

CALIFORNIA SILVER 2000 COPAY-SCHEDULE OF BENEFITS

Policyholder:	[Employer name] ¹
Employer:	[Employer name] ²
Insured:	[Last name, First name] ³
Certificate Number:	NHIC SG ACA CER CA 2017
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:	[November 1, 2017 – November 31, 2017] ¹¹
Year:	Plan

Medical Expense Benefits

Covered Services		In-Network		Out-of-Network	
Deductible per Year					
Medical:	Individual	\$2,000		\$4,000	
	Family	\$4,000		\$8,000	
Pediatric Dental:	Individual			\$0	
	Family			\$0	
Prescription Drugs:	Individual			\$125	
	Family			\$250	
NOTE: See items 1 and 2 under NOTES below.					
Coinsurance for Eligible Expenses		20%		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	\$7,000		\$14,000	
	Family	\$14,000		\$28,000	
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.

Covered Services	In-Network		Out-of-Network	
	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
NOTE: Cost sharing for services with Copayments is the lesser of the Copayment amount or allowed amount.				

VISIT TO A HEALTH CARE PROVIDERS OFFICE OR CLINIC:

- Primary care visit to treat an injury or illness	\$45 Copay	No	50% Coinsurance	Yes
- Specialist visit	\$75 Copay	No	50% Coinsurance	Yes
- Other practitioner office visit - NOTE: See item 3 under NOTES below.	\$45 Copay	No	50% Coinsurance	Yes
- Preventive care/screening/immunizations	No cost share	No	50% Coinsurance	Yes
- California Prenatal Screening Program	No cost share	No	No cost share	No
- Vision Exam (Adult Routine)	No cost share	No	50% Coinsurance	Yes
- Hearing Exam (Routine)	No cost share	No	50% Coinsurance	Yes
- Allergy injections	\$45 Copay	No	50% Coinsurance	Yes

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TESTS:				
Diagnostic Testing Services - Minor				
- Laboratory Tests	\$40 Copay	No	50% Coinsurance	Yes
- X-rays and Diagnostic Imaging	\$70 Copay	No	50% Coinsurance	Yes
Diagnostic Testing Services - Major				
- Imaging (CT/PET scans/MRIs)	\$300 Copay	No	50% Coinsurance	Yes
OUTPATIENT SERVICES:				
- Facility Fee	20% Coinsurance	No	50% Coinsurance	Yes
- Physician/surgeon fees	20% Coinsurance	No	50% Coinsurance	Yes
- Outpatient Visit - includes outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.	20% Coinsurance	Yes	50% Coinsurance	Yes
NEED IMMEDIATE ATTENTION:				
- Emergency room services (Copay waived if admitted)	\$350 Copay	No	\$350 Copay	No
- Emergency medical transportation	\$250 Copay	Yes	\$250 Copay	Yes
- Urgent care	\$45 Copay	No	\$45 Copay	No
HOSPITAL STAYS:				
- Facility Fee (e.g. hospital room)	20% Coinsurance	Yes	50% Coinsurance	Yes
- Physician/surgeon fees		Yes	50% Coinsurance	Yes
MENTAL/BEHAVIORAL HEALTH NEEDS:				
- Inpatient services	20% Coinsurance	Yes	50% Coinsurance	Yes
- Outpatient office visit	\$45 Copay	No	50% Coinsurance	Yes
- Other outpatient items and services - NOTE: See item 4 under NOTES below.	No cost share	No	50% Coinsurance	Yes
SUBSTANCE ABUSE NEEDS:				
- Inpatient services	20% Coinsurance	Yes	50% Coinsurance	Yes
- Outpatient office visit	\$45 Copay	No	50% Coinsurance	Yes
- Other outpatient items and services - NOTE: See item 4 under NOTES below.	No cost share	No	50% Coinsurance	Yes
PREGNANCY:				
- Prenatal care & preconception visits	No cost share	No	50% Coinsurance	Yes
- nonpreventive prenatal care office visits	\$45 Copay	No	50% coinsurance	Yes
- Delivery & all inpatient services	20% Coinsurance	Yes	50% Coinsurance	Yes
- Prenatal diagnosis genetic disorders of the fetus	20% Coinsurance	Yes	50% Coinsurance	Yes
- Physician/surgeon fees	20% Coinsurance	Yes	50% Coinsurance	Yes
- Termination of Pregnancy				
- Inpatient Services	20% Coinsurance	Yes	50% Coinsurance	Yes
- Outpatient Surgical Facility	20% Coinsurance	No	50% Coinsurance	Yes
- Office visit	\$45 Copay	No	50% Coinsurance	Yes
HELP RECOVERING OR OTHER SPECIAL HEALTH NEEDS:				
- Home health care (cost share per visit)	\$45 Copay	No	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	20% Coinsurance	Yes	50% Coinsurance	Yes
- Outpatient services	\$45 Copay	No	50% Coinsurance	Yes
- Habilitation services				
- Inpatient services	20% Coinsurance	Yes	50% Coinsurance	Yes
- Outpatient services	\$45 Copay	No	50% Coinsurance	Yes
- Skilled nursing care	20% Coinsurance	Yes	50% Coinsurance	Yes
	Limited to 100 days per benefit period.			
- Durable medical equipment	20% Coinsurance	No	50% Coinsurance	Yes
- Hospice services	No cost share	No	50% Coinsurance	Yes
OTHER COVERED SERVICES:				
- Bariatric Surgery				
- Inpatient	20% Coinsurance	Yes	50% Coinsurance	Yes
- Outpatient Surgical Facility	20% Coinsurance	No	50% Coinsurance	Yes
- Weight Loss Management	\$45 Copay	No	50% Coinsurance	Yes
- Infertility Services	50% Coinsurance	Yes	50% Coinsurance	Yes
	Limited to max benefit per year of \$2,000			

