



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.MySeeChangeHealth.com or by calling 1-866-218-6009.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network Out-of-Network \$4,000 \$6,000 The deductible doesn't apply to preventive care.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In-Network Out-of-Network \$5,500 \$8,000 Standard Standard \$5,000 \$7,000 Enhanced Enhanced	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums and excluded services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	Yes, this policy has an overall annual limit of \$5,000,000.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes specific coverage limits such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See www.MySeeChangeHealth.com or call 1-866-218-6009 for a list of participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist .	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan documents for additional information about excluded services .

Enhanced Benefits: This plan will provide you with Enhanced benefits when you complete Preventive Health Actions: annual health questionnaire, biometric screening and age/gender specific preventive health examination. Incentives are based on compliance efforts; not on the outcome of your health. Co-insurance will be reduced or eliminated retroactive to the first day of the plan year.

Questions: Call 1-866-218-6009 or visit us at www.MySeeChangeHealth.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.MySeeChangeHealth.com

SeeChange Health Insurance : California HSA 4000 2-50

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: _____ - _____

Coverage for: Single

Plan Type: PPO



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Standard Benefits In-Network/Out-of-network	Enhanced Benefits In-Network/Out-of-network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% / 30% co-insurance	0% / 10% co-insurance	-----none-----
	Specialist visit	20% / 30% co-insurance	0% / 10% co-insurance	-----none-----
	Other practitioner office visit	20% / 30% co-insurance	0% / 10% co-insurance	-----none-----
	Preventive care/screening/immunization	0% / Not covered	0% / Not covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	20% / 30% co-insurance	0% / 10% co-insurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% / 30% co-insurance	0% / 10% co-insurance	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.MySeeChangeHealth.com	Tier 1: Generic Drugs	\$10 Rx (retail), \$25 Rx (mail order) after full health plan deductible is satisfied. / Not covered (NC)	Same as Standard / Not covered (NC)	Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail-order prescription).
	Tier 2: Preferred Brand-Name Drug	\$35 Rx (retail), \$87.50 Rx (mail order after full health plan deductible is satisfied. / NC	Same as Standard / Not covered	Out-of-Network NC
	Tier 3: Non-Preferred Brand-Name Drugs (Non-Formulary)	50% co-insurance (retail and mail order) after full health plan deductible is satisfied./ NC	Same as Standard / Not covered	Out of network Rx benefits are not available
	Tier 4: Specialty Pharmacy / Injectable drugs (Mail Order available in 30 day supply only)	35% co-insurance up to \$300 (retail and mail order) after full health plan deductible is satisfied./ NC	Same as Standard / Not covered	Out of network Rx benefits are not available
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% / 30% co-insurance	0% / 10% co-insurance	Preauthorization required
	Physician/surgeon fees	20% / 30% co-insurance	0% / 10% co-insurance	-----none-----

Questions: Call 1-866-218-6009 or visit us at www.MySeeChangeHealth.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.MySeeChangeHealth.com

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Standard Benefits In-Network/Out-of-network	Enhanced Benefits In-Network/Out-of-network	
If you need immediate medical attention	Emergency room services	\$250 co-pay (waived if admitted) plus 20% / 30% for diagnostic.	\$250 co-pay (waived if admitted) plus 0% / 10% for diagnostic.	none
	Emergency medical transportation	20% co-insurance	0% co-insurance	none
	Urgent care	0% after \$150 co-payment	0% after \$150 co-payment	none
If you have a hospital stay	Facility fee (e.g., hospital room)	20% / 30% co-insurance	0% / 10% co-insurance	Preauthorization required
	Physician/surgeon fee	20% / 30% co-insurance	0% / 10% co-insurance	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% / 30% co-insurance	0% / 10% co-insurance	30 visits per year max
	Mental/Behavioral health inpatient services	20% / 30% co-insurance	0% / 10% co-insurance	30 days per year max Preauthorization required
	Chemical Dependency outpatient services	20% / 30% co-insurance	0% / 10% co-insurance	30 visits per year max
	Chemical Dependency inpatient services	20% / 30% co-insurance	0% / 10% co-insurance	30 days per year max Preauthorization required
If you are pregnant	Prenatal and postnatal care	20% / 30% co-insurance	0% / 10% co-insurance	none
	Delivery and all inpatient services	20% / 30% co-insurance	0% / 10% co-insurance	Preauthorization required

