Individual & Family Plans | 2021 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 Platinum HMO**	**Silver 70 Off-Exchange HMO**	**Amber 50 Silver HMO**	***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 / 90.76%	Silver / 70.45%	Silver / 66.99%	Silver / 67.73 %		Platinum / 89.30%	Gold / 78.00%	Silver / 70.80 %	Bronze / 64.60%	Bronze / 62.60%	N/A
SERVICES AND FEATURES											
Annual Deductible	$0	Individual $4,000 / Family $8,000 (A)	Individual $2,750 / Family $5,500 (A)	Individual $2,500 / Family $5,000 (A) Medical/ Rx(1)		$0	$0	Individual $4,000 / Family $8,000 (A)	Individual $6,300 / Family $12,600(A)	Individual $7,000/ Family $14,000 (A) Medical/ Rx(1)	Individual $8,550 / Family $17,100 (A) Medical / Rx (1)
Out–of–Pocket Limit on Expenses	Individual $3,000/ Family $6,000	Individual $8,200 / Family $16,400	Individual $7,500 / Family $15,000	Individual $7,500 / Family $15,000		Individual $4,500 / Family $9,000	Individual $8,200/ Family $16,400	Individual $8,200/ Family $16,400	Individual $8,200/ Family $16,400	Individual $7,000/ Family $14,000	Individual $8,550 / Family $17,100
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	$40 Copay	$0 Copay for First (3) PCP Visits (Deductible does not apply), Then $50 Copay (After Deductible)	$0 Copay for First (3) PCP Visits (Deductible does not apply), Then $50 Copay (After Deductible)	50% Coinsurance (After Deductible)	$15 Copay	$35 Copay	$40 Copay	$65 Copay (Deductible Applies After First (3) Non-Preventive Visits)	Full Cost Until Out-of-Pocket is Met	$0 Copay for First (3) Non-Preventive Visits, then Full Cost Until Out-of-Pocket is Met
Specialist Visit	$30 Copay	$80 Copay	$50 Copay (After Deductible)	$50 Copay (After Deductible)	50% Coinsurance (After Deductible)	$30 Copay	$65 Copay	$80 Copay	$95 Copay (Deductible Applies After First (3) Non-Preventive Visits)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
Prenatal and Preconception Visits	$0 Copay	$0 Copay	$0 Copay	$0 Copay	50% Coinsurance (After Deductible)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
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 (After Deductible)	$250 Per day (Up to First 5 Days)	$600 Per day (Up to First 5 Days)	20% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
Delivery and All Inpatient Services (Professional Services)	$0 Copay	20% Coinsurance	$0 Copay	$0 Copay	50% Coinsurance (After Deductible)	$0 Copay	$0 Copay	20% Coinsurance	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
OUTPATIENT SERVICES											
Laboratory Tests	$5 Copay	$40 Copay	$25 Copay (After Deductible)	$10 Copay (After Deductible)	50% Coinsurance (After Deductible)	$15 Copay	$40 Copay	$40 Copay	$40 Copay	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
X-Rays	$5 Copay	$85 Copay	$50 Copay (After Deductible)	$50 Copay (After Deductible)	50% Coinsurance (After Deductible)	$30 Copay	$75 Copay	$85 Copay	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
Imaging (CT/PET Scans, MRIs)	$100 Copay	$325 Copay	$350 Copay (After Deductible)	$200 Copay (After Deductible)	50% Coinsurance (After Deductible)	$75 Copay	$150 Copay	$325 Copay	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	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 Facilities (After Deductible)	20% Coinsurance Chinese Hospital / 40% Coinsurance Other Facilities (After Deductible)	50% Coinsurance (After Deductible)	$100 Copay	$300 Copay	20% Coinsurance	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
Physician/Surgeon Fees	$0 Copay	20% Coinsurance	$0 Copay (After Deductible)	20% Coinsurance Chinese Hospital / 40% Coinsurance Other Facilities (After Deductible)	50% Coinsurance (After Deductible)	$25 Copay	$40 Copay	20% Coinsurance	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met

Footnotes: * Available in Covered California only.
