

## Individual Health Insurance Options after Graduation<sup>§</sup>

These sample plans were selected based on their mix of an affordable monthly premium, a low deductible, and strong benefits.\*  
CONSULT PLAN CERTIFICATE OF COVERAGE FOR FULL DISCLOSURE OF ELIGIBILITY, BENEFITS, AND EXCLUSIONS.

These plans apply to individuals with special medical and/or financial needs

Plan Category:	Limited Benefit PPOs							PPOs		HMO	Short-Term Health PPOs		Conversion PPO	Public Health Insurance Programs	
Company Name:	Anthem Blue Cross	Blue Shield	Health Net	Anthem Blue Cross	Blue Shield	Kaiser	Anthem Blue Cross	Health Net	Anthem Blue Cross	Health Net	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	MRMIP Individual PPO and HMO Plans	Medi-Cal AIM Healthy Families Federal-State Funded Programs
<b>Plan Name:</b>	<b>Tonik "Calculated Risk Taker"</b>	<b>Essential Plan 1750</b>	<b>NetFirst PPO w/3-Tier Rx Plan</b>	<b>PPO Share 1,000</b>	<b>Shield Spectrum 750</b>	<b>Deductible 20/500</b>	<b>Short-Term</b> (minimum one month up to 6 months/180 days)	<b>Quick Net</b> (minimum one month up to 6 months/185 days)	<b>Conversion 2500 Plan</b> For former SHIP members who have an ongoing need for care and are not eligible for Medi-Cal						
<b>Monthly Premium**:</b>	\$187 — \$201 male \$170 — \$195 female	\$154 male / \$165 female	\$124 — \$138 male \$132 — \$147 female	\$297 — \$372	\$287 male / \$334 female	\$218 — \$245 male \$229 — \$257 female	\$102 — \$109 male \$97 — \$112 female	\$98	\$343						
<b>Annual Deductible:</b>	\$1,500	\$1,750	No deductible	\$1,000	\$750	\$500	\$500	\$750	\$2,500						
<b>Out-of-Pocket Maximum:</b> (includes deductible)	\$1,500	\$1,750	\$7,500	\$5,000	\$4,750	\$2,500	\$1,500	\$1,750	\$7,500						
<b>Medical Office Visits:</b>	\$40 copay (not subject to deductible)	\$40 copay for 1 <sup>st</sup> 3 visits Additional visits subject to deductible	\$35 copay	You pay 30% (not subject to deductible)	\$35 copay (not subject to deductible)	\$20 copay	You pay 20% (after deductible)	\$40 copay 6 visit maximum	\$35 copay (not subject to deductible)						
<b>Emergency Room:</b>	After the deductible, you pay nothing	\$100 copay (waived if admitted)	You pay 35% + \$100 copay (waived if admitted)	After the deductible, you pay 30% + \$100 copay (waived if admitted)	After the deductible, you pay 30% + \$100 copay (waived if admitted)	After the deductible, you pay \$100 copay (waived if admitted)	After the deductible, you pay 20% + \$50 copay (waived if admitted or for treatment of accidental injuries)	After the deductible, you pay 20% + \$50 copay	After the deductible, you pay 30% + \$100 copay (waived if admitted)						
<b>Hospitalization (Inpatient) Services:</b>	After the deductible, you pay nothing	After the deductible, you pay nothing	You pay 35% + \$500 copay/day (4 day copay maximum)	After the deductible, you pay 30% + \$500 copay	After the deductible, you pay 30% + \$250 copay	After the deductible, you pay \$100 copay/day	After the deductible, you pay 20%	After the deductible, you pay 20%	After the deductible, you pay 30% (+ \$500 admission charge for inpatient surgery)						
<b>Maternity:</b>	Not covered Can apply for free transfer to PPO Share 5000 Plan	Not covered Can apply for free transfer to Spectrum 5000 PPO Plan	Not covered	After the deductible, you pay 30%	After the deductible, you pay 30% for prenatal/postpartum care and 30% + \$250 copay for delivery	No charge for prenatal care /1 <sup>st</sup> postpartum visit Delivery: After the deductible, you pay \$100 copay/day	Not covered	Not covered	After the deductible, you pay 30%						
