CALIFORNIA BRONZE 4800 HDHP-SCHEDULE OF BENEFITS

Policyholder:	[Employer name][1]
Employer:	[Employer name][2]
Insured:	[Last name, First name][3]
Certificate Number:	NHIC SG ACA CER CA 2016
Effective Date:	[MM-DD-YY][Original Effective Date of Group][4]
Premium Due Date:	[1st of the month][15th of the month][5]
Schedule Date:	[MM-DD-YY] [Effective date of schedule][6]
Dependent Domestic Partner:	[Last name][,] [First name][7]
Dependent Spouse:	[Last name][,] [First name][8]
Dependent Child(ren):	[Last name][,] [First name][9]
Dependent Child(ren) Limiting Age:	up to age 26
Service Waiting Period:	[less than 90 days][10]
Open Enrollment Period:	[May 1, 2017 – May 31, 2017][11]
Year:	Plan

Medical Expense Benefits

Covered Services		**In-Network**		**Out-of-Network**	
Deductible per Year					
Medical:	Individual	$4,800		$9,000	
	Family	$9,600		$14,000	
Pediatric Dental:	Individual	$0			
	Family	$0			
Prescription Drugs:	Individual	Included in Medical Deductible			
	Family	Included in Medical Deductible			
NOTE: See items 1 and 2 under NOTES below.					
Coinsurance for Eligible Expenses		40%		50%	
		Applies to covered benefits for which the cost share is not otherwise specified in the Schedule of Benefits			
Out-of-pocket Maximum (OOP)					
Medical & Dental:	Individual	$6,550		$13,300	
	Family	$13,100		$26,600	
Prescription Drugs:	Individual	Included in Medical Out of Pocket			
	Family	Included in Medical Out of Pocket			
Deductible Applies		Yes		Yes	
Coinsurance Applies		Yes		Yes	
Copayment Applies		Yes		Yes	
NOTE: See items 1 and 2 under NOTES below.					

	In-Network		**Out-of-Network**	
Covered Services	**Member Cost Share**	**Deductible Applies**	**Member Cost Share**	**Deductible Applies**
VISIT TO A HEALTH CARE PROVIDERS OFFICE OR CLINIC:				
- Primary care visit to treat an injury or illness	40% Coinsurance	Yes	50% Coinsurance	Yes
- Specialist visit	40% Coinsurance	Yes	50% Coinsurance	Yes
- Other practitioner office visit - **NOTE: See item 3 under NOTES below.**	40% Coinsurance	Yes	50% Coinsurance	Yes
- Preventive care/screening/immunizations	No cost share	No	50% Coinsurance	Yes
- Vision Exam (Adult Routine)	No cost share	No	50% Coinsurance	Yes
- California Prenatal Screening Program	No cost share	No	50% Coinsurance	Yes
- Hearing Exam (Routine)	No cost share	No	50% Coinsurance	Yes
- Allergy injections	40% Coinsurance	Yes	50% Coinsurance	Yes
TESTS:				
Diagnostic Testing Services - Minor				
- Laboratory Tests	40% Coinsurance	Yes	50% Coinsurance	Yes
- X-rays and Diagnostic Imaging	40% Coinsurance	Yes	50% Coinsurance	Yes
Diagnostic Testing Services - Major				
- Imaging (CT/PET scans/MRIs)	40% Coinsurance	Yes	50% Coinsurance	Yes
OUTPATIENT SERVICES:				

