

CalOptima Health – Covered California Plans

Schedule of Benefits

CalOptima Health Covered Silver 70 HMO

Individual and Family Plan

The Schedule of Benefits sets forth the Member's share-of-cost for Covered Benefits under this benefit plan and represents only a brief description of the benefit plan. Please read the Evidence of Coverage carefully for a complete description of provisions, benefits, exclusions, prior authorization and other important information pertaining to this benefit plan.

Calendar Year Deductibles

A Calendar Year Deductible is the amount a Member pays each Calendar Year before CalOptima pays for Covered Services under the Plan.

		When using a Participating Provider
Calendar Year Deductible	<i>Individual coverage:</i>	\$4,700
	<i>Family coverage:</i>	\$4,700: Individual
		\$9,400: Family
Calendar Year Pharmacy Deductible	<i>Individual coverage:</i>	\$50
	<i>Family coverage:</i>	\$50: Individual
		\$100: Family

Calendar Year Out-of-Pocket Maximum

An Out-of-Pocket Maximum is the most a Member will pay for Covered Benefits each Calendar Year. Any exceptions are listed in the Evidence of Coverage.

	When using a Participating Provider
<i>Individual coverage:</i>	\$11,650
<i>Family coverage:</i>	\$11,650: Individual
	\$23,300: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount the Plan will pay for Covered Services.

2027 Patient-Centered Benefit Plan Designs 10.0 EHB Summary of Benefits and Coverage Member Cost Share amounts describe the Member's out of pocket costs.	
	CalOptima Health Covered Silver 70 HMO
Actuarial Value – AV Calculator	71.6%
Plan design includes a deductible?	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,700 / \$50 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$9,400 / \$100 / \$0
Individual Out-of-pocket maximum	\$11,650
Family Out-of-pocket maximum	\$23,300
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health Care Provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$50	
	Other practitioner office visit	\$50	
	Specialist visit	\$100	
	Preventive care/screening/immunization	No charge	
Tests	Laboratory Tests	\$50	
	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
Drugs to treat illness or condition	Tier 1	\$20	
	Tier 2	\$65	Pharmacy deductible
	Tier 3	\$95	Pharmacy deductible
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	30%	
	Physician/surgeon fees	30%	
	Outpatient visit	30%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waiver if admitted)	No charge	
	Medical transportation (including emergency and non-emergency)	\$250	

	Urgent care	\$50	
Hospital stay	Facility fee (<i>e.g.</i> , hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	X
	Physician/surgeon fee	30%	
Mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	\$50	
	Mental/behavioral health and substance use disorder other outpatient items and services	\$50	
Pregnancy	Prenatal care and preconception visits	No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	\$45	X
	Outpatient Rehabilitation and Habilitation services	\$50	
	Skilled nursing care	30%	
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Child Dental Diagnostic and Preventive	Oral Exam Preventive – Cleaning Preventive – X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No charge	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	20%	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	50%	
Child Orthodontics	Medically necessary orthodontics	50%	

Endnotes to Covered California 2027 Patient-Centered Benefit Plan Designs

These endnotes and the Patient-Centered Benefit Plan Designs apply only to Covered Benefits.

Notes:

1)	Any and all cost-sharing payments for in-network Covered Benefits apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In-network services include services provided by an out-of-network Health Care Provider but are approved as in-network by the issuer.
2)	For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
3)	Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
4)	For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for Covered Benefits for all family members.
5)	For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2027 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
6)	Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the \$45 copayment, the lesser amount is the applicable cost-sharing amount.
7)	Where indicated, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, and/or outpatient Mental Health/Substance Use Disorder visits.
8)	Member cost-share for oral anti-cancer drugs shall not exceed \$250 for a script of up to 30 days per state law (Health and Safety Code § 1367.656; Insurance Code § 10123.206).
9)	In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.
10)	For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.
11)	As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits, and glasses (or contact lenses in lieu of glasses) under Child Eye Care.
12)	A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2027 Dental Copay Schedule.
13)	Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This Member cost share applies to the course of treatment as long as the Member remains enrolled in the plan.
14)	Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are Covered Benefits are not addressed by these Patient-Centered Benefit Plan Designs.
15)	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, behavioral health treatment

