (Deductible does not apply), Then $50 Copay (After Deductible)	50% Coinsurance (After Deductible)	$15 Copay	$25 Copay	$35 Copay	$75 Copay (Deductible Applies After 1st (3) Non-Preventive Visits)	40% Coinsurance (After Deductible)	After 1st (3) Non-Preventive Visits, Full Cost Until Out-of-Pocket is Met
Specialist Visit	$30 Copay	$75 Copay	$50 Copay (After Deductible)	$50 Copay (After Deductible)	50% Coinsurance (After Deductible)	$30 Copay	$55 Copay	$75 Copay	$105 Copay (Deductible Applies After 1st (3) Non-Preventive Visits)	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
Maternity Care - Preconception/ Prenatal/Postnatal Care	$0 Copay	$0 Copay	$0 Copay	$0 Copay		$0 Copay	$0 Copay	$0 Copay	$0 Copay	No Charge	No Charge
Delivery and all Inpatient Services (Hospital Services)	$150 Copay Per Day (Up To First 5 Days)	20% Coinsurance (After Deductible)	$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 per day (Up to First 5 Days)	$600 per day (Up to First 5 Days)	20% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
Delivery and all Inpatient Services (Professional Services)	$0 Copay	20% Coinsurance (After Deductible)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	20% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
OUTPATIENT SERVICES											
Laboratory Tests & X-Rays	$0 Copay	$35 Copay (Laboratory) / $75 Copay (X-Ray)	$0 Copay (After Deductible)	$0 Copay (After Deductible)	50% Coinsurance (After Deductible)	$15 Copay (Laboratory) / $30 Copay (X-Ray)	$35 Copay (Laboratory) / $55 Copay (X-Ray)	$35 Copay (Laboratory) / $75 Copay (X-Ray)	$40 Copay (Laboratory)/ Full Cost Until Out-of-Pocket is Met (X-Ray)	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
Imaging (CT/PET Scans, MRIs)	$100 Copay	$300 Copay	$300 Copay (After Deductible)	$200 Copay (After Deductible)	50% Coinsurance (After Deductible)	$75 Copay	$275 Copay	$300 Copay	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$250 Copay	20% Coinsurance	$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)	$100 Copay	$300 Copay	20% Coinsurance	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
Physician/Surgeon Fees	$0 Copay	20% Coinsurance	$0 Copay	$0 Copay	$0 Copay	$25 Copay	$40 Copay	20% Coinsurance	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met

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 15 HMO Platinum	Silver 70 Off Exchange HMO	Amber 50 HMO Silver	*ActiveChoice* PPO Silver (In-Network)	*ActiveChoice* PPO Silver (Out-of-Network)	Platinum 90 HMO	Gold 80 HMO	Silver 70 HMO	Bronze 60 HMO	Bronze 60 HDHP HMO	Minimum Coverage HMO
						PLANS AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA					
HOSPITALIZATION SERVICES	**Member Cost Share**					**Member Cost Share**					
Facility Fee (e.g., Hospital Room)	$150 Copay Per Day (Chinese Hospital) $450 Copay Per Day (Other Contracted Facilities) (Up To First 5 Days)	20% Coinsurance (After Deductible)	$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 Per Day (Up To First 5 Days)	$600 Per Day (Up To First 5 Days)	20% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
Physician/Surgeon Fees	$0 Copay	20% Coinsurance (After Deductible)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	20% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
EMERGENCY HEALTH COVERAGE											
Emergency Room Services	$100 Copay	$350 Copay	$250 Copay (After Deductible)	$200 Copay (After Deductible)		$150 Copay	$325 Copay	$350 Copay	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
Professional Services	$0 Copay	$0 Copay	$0 Copay	$0 Copay		$0 Copay	$0 Copay	$0 Copay	No Charge	No Charge	No Charge
Urgent Care Center	$50 Copay	$35 Copay	$50 Copay (After Deductible)	$50 Copay (After Deductible)		$15 Copay	$25 Copay	$35 Copay	$75 Copay (Deductible Applies After 1st (3) Non-Preventive Visits)	40% Coinsurance (After Deductible)	After 1st (3) Non-Preventive Visits, Full Cost Until Out-of-Pocket is Met
PRESCRIPTION DRUG COVERAGE											
Annual Rx Deductible	$0	Individual $130/ Family $260	Individual $250/ Family $500	Individual $2,000 / Family $4,000 (A) Medical / Rx (1)		$0	$0	Individual $130/ Family $260	Individual $500 / Family $1,000 All Tiers Rx (A)	Individual $4,800/ Family $9,600 (A) Medical/ Rx(1)	Individual $7,150 / Family $$14,300 (A) Medical / Rx (1)
Tier 1 Drugs (30-Day Supply)	$5 Copay	$15 Copay (After Rx Deductible)	$15 Copay	$15 Copay	Not Covered	$5 Copay	$ 15 Copay	$15 Copay (After Rx Deductible)	Full Cost up to $500 Until Out-of-Pocket is Met per Prescription (After Rx Deductible)	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
Tier 2 Drugs (30-Day Supply)	$ 15 Copay	$55 Copay (After Rx Deductible)	$ 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)	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
Tier 3 Drugs (30-Day Supply)	$25 Copay	$80 Copay (After Rx Deductible)	$ 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)	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
Tier 4 Drugs (30-Day Supply)	10% Coinsurance Up to $250 Per Prescription	20% Coinsurance up to $250 per Prescription (After Rx Deductible)	20% Coinsurance Up to $250 Per Prescription (After Rx Deductible)	20% Coinsurance Up to $250 Per Prescription (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)	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met
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	$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	Full Cost Until Out-of-Pocket is Met
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	Single Vision / Bi-focal / Tri-focal / Lenticular Full Cost Until Out-of-Pocket is Met
Eyewear (Contact Lenses)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	Not Covered	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	Full Cost Until Out-of-Pocket is Met
Pediatric Dental (Ages 0-18)	Included in Plan. See Dental Summary Page					Included in Plan. See Dental Summary Page					