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- Facility Fee	40% Coinsurance	Yes	50% Coinsurance	Yes
- Physician/surgeon fees	40% Coinsurance	Yes	50% Coinsurance	Yes
- Outpatient Visit - includes outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.	40% Coinsurance	Yes	50% Coinsurance	Yes
NEED IMMEDIATE ATTENTION:				
- Emergency room services	40% Coinsurance	Yes	40% Coinsurance	Yes
- Emergency medical transportation	40% Coinsurance	Yes	40% Coinsurance	Yes
- Urgent care	40% Coinsurance	Yes	40% Coinsurance	Yes
HOSPITAL STAYS:				
- Facility Fee (e.g. hospital room)	40% Coinsurance	Yes	50% Coinsurance	Yes
- Physician/surgeon fees	40% Coinsurance	Yes	50% Coinsurance	Yes
MENTAL/BEHAVIORAL HEALTH NEEDS:				
- Inpatient services	40% Coinsurance	Yes	50% Coinsurance	Yes
- Outpatient office visits	40% Coinsurance	Yes	50% Coinsurance	Yes
- Other Outpatient items and services - **NOTE: See item 4 under NOTES below.**	40% Coinsurance	Yes	50% Coinsurance	Yes
SUBSTANCE ABUSE NEEDS:				
- Inpatient services	40% Coinsurance	Yes	50% Coinsurance	Yes
- Outpatient office visits	40% Coinsurance	Yes	50% Coinsurance	Yes
- Other Outpatient items and services - **NOTE: See item 4 under NOTES below**	40% Coinsurance	Yes	50% Coinsurance	Yes
PREGNANCY:				
- Prenatal care & preconception visits	No cost share	No	50% Coinsurance	Yes
- nonpreventive prenatal care office visits	40% Coinsurance	Yes	50% coinsurance	Yes
- Prenatal diagnosis genetic disorders of the fetus	40% Coinsurance	Yes	50% Coinsurance	Yes
- Delivery & all inpatient services	40% Coinsurance	Yes	50% Coinsurance	Yes
- Physician/surgeon fee	40% Coinsurance	Yes	50% Coinsurance	Yes
- Termination of Pregnancy				
- Inpatient Services	40% Coinsurance	Yes	50% Coinsurance	Yes
- Outpatient Surgical Facility	40% Coinsurance	Yes	50% Coinsurance	Yes
- Office visit	40% Coinsurance	Yes	50% Coinsurance	Yes
HELP RECOVERING OR OTHER SPECIAL HEALTH NEEDS:				
- Home health care	40% Coinsurance	Yes	50% Coinsurance	Yes
	Limited to 100 visits per year. Rehabilitation services - 100 visits per year - Habilitative Services - 100 visits per year			
- Rehabilitation services				
- Inpatient services	40% Coinsurance	Yes	50% Coinsurance	Yes
- Outpatient services	40% Coinsurance	Yes	50% Coinsurance	Yes
- Habilitation services				
- Inpatient services	40% Coinsurance	Yes	50% Coinsurance	Yes
- Outpatient services	40% Coinsurance	Yes	50% Coinsurance	Yes
- Skilled nursing care	40% Coinsurance	Yes	50% Coinsurance	Yes
	Limited to 100 days per benefit period.			
- Durable medical equipment	40% Coinsurance	Yes	50% Coinsurance	Yes
- Hospice services	0% Coinsurance	Yes	50% Coinsurance	Yes
OTHER COVERED SERVICES:				
- Bariatric Surgery				
- Inpatient	40% Coinsurance	Yes	50% Coinsurance	Yes
- Outpatient Surgical Facility	40% Coinsurance	Yes	50% Coinsurance	Yes
- Weight Loss Management	40% Coinsurance	Yes	50% Coinsurance	Yes
- Infertility Services	50% Coinsurance	Yes	50% Coinsurance	Yes
	Limited to max benefit per year of $2,000			
- Procedures of the Jawbone				
- Non-surgical	40% Coinsurance	Yes	50% Coinsurance	Yes
- Surgical - Inpatient	40% Coinsurance	Yes	50% Coinsurance	Yes
- Outpatient Surgical Facility	40% Coinsurance	Yes	50% Coinsurance	Yes
- Office Surgery	40% Coinsurance	Yes	50% Coinsurance	Yes
- Clinical Trials				
- Inpatient services	40% Coinsurance	Yes	50% Coinsurance	Yes
- Office Visit	40% Coinsurance	Yes	50% Coinsurance	Yes
- Outpatient services other than office visits	40% Coinsurance	Yes	50% Coinsurance	Yes
- Organ Transplant (Inpatient services)	40% Coinsurance	Yes	50% Coinsurance	Yes