<b>Prescription Drugs:</b>	Generic: \$10 copay Brand: Not covered Mail service available	Generic: \$10 copay Brand: Not covered Mail service available	Three-tier Rx Plan: Generic: \$10 copay Brand: \$35 copay Brand non-formulary: \$50 or 50% (whichever is greater) after \$750 brand-name drug deductible Mail service available	Generic: \$10 copay Brand: \$30 copay after \$250 brand-name drug deductible Mail service available	Generic: \$10 copay Brand: \$35 copay after \$250 brand-name drug deductible Mail service available	Generic: \$10 copay Brand: \$35 copay Mail service available	Generic: \$10 copay Brand: \$30 copay Maximum \$500 brand-name drug benefit No mail order benefit	Generic: \$10 copay Brand: \$35 copay \$250 deductible Maximum \$1,000 benefit	Generic: \$10 copay Brand: \$30 copay after \$500 brand-name drug deductible Mail service available						
<b>Mental Health Office Visits:</b>	After the deductible, you pay all but \$25/visit Limited to one visit/day and 20 visits/year	After the deductible, you pay nothing Limited to 30 visits/year	You pay 35%/visit Limited to \$500/year	After the deductible, you pay all but \$25/visit Limited to one visit/day and 20 visits/year	After the deductible, you pay 30%/visit Limited to 20 visits/year	\$20 copay/individual visit or \$10 copay/group visit Limited to 20 visits/year	After the deductible, you pay all but \$40/visit Limited to one visit/week \$5,000 max (combined w/inpt)	Not covered	After the deductible, you pay all but \$20/visit Limited to one visit/day, 20 visits/year						
<b>Mental Health Inpatient:</b>	After the deductible, you pay all but \$175/day Limited to 30 days/year \$5,250 max benefit/year	After the deductible, you pay nothing	You pay 35%/visit Limited to \$5,000/year	After the deductible, you pay all but \$175/day Limited to 30 days/year	After the deductible, you pay 30% + \$250 copay	After the deductible, you pay \$100/day Limited to 30 days/year	You pay 50% \$5,000 max benefit (combined w/outpatient)	Not covered	After the deductible, you pay all but \$175/day Limited to 30 days/year						
<b>Dental and Vision:</b>	<u>Dental</u> : \$500 benefit after \$25 deductible <u>Vision</u> : \$50 copay for vision exams \$25-\$100 copay for choice of contacts, lenses, or frames	<u>Dental</u> : \$500 benefit after \$25 deductible <u>Vision</u> : \$5 copay for vision exams	<u>Dental and Vision</u> package available for separate \$25/month premium	<u>Dental</u> : Dental PPO or HMO plans available (separate premium) <u>Vision</u> is not covered	<u>Dental</u> : Dental PPO or HMO plans available (separate premium) <u>Vision</u> is not covered	<u>Dental</u> : Dental Assistance Plan available (separate premium) <u>Vision</u> : \$20 copay for vision exams	<u>Dental</u> : Dental PPO or HMO plans available (separate premium) <u>Vision</u> is not covered	Not covered	<u>Dental</u> : Dental PPO or HMO plans available (separate premium) <u>Vision</u> is not covered						
<b>Lifetime Maximum:</b>	\$5,000,000	\$6,000,000	\$6,000,000	\$5,000,000	\$6,000,000	Unlimited	\$3,000,000	\$2,000,000	\$5,000,000						

<sup>§</sup> We recommend you call us or stop by the office to obtain a Certificate of Creditable Coverage as proof of your continuous insurance coverage prior to your departure from UC Berkeley. This may help you to avoid being subject to a pre-existing condition exclusion when you sign up for a new health insurance plan.

\* 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.*

\*\* The premiums shown are for a Bay Area resident who is between the ages of 21 and 29. Some plans are gender-rated (different rates for males and females). *Rates are estimates and are subject to change based on your medical conditions at the time of application.*

**Definitions:**

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

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

**Deductible:** The amount you need to 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): A plan in which you choose a primary care physician who coordinates your care with providers in the plan network

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

**Limited Benefit PPO:** Some PPO plans have lower premiums because certain benefits are not included, such as maternity services or brand-name prescription drugs

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