Actuarial Value is the Percentage of total average costs for covered benefits that a plan will cover.
Preventive care is 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).

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				In-Network	Out-of-Network						
	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 Facilities (Up to First 5 Days)	20% Coinsurance (After Deductible)	$500 Copay Per Day Chinese Hospital / $1,500 Copay Per Day Other Facilities (Up to First 5 Days) (After Deductible)	20% Coinsurance Chinese Hospital / 40% Coinsurance Other Facilities (Up to First 5 Days) (After Deductible)	50% Coinsurance (After Deductible)	$250 Per Day (Up to First 5 Days)	$600 Per Day (Up to First 5 Days)	20% Coinsurance (After Deductible)	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
Physician/Surgeon Fees	$0 Copay	20% Coinsurance	$0 Copay	$0 Copay	50% Coinsurance (After Deductible)	$0 Copay	$0 Copay	20% Coinsurance	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
EMERGENCY HEALTH COVERAGE											
Emergency Room Services (waived if admitted)	$100 Copay	$400 Copay	$300 Copay (After Deductible)	$200 Copay (After Deductible)	$200 Copay (After Deductible)	$150 Copay	$350 Copay	$400 Copay	40% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
Emergency Room Physician Fee (waived if admitted)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	Full Cost Until Out-of-Pocket is Met	$0 Copay
Urgent Care Center	$50 Copay	$40 Copay	$50 Copay (After Deductible)	$50 Copay (After Deductible)	$50 Copay (After Deductible)	$15 Copay	$35 Copay	$40 Copay	$65 Copay (Deductible Applies After First (3) Non-Preventive Visits)	Full Cost Until Out-of-Pocket is Met	$0 Copay for First (3) Non-Preventive Visits, then Full Cost until Out-of-Pocket is Met
PRESCRIPTION DRUG COVERAGE											
Annual Prescription Deductible	$0	Individual $300/ Family $600	Individual $275/ Family $550	Individual $2,500 / Family $5,000 [A] Medical/ Rx[1]		$0	$0	Individual $300/ Family $600	Individual $500 / Family $1,000	Individual $7,000/ Family $14,000 [A] Medical/ Rx[1]	Individual $8,550 / Family $17,100 [A] Medical / Rx[1]
Tier 1: Generic Drugs (30-Day Supply)	$5 Copay	$16 Copay (After Rx Deductible)	$15 Copay	$15 Copay (After Rx Deductible)	Not Covered	$5 Copay	$ 15 Copay	$16 Copay (After Rx Deductible)	$18 Copay (After Rx Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
Tier 2: Preferred Brand Drugs (30-Day Supply)	$ 15 Copay	$60 Copay (After Rx Deductible)	$ 50 Copay (After Rx Deductible)	$ 50 Copay (After Rx Deductible)	Not Covered	$15 Copay	$55 Copay	$60 Copay (After Rx Deductible)	40% Coinsurance Up to $500 Per Prescription (After Rx Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
Tier 3: Non-preferred Brand Drugs (30-Day Supply)	$25 Copay	$90 Copay (After Rx Deductible)	$ 70 Copay (After Rx Deductible)	$ 70 Copay (After Rx Deductible)	Not Covered	$25 Copay	$80 Copay	$90 Copay (After Rx Deductible)	40% Coinsurance Up to $500 Per Prescription (After Rx Deductible)	Full Cost Until Out-of-Pocket is Met	Full Cost Until Out-of-Pocket is Met
Tier 4: Specialty 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)	40% Coinsurance Up to $500 Per Prescription (After Rx Deductible)	Full Cost Until Out-of-Pocket is Met	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)	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 in Lieu of Glasses)s	$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					