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- Acupuncture	40% Coinsurance	Yes	50% Coinsurance	Yes
- Manipulative Services	40% Coinsurance	Yes	50% Coinsurance	Yes
	Limited to max benefit per year of 12 visits			
- Orthotics	40% Coinsurance	Yes	50% Coinsurance	Yes
- Prosthetics	40% Coinsurance	Yes	50% Coinsurance	Yes
- Health Education Programs	40% Coinsurance	Yes	50% Coinsurance	Yes
- Contact lenses to treat aniridia	40% Coinsurance	Yes	50% Coinsurance	Yes
- Dialysis	40% Coinsurance	Yes	50% Coinsurance	Yes
- Phenylketonuria (PKU)	40% Coinsurance	Yes	50% Coinsurance	Yes
- Osteoporosis	40% Coinsurance	Yes	50% Coinsurance	Yes
- Transgender Surgery	40% Coinsurance	Yes	50% Coinsurance	Yes
- Ostomy, urological and incontinence supplies	40% Coinsurance	Yes	50% Coinsurance	Yes
- Male sterilization procedures	40% Coinsurance	Yes	50% Coinsurance	Yes
- Nonemergency licensed ambulance and psychiatric transport van services	40% Coinsurance	Yes	50% Coinsurance	Yes
- Diabetic Outpatient self management training education and medical nutrition therapy	No cost share	No	50% Coinsurance	Yes
CHILD NEEDS DENTAL OR EYE CARE:				
PEDIATRIC VISION SERVICES:				
Comprehensive eye exam	No cost share	No	50% Coinsurance	Yes
	Limit one visit per year			
Prescription lenses, Single vision lenses, bifocal lenses, trifocal lenses, lenticular lenses	No cost share	No	50% Coinsurance	Yes
Frames	No cost share	No	50% Coinsurance	Yes
	Limit one pair of frames and lenses per year			
Elective contact lenses (in lieu of all other benefits for frames and/or lenses)	No cost share	No	50% Coinsurance	Yes
	Limit to a one year supply			
Medically Necessary contact lenses	No cost share	No	50% Coinsurance	Yes
	Limit to a one year supply			
Contact lenses fitting and follow up exam	No cost share	No	50% Coinsurance	Yes
Low Vision				
- Supplementary Testing and Comprehensive low vision evaluation	No cost share	No	50% Coinsurance	Yes
- Aids	40% Coinsurance	Yes	50% Coinsurance	Yes
	One comprehensive low vision evaluation once every 5 years and follow-up visits/supplementary testing limited to four (4) visits in any five (5) Year period. Limit 1 low vision aid in any 3 month period except for video magnification which is limited to 1 per year.			
PEDIATRIC DENTAL SERVICES:				
Diagnostic & Preventive (D&P) - examples of covered services Oral Exam, Preventive - Cleaning, Preventive - X-ray, Sealants per Tooth, Topical Fluoride Application, Space Maintainers-Fixed	No Cost Share	No	50% Coinsurance	Yes
Basic Services - examples of covered services				
- Basic Restoration and Periodontal Maintenance Services	20% Coinsurance	No	50% Coinsurance	Yes
Major Services - examples of covered services				
- Crowns and Casts	50% Coinsurance	No	50% Coinsurance	Yes
- Endodontics				
- Periodontics (other than maintenance)				
- Prosthodontics				
- Oral Surgery				
Orthodontics (Medically Necessary)	50% Coinsurance	No	50% Coinsurance	Yes
Refer to the Pediatric Dental Care Covered Charges in the Certificate for coverages and limitations.				
PRESCRIPTION DRUGS:				
Retail - 34 day supply				
- Tier 1 - Generic Drugs	40% Coinsurance after deductible up to $500 per script Mandatory when available unless a non-generic drug is medically necessary.			
- Tier 2 - Brand Preferred Drugs	40% Coinsurance after deductible up to $500 per script			
- Tier 3 - Brand Non-Preferred Drugs	40% Coinsurance after deductible up to $500 per script			
- Tier 4 - Injectables and Specialty Drugs	40% Coinsurance after the deductible is met up to $500 per script			
Mail Order Pharmacy - 90 day supply				

