

## Individual Health Insurance Options for Dependents of Students

These sample plans for individuals and families were selected based on their mix of an affordable monthly premium, a low deductible, and strong benefits. <sup>1</sup> CONSULT PLAN EVIDENCE OF COVERAGE FOR FULL DISCLOSURE OF ELIGIBILITY, BENEFITS, AND EXCLUSIONS.																					Federal / State Public Health Insurance Programs				
Anthem Blue Cross PPO Share 1,000					Blue Shield Spectrum PPO Plan 750 [Premiums are gender-based (M/F)]					Health Net HMO 40					Kaiser \$25 Copayment Plan [Premiums are gender-based (M/F)]						Healthy Families	Access for Infants and Mothers (AIM)	Medi-Cal		
Monthly Premium (\$) (by age) <sup>2</sup> :	19-29	30-34	35-39	40-44	45-49	19-29	30-34	35-39	40-44	45-49	19-24	25-29	30-34	35-39	40-44	45-49	19-24	25-29	30-34	35-39	40-44	45-49	The Healthy Families Program provides low-cost health, dental and vision coverage to children and teens up to age 19 in families with incomes up to 250% of federal poverty guidelines who do not qualify for no-cost Medi-Cal and do not have access to private health insurance. Monthly premium is \$9-17 per child, up to a \$51 maximum per family per month. Children must be U.S. citizens, nationals, or eligible immigrants.	The AIM Program is low-cost health coverage for pregnant women. It is designed for middle-income families who don't have health insurance and whose income is too high to qualify for no-cost Medi-Cal. AIM is also available to those who have health insurance if their deductible or co-payment/co-insurance for maternity services is more than \$500. If you qualify for AIM, your baby is automatically eligible for enrollment in the Healthy Families Program.	Medi-Cal provides health insurance to low-income residents of California. For all Medi-Cal programs, certain financial eligibility criteria apply, and the individual or family may have a share of cost requirement. Eligible groups include: • Low-income families • Children • Pregnant women • Medically needy or medically indigent adults • People with certain serious illnesses
<b>Subscriber</b>	\$296-\$372	\$2,009-\$625	\$448-\$450	\$494-\$516	\$517-\$568	M-\$ 287 F-\$334	M-\$376 F-\$452	M-\$425 F-\$488	M-\$501 F-\$593	M-\$601 F-\$646	\$323	\$380	\$480	\$527	\$550	\$584	M-\$225 F-\$237	M-\$254 F-\$266	M-\$282 F-\$296	M-\$310 F-\$326	M-\$341 F-\$358	M-\$378 F-\$397			
<b>Subscriber + 1 Child</b>	\$524-\$563	\$565-\$603	\$603	\$661-\$677	\$688-\$735	M-\$555 F-\$599	M-\$757 F-\$825	M-\$833 F-\$906	M-\$936 F-\$1,031	M-\$1,048 F-\$1,001	\$557	\$615	\$717	\$763	\$784	\$819	M-\$418 F-\$439	M-\$446 F-\$469	M-\$475 F-\$498	M-\$503 F-\$528	M-\$533 F-\$560	M-\$571 F-\$600			
<b>Subscriber + 2 Children</b>	\$821-\$822	\$822-\$871	\$871	\$924-\$958	\$959-\$997	M-\$921 F-\$977	M-\$1,173 F-\$1,265	M-\$1,124 F-\$1,309	M-\$1,129 F-\$1,201	M-\$1,270 F-\$1,298	\$799	\$854	\$959	\$1,005	\$1,024	\$1,060	M-\$668 F-\$701	M-\$703 F-\$738	M-\$742 F-\$779	M-\$786 F-\$825	M-\$823 F-\$864	M-\$831 F-\$873			
<b>Family</b>	\$821-\$985	\$1,011-\$1,070	\$1,085-\$1,105	\$1,105-\$1,162	\$1,191-\$1,308	\$968	\$1,235	\$1,359	\$1,345	\$1,591	\$1,071	\$1,187	\$1,390	\$1,482	\$1,524	\$1,592	\$788	\$923	\$1,027	\$1,106	\$1,160	\$1,174			
<b>Children Only:</b>	< 1 yr	1-18				< 1 yr	1-18				< 1 yr	1-4	5-18				< 1 yr	1-18							
<b>1 Child</b>	\$276	\$207-\$232				\$448	\$197				Cannot be enrolled without parent	\$246	\$246				\$198	\$198							
<b>2 Children</b>	\$512	\$435-\$464				\$896	\$394					\$492	\$492				\$395	\$395							
<b>3+ Children</b>	\$842	\$653-\$714				\$1,344	\$591					\$738	\$738				\$675	\$675							
<b>Annual Deductible:</b>	\$1,000 Individual / \$2,000 maximum per Family					\$750 Individual / \$1,500 maximum per Family					\$1,500 per individual (inpatient only)					None						None			
<b>Annual Out-of-Pocket Maximum:</b>	\$5,000 Individual / \$10,000 Family					\$4,750 Individual / \$9,500 Family					\$3,000 Individual / \$6,000 Family					\$2,500 Individual / \$5,000 Family						\$250			
<b>Medical Office Visits:</b>	You pay 30% (not subject to deductible)					You pay 30% (not subject to deductible)					\$40 copay					\$25 copay						\$5 copay			
<b>Emergency Room:</b>	After the deductible, you pay 30% + \$100 copay (copay waived if admitted)					After the deductible, you pay 30% + \$100 copay (copay waived if admitted)					\$100 copay (waived if admitted)					\$100 copay (waived if admitted)						\$5 copay (unless hospitalized)			
<b>Inpatient Hospital Services:</b>	After the deductible, you pay 30% + \$500 copay					After the deductible, you pay 30% + \$500 copay					After the deductible, you pay nothing					\$200 copay per day						No charge			
<b>Maternity<sup>3</sup>:</b>						Prenatal / postpartum care: After deductible, you pay 30% Delivery: After deductible, you pay 30% + \$500 copay																No charge			
<b>Prescription Drugs:</b>	Generic: \$10 copay Brand: \$30 copay after \$250 brand-name drug deductible Prescription mail order service available					Generic: \$10 copay Brand: \$35 copay after \$250 brand-name drug deductible Non-formulary brand-name drugs: \$50 copay Prescription mail order service available					\$100 Prescription Drug deductible Generic: \$15 copay Brand: \$25 copay Not on Recommended Drug List: \$50 copay Prescription mail order service available					Generic: \$10 copay Brand: \$35 copay Prescription mail order service available						\$5 copay per prescription			
<b>Mental Health<sup>4</sup> Office Visits:</b>	After the deductible, you pay all but \$25 per visit Limited to 1 visit per day and 20 visits per year					After the deductible, you pay 30% Limited to 20 visits per year					\$40 copay Limited to 20 visits per year					\$25 copay per individual visit and \$12 copay for group visits Limited to 20 individual/group visits per year (in combination)						\$5 copay Limited to 20 visits per year			
<b>Mental Health<sup>4</sup> Inpatient:</b>	After the deductible, you pay all but \$175 per day Limited to 30 days per year					After the deductible, you pay 30% plus \$250 copay					After the deductible, you pay nothing Limited to 30 days per year					\$200 copay per day Limited to 30 days per year						No charge Limited to 30 days per year			
<b>Dental and Vision:</b>	<u>Dental:</u> Range of optional dental plans available (stand-alone plans; can be purchased by non-members) <u>Vision:</u> Not covered					<u>Dental:</u> Range of optional dental plans available (stand-alone plans; can be purchased by non-members); separate premium <u>Vision:</u> Not covered.					Plus Plans include optional dental and vision coverage for separate premium. No deductibles or maximum dollar benefit limit for covered services. <u>Dental:</u> oral evaluations and x-rays at no charge; cleanings/other services with various co-pays <u>Vision:</u> annual vision exam, \$10 co-pay; one set of frames, lenses or contact lenses, \$40 co-pay					<u>Dental:</u> An optional "Dental Assistance Insurance Plan" is available <u>Vision:</u> Eye exams are covered, but not glasses, contact lenses or contact lens exams						<u>Dental:</u> No charge for most dental visits; \$5 for major dental services <u>Vision:</u> \$5 for eye exam and \$5 for glasses, frames or contacts			
<b>Lifetime Maximum:</b>	\$5,000,000					\$6,000,000					None					None						None			
<b>California Residency Requirement:</b>	Permanent legal resident of California; US resident for at least the last 3 months					US resident for at least the last 6 months					Must reside in California (Non-US citizens must reside in U.S. for at least 6 months)					Must reside in California within Kaiser service area						Must reside in California No J-2 or F-2 visa status			
<b>Social Security Number Requirement:</b>	Not required					Not required					Not required					SSN or Taxpayer ID # required						Not required			