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- Procedures of the Jawbone				
- Non-surgical	\$45 Copay	No	50% Coinsurance	Yes
- Surgical - Inpatient	20% Coinsurance	Yes	50% Coinsurance	Yes
- Outpatient Surgical Facility	20% Coinsurance	No	50% Coinsurance	Yes
- Office Surgery	\$45 Copay	No	50% Coinsurance	Yes
- Clinical Trials				
- Inpatient services	20% Coinsurance	Yes	50% Coinsurance	Yes
- Office Visit	\$45 Copay	No	50% Coinsurance	Yes
- Outpatient services other than office visits	20% Coinsurance	Yes	50% Coinsurance	Yes
- Organ Transplant (Inpatient services)	20% Coinsurance	Yes	50% Coinsurance	Yes
- Acupuncture	\$45 Copay	No	50% Coinsurance	Yes
- Manipulative Services	\$45 Copay	No	50% Coinsurance	Yes
	Limited to max benefit per year of 12 visits			
- Orthotics	20% Coinsurance	No	50% Coinsurance	Yes
- Prosthetics	20% Coinsurance	No	50% Coinsurance	Yes
- Diabetic Outpatient self management training education and medical nutrition therapy	No cost share	No	50% Coinsurance	Yes
- Health Education Programs	\$45 Copay	No	50% Coinsurance	Yes
- Contact lenses to treat aniridia	20% Coinsurance	Yes	50% Coinsurance	Yes
- Dialysis	20% Coinsurance	Yes	50% Coinsurance	Yes
- Phenylketonuria (PKU)	20% Coinsurance	Yes	50% Coinsurance	Yes
- Osteoporosis	20% Coinsurance	Yes	50% Coinsurance	Yes
- Transgender Surgery	20% Coinsurance	Yes	50% Coinsurance	Yes
- Ostomy, urological and incontinence supplies	20% Coinsurance	Yes	50% Coinsurance	Yes
- Male sterilization procedures	20% Coinsurance	Yes	50% Coinsurance	Yes
- Nonemergency licensed ambulance and psychiatric transport van services	20% Coinsurance	Yes	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	No cost share	Yes
Frames	No cost share	No	No cost share	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	No cost share	Yes
	Limit to a one year supply			
Medically Necessary contact lenses	No cost share	No	No cost share	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	20% Coinsurance	No	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				

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- Endodontics	50% Coinsurance	No	50% Coinsurance	Yes
- 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	\$15 Copay, after deductible is met Mandatory when available unless a non-generic drug is medically necessary.			
- Tier 2 - Brand Preferred Drugs	\$55 Copay, after deductible is met			
- Tier 3 - Brand Non-Preferred Drugs	\$85 Copay, after deductible is met			
- Tier 4 - Injectables and Specialty Drugs	20% Coinsurance after the deductible is met up to \$250 per script			
- Tier 5 - Zero Cost Share Preventive Drugs	No Cost Share			
Mail Order Pharmacy - 90 day supply				
- Tier 1 - Generic Drugs	\$30 Copay Mandatory when available unless a non-generic drug is medically necessary.			
- Tier 2 - Brand Preferred Drugs	\$110 Copay, after deductible is met			
- Tier 3 - Brand Non-Preferred Drugs	\$170 Copay, after the deductible is met			
- Tier 4 - Injectables and Specialty Drugs	20% Coinsurance after the deductible is met up to \$250 per script			
- Tier 5 - Zero Cost Share Preventive Drugs	No Cost Share			
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	Orthotics
Durable Medical Equipment	Outpatient Angiographic Procedures
Home Health Care	Outpatient MRI, CT and PET Scans
Hospice Care	Outpatient Nuclear Imaging
Infertility Services	Outpatient Rehabilitation/Habilitation
Inpatient Facility and Physician/Surgeon Fees	Outpatient Surgery
Inpatient Rehabilitation/Habilitation	Prosthetics
Low Vision Services/Aids	Skilled Nursing Facility
Medically Necessary Contact Lenses	Weight Management Programs
Organ Transplants	

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.

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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

5. For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment(either alone or in combination will be imposed during the plan year.

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