Individual & Family Plans | 2014 Plan Benefit Highlights

						(ALSO AVAILABLE IN 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 / 89.1%	Gold / 81.8%	Silver / 72.0%	Silver / 70.7%		Platinum / 88.0%	Gold / 78.8%	Silver / 69.2%	Bronze / 60.5%	Bronze / 60.4%
SERVICES AND FEATURES										
Annual Deductible	$0	$0	Individual $2,000 / Family $4,000 (A)	Individual $2,500 / Family $5,000 (A)		$0	$0	Individual $2,000 / Family $4,000 (A)	Individual $5,000 / Family $10,000 Medical / Rx (1)	Individual $6,350 / Family $12,700 Medical / Rx (1)
Out–of–Pocket Limit On Expenses	Individual $2,000 / Family $4,000	Individual $5,500 / Family $11,000	Individual $6,350 / Family $12,700	Individual $6,000 / Family $12,000		Individual $4,000 / Family $8,000	Individual $6,350 / Family $12,700	Individual $6,350 / Family $12,700	Individual $6,350 / Family $12,700	Individual $6,350 / Family $12,700
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	$30 Copay	$25 Copay	$0 Copay for 1st (3) PCP Visits. Then $50 Copay After Deductible.	$0 Copay for 1st (3) PCP Visits. Then $50 Copay After Deductible.	50% Coinsurance (After Deductible)	$20 Copay	$30 Copay	$45 Copay	$60 Copay (Deductible Applies After 1st (3) Non-Preventive Visits)	0% Coinsurance (Deductible Applies After 1st (3) Non-Preventive Visits)
Specialist Visit	$30 Copay	$25 Copay	$50 Copay (After Deductible)	$50 Copay (After Deductible)	50% Coinsurance (After Deductible)	$40 Copay	$50 Copay	$65 Copay	$70 Copay (After Deductible)	0% Coinsurance (After Deductible)
Maternity Care - Prenatal and Postnatal Care	$0 Copay	$0 Copay	$0 Copay	$0 Copay		$0 Copay	$0 Copay	$0 Copay	$0 Copay	0% Coinsurance
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)	$30 Copay (Laboratory) / $50 Copay (X-Ray)	$45 Copay (Laboratory) / $65 Copay (X-Ray)	30% Coinsurance (After Deductible)	0% Coinsurance (After Deductible)
Imaging (CT/PET Scans, MRIs)	$100 Copay	$250 Copay	$300 Copay (After Deductible)	$200 Copay (After Deductible)	50% Coinsurance (After Deductible)	$150 Copay	$250 Copay	$250 Copay	30% Coinsurance (After Deductible)	0% Coinsurance (After Deductible)
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$75 Copay (Chinese Hospital) / $150 Copay (Other Contracted Facilities)	$250 Copay	$400 Copay (Chinese Hospital) / $800 Copay (Other Contracted Facilities) (After Deductible)	20% Coinsurance (Chinese Hospital) / 30% Coinsurance (Other Contracted Facilities) (After Deductible)	50% Coinsurance (After Deductible)	$250 Copay	$600 Copay	20% Coinsurance	30% Coinsurance (After Deductible)	0% Coinsurance (After Deductible)

Footnotes: * Acturial Benefit Value indicates relative value of how much the plans return in benefits.
(1) Preventive care are not subject to the deductible.
(A) You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st).
(D1) For brand name and specialty prescription drugs. There are no other specific deductibles.

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				(In-Network)	**(Out-of-Network)**					
HOSPITALIZATION SERVICES	**Member Cost Share**					**Member Cost Share**				
Facility Fee (e.g., Hospital Room)	$200 Copay Per Day (Chinese Hospital) / $400 Copay Per Day (Other Contracted Facilities) (Up To First 5 Days)	$500 Copay Per Day (Up To First 5 Days)	$500 Copay Per Day (Chinese Hospital) / $1,000 Copay Per Day (Other Contracted Facilities) (Up To First 5 Days) (After Deductible)	20% Coinsurance (Chinese Hospital) / 30% 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)	30% Coinsurance (After Deductible)	0% Coinsurance (After Deductible)
EMERGENCY HEALTH COVERAGE										
Emergency Room Services	$100 Copay	$250 Copay	$250 Copay (After Deductible)	$200 Copay (After Deductible)		$150 Copay	$250 Copay	$250 Copay (After Deductible)	$300 Copay (After Deductible)	0% Coinsurance (After Deductible)
Urgent Care	$30 Copay	$25 Copay	$50 Copay (After Deductible)	$50 Copay (After Deductible)		$40 Copay	$60 Copay	$90 Copay	$120 Copay (Deductible Applies After 1st (3) Non-Preventive Visits)	0% Coinsurance (Deductible Applies After 1st (3) Non-Preventive Visits)
PRESCRIPTION DRUG COVERAGE										
Annual Brand Name / Specialty Prescription Rx Deductible [(D1)]	Individual $250 Brand Name / Specialty Prescription Rx [(D1)]	Not Applicable	Individual $250 Brand Name / Specialty Prescription Rx [(D1)]	Individual $500 Brand Name / Specialty Prescription Rx [(D1)]	Not Applicable	Not Applicable	Not Applicable	Individual $250 / Family $500 Brand Name / Special Prescription Rx [(D1)]	See Annual Deductible	
Generic Drugs (30-Day Supply)	$10 Copay	$19 Copay	$19 Copay	$19 Copay	Not Applicable	$5 Copay	$19 Copay	$19 Copay	$19 Copay (After Deductible)	0% Coinsurance (After Deductible)
Preferred Brand Drugs (30-Day Supply)	$30 Copay (After Rx Deductible)	$50 Copay	$50 Copay (After Rx Deductible)	$50 Copay (After Rx Deductible)	Not Applicable	$15 Copay	$50 Copay	$50 Copay (After Rx Deductible)	$50 Copay (After Deductible)	0% Coinsurance (After Deductible)
Non-preferred Brand Drugs (30-Day Supply)	$30 Copay (After Rx Deductible)	$70 Copay	$70 Copay (After Rx Deductible)	$ 70 Copay (After Rx Deductible)	Not Applicable	$25 Copay	$70 Copay	$70 Copay (After Rx Deductible)	$75 Copay (After Deductible)	0% Coinsurance (After Deductible)
Specialty Drugs (30-Day Supply)	$30 Copay (After Rx Deductible)	20% Coinsurance	20% Coinsurance (After Rx Deductible)	20% Coinsurance (After Rx Deductible)	Not Applicable	10% Coinsurance	20% Coinsurance	20% Coinsurance (After Rx Deductible)	30% Coinsurance (After 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 Applicable	$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 Applicable	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
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 Applicable	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
Eyewear (Contact Lenses)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	Not Applicable	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Pediatric Dental (Ages 0-18)	See Dental Summary Page					**Pediatric Dental Options are Different for Plans Offered through Covered California**				

How to Contact Us?

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