Questions: Call 1-866-218-6009 or visit us at www.MySeeChangeHealth.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.MySeeChangeHealth.com

SeeChange Health Insurance : California HSA 4000 2-50

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: _____ - _____

Coverage for: Single

Plan Type: PPO

	Home health care	20% / 30% co-insurance	0% / 10% co-insurance	60 visits per year Preauthorization required
	Rehabilitation services	20% / 30% co-insurance	0% / 10% co-insurance	30 visits per year Preauthorization required
	Skilled nursing care	20% / 30% co-insurance	0% / 10% co-insurance	60 days per year Preauthorization required
	Durable medical equipment	20% / 30% co-insurance	0% / 10% co-insurance	\$2,000 per year max per single equipment purchase
	Hospice service	20% / 30% co-insurance	0% / 10% co-insurance	Preauthorization required
	Eye exam	20% co-insurance / Not covered	0% co-insurance / Not covered	1 exam per covered person per year.
	Glasses	Not covered	Not covered	—none—
	Dental check-up	Not covered	Not covered	—none—

Questions: Call 1-866-218-6009 or visit us at www.MySeeChangeHealth.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.MySeeChangeHealth.com

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (Services that are not Medically Necessary): This isn't a complete list.
Check your policy or plan document for other excluded services.

- | | | |
|---------------------|--|--------------------------|
| • Bariatric surgery | • Cosmetic surgery | • Dental care (Adult) |
| • Long-term care | • Non-emergency care while traveling outside of the U.S. | • Private-duty nursing |
| • Routine foot care | • Weight-loss programs | • Alternative treatments |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|-------------------------|----------------------------|---------------------------|
| • Acupuncture | • Chiropractic care | • Hearing aids |
| • Infertility treatment | • Routine eye care (Adult) | • Voluntary sterilization |

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-218-6009. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Member Services toll free at 1-866-218-6009. Additionally, a consumer assistance program can help you file your appeal. Please go to <http://www.insurance.ca.gov/contact-us/0200-file-complaint/index.cfm> for more information.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Questions: Call 1-866-218-6009 or visit us at www.MySeeChangeHealth.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.MySeeChangeHealth.com

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby

(normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays:** \$2,870
- **Patient pays:** \$4,670

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions – Outpatient Generic	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$4,000
Co-pays	\$10
Co-insurance	\$660
Limits or exclusions	\$0
Total	\$4,670

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$4,100
- **Plan pays:** \$140
- **Patient pays:** \$3,960

Sample care costs:

Prescriptions – Specialty/Injectable	\$1,500
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures – 1 visit	\$730
Education	\$290
Laboratory tests	\$140
Vaccines, other preventive	\$140
Total	\$4,100

Patient pays:

Deductibles	\$3,960
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$0
Total	\$3,960

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.MySeeChangeHealth.com or by calling 1-866-218-6009.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network Out-of-Network \$8,000 \$12,000 The deductible doesn't apply to preventive care.	Aggregate family deductible : All family members contribute to a combined family deductible amount before your plan begins to pay. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In-Network Out-of-Network \$11,000 \$16,000 Standard Standard \$10,000 \$14,000 Enhanced Enhanced	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums and excluded services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	Yes, this policy has an overall annual limit of \$5,000,000.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes specific coverage limits such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See www.MySeeChangeHealth.com or call 1-866-218-6009 for a list of participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist .	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan documents for additional information about excluded services .