	for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.																
16)	Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.																
17)	Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.																
18)	The Other Practitioner category may include 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, Podiatrists, acupuncture practitioners, Registered Dietitians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit category for a service provided by one of these practitioners. Services provided by other practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.																
19)	The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.																
20)	The inpatient physician cost share may apply for any physician who bills separately from the facility (e.g. surgeon). A Member's primary care physician or specialist may apply the office visit cost share when conducting a visit to the Member in a hospital or skilled nursing facility.																
21)	Covered California may approve deviations from the benefit plan designs for certain services on a case by case basis if necessary to comply with the California Mental Health Parity Act or federal Mental Health Parity and Addiction Equity Act (MHPAEA).																
22)	Behavioral health treatment for autism and pervasive developmental disorder is covered under Mental/Behavioral health outpatient services.																
23)	Drug tiers are defined as follows:																
	<table border="1"> <thead> <tr> <th>Tier</th><th>Definition</th></tr> </thead> <tbody> <tr> <td>1</td><td>1) Most generic drugs and low cost preferred brands.</td></tr> <tr> <td rowspan="3">2</td><td>1) Non-preferred generic drugs;</td></tr> <tr> <td>2) Preferred brand name drugs; and</td></tr> <tr> <td>3) Any other drugs recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.</td></tr> <tr> <td rowspan="3">3</td><td>1) Non-preferred brand name drugs or;</td></tr> <tr> <td>2) Drugs that are recommended by P&T committee based on drug safety, efficacy and cost or;</td></tr> <tr> <td>3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.</td></tr> <tr> <td rowspan="3">4</td><td>1) Drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies;</td></tr> <tr> <td>2) Drugs that require the Member to have special training or clinical monitoring;</td></tr> <tr> <td>3) Drugs that cost the health plan (net of rebates) more than six hundred dollars (\$600) net of rebates for a one-month supply.</td></tr> </tbody> </table> Some drugs may be subject to zero cost-sharing under the preventive services rules.	Tier	Definition	1	1) Most generic drugs and low cost preferred brands.	2	1) Non-preferred generic drugs;	2) Preferred brand name drugs; and	3) Any other drugs 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) Drugs that are recommended by P&T committee based on drug safety, efficacy and cost or;	3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.	4	1) Drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies;	2) Drugs that require the Member to have special training or clinical monitoring;	3) Drugs that cost the health plan (net of rebates) more than six hundred dollars (\$600) net of rebates for a one-month supply.
Tier	Definition																
1	1) Most generic drugs and low cost preferred brands.																
2	1) Non-preferred generic drugs;																
	2) Preferred brand name drugs; and																
	3) Any other drugs 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) Drugs that are recommended by P&T committee based on drug safety, efficacy and cost or;																
	3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.																
4	1) Drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies;																
	2) Drugs that require the Member to have special training or clinical monitoring;																
	3) Drugs that cost the health plan (net of rebates) more than six hundred dollars (\$600) net of rebates for a one-month supply.																

24)	Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted.
25)	A plan's formulary must include a clear written description of the exception process that an Member could use to obtain coverage of a drug that is not included on the plan's formulary.
26)	The health issuer may not impose a Member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a Member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the Member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.
27)	The cost sharing for hospice services applies regardless of the place of service.
28)	For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.
29)	For inpatient stays, if the facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.
30)	For any benefit plan design in which a designation of Individual-Only or CCSB-Only is not present, the benefit plan design shall be applicable to the individual and small group markets. If a health plan seeks to offer such benefit plan design(s) in both markets, they shall be treated as separate benefit plan designs for purposes of regulatory compliance.
31)	The out-of-pocket maximum in the Bronze HDHP shall not exceed the maximum out-of-pocket limit specified by the IRS in its revenue procedure for the 2027 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.
32)	These Endnotes do not limit an issuer's obligations to comply with applicable Federal, State, or local laws, rules, or regulations. In the event an issuer is subject to a newly enacted or amended law, rule, or regulation that conflicts with the requirements of these Endnotes, an issuer shall comply with the law, rule, or regulation and any applicable guidance from its regulatory authority. Where these Endnotes exceed requirements imposed by law, an issuer shall comply with the requirements in these Endnotes.
33)	HSA-eligible plans may offer telehealth and other remote care services on a pre-deductible basis consistent with 26 U.S.C. Section 223.