Plan Design Comparison: Covered California Silver Plan vs. Short-Term Limited Duration Insurance Plans (various states)
3/7/2018

Issuer Name, Plan Type, and Year Offered	Covered California (Various Issuers)		Aliera Healthcare		The IHC Group		Blue Cross BlueShield of Arizona		Pivot Health / Companion Life		Agile Health Insurance	
	Standard Silver Plan		InterimCare PLUS		Secture STM		Short-Term Medical Insurance		Short-Term Medical Companion Economy		Everest Prime 5000/30/10000/750000	
	Offered in 2018		***Offered in 2018***		***Offered in 2018***		***Offered in 2018***		***Offered in 2018***		***Offered in 2018***	
	California		*California*		*California*		*Arizona*		*Arkansas*		*New Hampshire*	
Monthly Premium	Age 30, Sacramento: **$424.68**		Age 0-39: **$294.67/mo**		Female, Age 30, Sacramento: **$175.84/mo**		Female, Age 30, Sedona: **$120.20**		Female, Age 30, Fayetteville: **$71.91**		Female, Age 30, Concord: **$74.70**	
Coverage Maximum	None		$1,000,000 ($500,000 per incident)		$2,000,000		$2,000,000		$100,000		$750,000	
Annual maximum out of pocket (MOOP)	$7,000 Individual	$14,000 Family	$10,000‡		$5,000 Individual/Family*†		$4,500 Individual / Family*†		$10,000 Individual†	$30,000 Family†	$10,000 Individual / Family†	
Annual deductible	$2,500 Medical $130 Pharmacy	$5,000 Medical $260 Pharmacy	$5,000 Individual	$5,000 Family†	$5,000 Individual*	$15,000 Family*	$2,500 Individual*	$7,500 Family*	$7,500 Individual / Family*		$5,000 Individual*	$15,000 Family*
Preventive care	No charge		One preventive visit₸		Coverage varies		30% coinsurance		Coverage varies		One annual routine physical: $50 copay	
Primary Care Office visits	$35		First office visit: $50 Additional visits: 25% coinsurance after deductible		50% coinsurance after deductible		First office visit: $50 copay Additional office visits: 30% coinsurance after deductible		30% coinsurance after deductible		$40	
Labs	$35		25% coinsurance after deductible		50% coinsurance after deductible		30% coinsurance after deductible		30% coinsurance after deductible		20% coinsurance after deductible	
X-ray	$75		25% coinsurance after deductible		50% coinsurance after deductible		30% coinsurance after deductible		30% coinsurance after deductible		20% coinsurance after deductible	
Generic Drugs	$15 copay after meeting $130 drug deductible		25% coinsurance after deductible*		Not covered		Not covered		Not covered. Prescription drug discount card included at no additional cost.		Not covered	
Brand Drugs	$55 copay after meeting $130 drug deductible		25% coinsurance after deductible*		Not covered		Not covered		Not covered. Prescription drug discount card included at no additional cost.		Not covered	
Emergency Room	$350 copay (waived if admitted)		25% coinsurance after deductible		50% coinsurance after deductible		30% coinsurance after deductible		Subject to deductible and coinsurance; extra $450 deductible applies if not admitted		$500 copay (after which the deductible and 20% coinsurance applies)	
Hospitalization	20% coinsurance after medical deductible		25% coinsurance after deductible		50% coinsurance after deductible		30% coinsurance after deductible (covered up to the most common average semi-private room rate)		$750 plus deductible and 30% coinsurance		20% coinsurance after deductible	
Maternity	20% coinsurance after medical deductible		Not covered		Not covered		Not covered		Not covered		Not covered	
Coverage for the treatment of pre-existing conditions	Yes		Not covered		Not covered		Not covered		Pre-existing conditions diagnosed within the sixty-month period immediately preceding such covered person's effective date are excluded for the first 12 months of coverage.		Charges resulting directly or indirectly from a condition for which a Covered Person received medical treatment, diagnosis, care or advice, including diagnostic tests or medications, within the 60-month period immediately preceding such person's Certificate Effective Date are excluded for the first 12 months of coverage hereunder.	
Enrollees subject to underwriting	No		Yes		Yes		Yes		Yes		Yes	

Service exclusions (non-exhaustive list)		Treatment for: --Chronic fatigue or pain disorders --Immunodeficiency disorder --AIDS --Contraceptives	Treatment for: --Birth control pills and other contraceptives --Alcoholism and substance use --Acne and varicose veins --Sleeping disorders --Injury from hang gliding, scuba diving, other recreational activities	Treatment for: --Mental illness or nervous disorders --Alcoholism or drug addiction --Tobacco use cessation --Acne or varicose veins --Sleeping disorders	Treatment for: --Alcoholism or drug addiction --Cataracts --Sexually transmitted disease --Immunizations and routine physicals --Any drug, treatment or procedure that either promotes or prevents conception	Treatment for: --Chronic fatigue or pain disorders --Cataracts --Mental, emotional or nervous disorders or counseling --Substance abuse --Any drug, treatment or procedure that either promotes or prevents conception
Notes		‡MOOP is per incident/per term †Each family member is subject to the individual deductible amount, i.e. a family of three would have a total $15,000 deductible, $5,000 per person)	*The enrollee may select the deductible amount from a set of choices. For individuals, the options are $1,000, $,2,500, and $5,000. The family equivalent is triple the amount of the individual deductible (each individual in a family is limited to the individual amount). The enrollee may also select the coinsurance amount (20%, 50%) and the MOOP amount ($2,000, $5,000)	*The enrollee may select the deductible amount from a set of choices. For individuals, the options are $1,000, $1,800, $,2,500, and $5,000. The family equivalent is triple the amount of the individual deductible. The enrollee may also select the coinsurance amount from a set of choices: 20%, 30%, 50%	*The enrollee may select the deductible amount from a set of choices. For individuals, the options are $3,000, $5,000, $7,500, and $10,000. The enrollee may also select the coinsurance amount: 20%, 30%	*The enrollee may select the deductible amount from a set of choices. For individuals, the options are $1,000, $2,500, $5,000. The family equivalent is triple the amount of the individual deductible. The enrollee may also select the coinsurance amount: 30%, 20%, 0%
		₸Preventive visit is only covered in policies of 180 days or more *$3,000 maximum Rx benefit per person, per term	†Annual maximum out of pocket is specific to charges applied to coinsurance and does not include the deductible.	†Annual maximum out of pocket does not include the deductible, any precertification penalty amounts or expenses not covered by the plan	†Annual maximum out of pocket does not include the deductible or copays. The family equivalent is triple the amount of the individual maximum.	†MOOP includes deductible