



Benefit Guide for California

Benefits

ClearProtectionSM Plus

Calendar Year Deductible

ALL COVERED NETWORK AND NON-NETWORK SERVICES APPLY TOWARD THE DEDUCTIBLES BELOW*

Individual	\$1,000 or \$4,500	\$3,300 or \$6,800	\$5,000 or \$8,500	For Inpatient/Surgical and Emergency Room Services or For Outpatient/Professional and Diagnostic Services
Family	\$2,000 or \$9,000	\$6,800 or \$13,600	\$10,000 or \$17,000	For Inpatient/Surgical and Emergency Room Services or For Outpatient/Professional and Diagnostic Services
Network Coinsurance Options	40% 0%	40% 0%	40% 0%	For Inpatient/Surgical and Emergency Room Services or For Outpatient/Professional and Diagnostic Services

Calendar Year Out-of-Pocket Maximum

ALL COVERED SERVICES, IN ANY COMBINATION, APPLY TOWARD YOUR OUT-OF-POCKET MAXIMUM BELOW*
This is the maximum you'll pay for most network covered services each calendar year; then the plan pays 100%

Individual	NETWORK: or NON-NETWORK:	\$4,500	\$6,800	\$8,500	(these amounts include the deductibles)
Family	NETWORK: or NON-NETWORK:	\$9,000	\$13,600	\$17,000	(these amounts include the deductibles)

How family deductibles and family out-of-pocket maximums work: Once one family member reaches their individual deductible or out-of-pocket maximum, the remaining amount of the family deductible or out-of-pocket maximum needs to be met by one or more other family members. The family deductible or out-of-pocket maximum can be met by the family combined.

Lifetime Maximum

Unlimited

Covered Services

Your Share of Costs (after deductible, if applicable)

Doctors' Office Visits	NETWORK:	First 2 Office Visits (per member): \$40 copay, deductible waived Additional Office Visits: 100% of negotiated fee; then 0% Coinsurance after out-of-pocket maximum is met
	NON-NETWORK:	100% Coinsurance; then 50% Coinsurance after out-of-pocket maximum is met
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	NETWORK:	Inpatient: 40% Coinsurance Outpatient: 100% of negotiated fee; then 0% Coinsurance after out-of-pocket maximum is met
	NON-NETWORK:	Inpatient: 50% Coinsurance Outpatient: 100% Coinsurance; then 50% Coinsurance after out-of-pocket maximum is met
Inpatient Services (overnight hospital/facility stays)	NETWORK:	40% Coinsurance
	NON-NETWORK:	All charges except \$650 per day
Outpatient Services (without overnight hospital/facility stays)	NETWORK:	Surgery: 40% Coinsurance Other Services: 100% of negotiated fee; then 0% Coinsurance after out-of-pocket maximum is met
	NON-NETWORK:	All charges except \$380 per day
Emergency Room Services	NETWORK:	40% Coinsurance plus \$100 Emergency Room copay (copay waived if admitted)
	NON-NETWORK:	40% Coinsurance plus \$100 Emergency Room copay (copay waived if admitted)
Preventive Care Services	Includes all nationally recommended preventive services including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.	
	NETWORK:	0% Coinsurance, not subject to deductible
	NON-NETWORK:	100% Coinsurance; then 50% Coinsurance after out-of-pocket maximum is met

Maternity

Not Covered

Optional Coverage (at additional cost)

Dental, Life

Prescription Drug Coverage

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Retail Drugs (and Mail Order Drugs when available)	NETWORK:	Tier 1 (Generic drugs): \$15 Copay \$7,500 annual Prescription Drug deductible per member applies before the following: · Tier 2 (Formulary Brand name drugs): \$40 Copay · Tier 3 (Non-Formulary Brand name drugs): \$60 Copay · Specialty: 25% Coinsurance up to a \$2,500 annual Prescription Drug out-of-pocket maximum (the most you'll have to pay), for network only and in addition to \$7,500 annual deductible.
	NON-NETWORK:	Not Covered

Optional Drug Coverage (when available)

Not Available

Other Covered Benefits include but are not limited to:

Ambulance, Home Health Care, Physical/Occupational Therapy, Urgent Care

IMPORTANT: This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the Policy. In the event of a conflict between the Policy and this Benefit Guide, the terms of the Policy will prevail.

*Network and non-network deductible are combined and accumulate toward each other. Network and non-network out-of-pocket maximums are also combined and accumulate toward each other.

NOTES: Discounted network rates apply for network covered services. For non-network services, member is responsible for the coinsurance plus charges in excess of the allowable amount. Copays/Coinsurance to network and non-network providers apply to annual out-of-pocket maximum except where specifically noted in the Policy.