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- Tier 1 - Generic Drugs	40% Coinsurance after deductible up to $500 per script Mandatory when available unless a non-generic drug is medically necessary.
- Tier 2 - Brand Preferred Drugs	40% Coinsurance after deductible up to $500 per script
- Tier 3 - Brand Non-Preferred Drugs	40% Coinsurance after deductible up to $500 per script
- Tier 4 - Injectables and Specialty Drugs	40% Coinsurance after the deductible is met up to $500 per script
NOTE: See item 5 under NOTES below.	
Not withstanding any deductible, the total amount of copayments and coinsurance an Insured is required to pay shall not exceed two hundred dollar ($200) for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication.	
Refer to the Prescription Drug and Medicines Benefit in the Certificate for coverages and exclusions to prescription coverage. Contact the Customer Service number on your RX card for information regarding any necessary prescription drug prior authorization requirements.	
PRIOR AUTHORIZATIONS REQUIRED FOR THE FOLLOWING:	
There is a penalty of $500 for failure to obtain Pre-Authorization, but in no event will the penalty exceed 50% of the total charges. Penalty payments apply toward the out of pocket maximum. All treatments or services are subject to the policy provisions, such as benefits, limitations and exclusions. A penalty will only be charged if the medical or health care service is determined to be Medically Necessary after it is received. **Pre-Authorization is not required for any Mental Health Conditions and Substance Use Disorders items or services.**	

Cardiac/Pulmonary Rehabilitation
Durable Medical Equipment
Home Health Care
Hospice Care
Infertility Services
Inpatient Facility and Physician/Surgeon Fees
Inpatient Rehabilitation/Habilitation
Low Vision Services/Aids
Medically Necessary Contact Lenses
Organ Transplants
Orthotics
Outpatient Angiographic Procedures
Outpatient MRI, CT and PET Scans
Outpatient Nuclear Imaging
Outpatient Rehabilitation/Habilitation
Outpatient Surgery
Prosthetics
Skilled Nursing Facility
Weight Management Programs

Non-Emergency Inpatient Services - the Insured Person or the Insured Persons attending Physician must request a Pre-Authorization at least 48 hours prior to obtaining the requested treatment, service or supply.

Emergency Inpatient Care - the Insured Person or the Insured Persons attending Physician must notify the Pre-Authorization service within 48 hours of the Inpatient Admission or as soon as reasonably possible.

Pregnancy (Delivery) - the Insured Person or the Insured Persons attending Physician must notify the Pre-Authorization service as soon as reasonably possible if following delivery your physician determines your need to stay longer than the allowed 48 hours (vaginal) or 96 hours (cesarean section).

NOTES:
1. Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. An individual is responsible only for the single deductible and a single out-of-pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible and out-of-pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, then plan Copays and/or Coinsurance apply until the family out-of-pocket maximum is reached, after which the plan pays all costs for covered services for all family members.
2. Cost sharing amounts for all in-network services and out-of-network emergency care (including emergency room services and emergency medical transportation) accumulate towards the in-network out of pocket maximum and deductible.
3. The Other Practitioner category includes, but is not limited to Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family , Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors.
4. Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs and behavioral health treatment.

5. Drug tiers are defined as follows:

Tier	Definition
1)	1) Most generic drugs and low cost preferred brands
2)	1) Non-preferred generic drugs or;
	2) Preferred brand name drugs or;
	3) Recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
3)	1) Non-preferred brand name drugs or;
	2) Recommended by P&T committee based on drug safety, efficacy and cost.
	3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.
	1) Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies or;

4)	2) Self administration requires training, clinical monitoring or;
	3) Drug was manufactured using biotechnology or;
	4) Plan cost (net of rebates) is >$600.