<sup>1</sup> Copays and coinsurance listed are for participating or in-network providers. Charges are higher for services obtained from non-participating or non-network providers. Some exceptions (e.g., emergency services) may apply. Plan benefits and rates may vary and are subject to change.

<sup>2</sup> Rates are estimates and subject to change based on your medical status at the time of application.

<sup>3</sup> All plans in this chart provide maternity benefits. However, some health insurance companies offer plans without maternity benefits for lower monthly premiums. Check with the insurance company for more information.

<sup>4</sup> Benefits listed in these categories are for non-severe mental health conditions. Benefits for certain severe mental health conditions (as defined by the Mental Health Parity Act) are paid according to the benefits listed above for medical office visits and inpatient hospital services.

**Definitions:**

**Copays:** Percentage of fees for services you must pay, in addition to what the plan pays

**Copay:** Set dollar amount you must pay for a covered service

**Deductible:** The amount you must pay out-of-pocket before the plan will pay for medical services

**Premium:** The rate you pay to be enrolled in an insurance plan, usually monthly

**HMO (Health Maintenance Organization) Plan:** A plan in which you choose a primary care physician (PCP) who coordinates your care with providers in the plan network

**PPO (Preferred Provider Organization) Plan:** A plan in which you have direct access to providers in the plan network, as well as other providers at higher cost

**Preferred, Participating or In-Network Providers:** Providers that accept a negotiated or contracted rate as full payment for services

**Out-of-pocket expenses:** Direct expenditure of money which is not reimbursed. Maximum is the most you would pay for certain covered health care services in a year