# 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.** | | | | |

| | **In-Network** | | **Out-of-Network** | |
|---|---|---|---|---|
| **Covered Services** | **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 | | | | |

# CALIFORNIA SILVER 2000 COPAY-SCHEDULE OF BENEFITS

| | | | | |
|---|---|---|---|---|
| - Endodontics<br>- Periodontics (other than maintenance)<br>- Prosthodontics<br>- Oral Surgery | 50% Coinsurance | No | 50% Coinsurance | Yes |
| 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<br>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<br>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<br>for coverages and exclusions to prescription coverage.<br>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

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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