Enhanced Benefits: This plan will provide you with Enhanced benefits when you complete Preventive Health Actions: annual health questionnaire, biometric screening and age/gender specific preventive health examination. Incentives are based on compliance efforts; not on the outcome of your health. Co-insurance will be reduced or eliminated retroactive to the first day of the plan year.

Questions: Call 1-866-218-6009 or visit us at www.MySeeChangeHealth.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.MySeeChangeHealth.com

SeeChange Health Insurance : California HSA 4000 2-50

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: _____ - _____

Coverage for: Family | Plan Type: PPO



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Standard Benefits In-Network/Out-of-network	Enhanced Benefits In-Network/Out-of-network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% / 30% co-insurance	0% / 10% co-insurance	none
	Specialist visit	20% / 30% co-insurance	0% / 10% co-insurance	none
	Other practitioner office visit	20% / 30% co-insurance	0% / 10% co-insurance	none
	Preventive care/screening/immunization	0% / Not covered	0% / Not covered	none
If you have a test	Diagnostic test (x-ray, blood work)	20% / 30% co-insurance	0% / 10% co-insurance	none
	Imaging (CT/PET scans, MRIs)	20% / 30% co-insurance	0% / 10% co-insurance	none
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.MySeeChangeHealth.com	Tier 1: Generic Drugs	\$10 Rx (retail), \$25 Rx (mail order) after full health plan deductible is satisfied. / Not covered (NC)	Same as Standard / Not covered (NC)	Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail-order prescription). Out-of-Network NC
	Tier 2: Preferred Brand-Name Drug	\$35 Rx (retail), \$87.50 Rx (mail order after full health plan deductible is satisfied. / NC	Same as Standard / Not covered	
	Tier 3: Non-Preferred Brand-Name Drugs (Non-Formulary)	50% co-insurance (retail and mail order) after full health plan deductible is satisfied./NC	Same as Standard / Not covered	Out of network Rx benefits are not available
	Tier 4: Specialty Pharmacy / Injectable drugs (Mail Order available in 30 day supply only)	35% co-insurance up to \$300 (retail and mail order) after full health plan deductible is satisfied. / NC	Same as Standard / Not covered	Out of network Rx benefits are not available
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% / 30% co-insurance	0% / 10% co-insurance	Preauthorization required
	Physician/surgeon fees	20% / 30% co-insurance	0% / 10% co-insurance	none

Questions: Call 1-866-218-6009 or visit us at www.MySeeChangeHealth.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.MySeeChangeHealth.com

2 of 7

CA SBC 2-50 HSA 4000 20130501b

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Standard Benefits In-Network/Out-of-network	Enhanced Benefits In-Network/Out-of-network	
If you need immediate medical attention	Emergency room services	\$250 co-pay (waived if admitted) plus 20% / 30% for diagnostic.	\$250 co-pay (waived if admitted) plus 0% / 10% for diagnostic.	none
	Emergency medical transportation	20% co-insurance	0% co-insurance	none
	Urgent care	0% after \$150 co-payment	0% after \$150 co-payment	none
If you have a hospital stay	Facility fee (e.g., hospital room)	20% / 30% co-insurance	0% / 10% co-insurance	Preauthorization required
	Physician/surgeon fee	20% / 30% co-insurance	0% / 10% co-insurance	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% / 30% co-insurance	0% / 10% co-insurance	30 visits per year max
	Mental/Behavioral health inpatient services	20% / 30% co-insurance	0% / 10% co-insurance	30 days per year max Preauthorization required
	Chemical Dependency outpatient services	20% / 30% co-insurance	0% / 10% co-insurance	30 visits per year max
	Chemical Dependency inpatient services	20% / 30% co-insurance	0% / 10% co-insurance	30 days per year max Preauthorization required
If you are pregnant	Prenatal and postnatal care	20% / 30% co-insurance	0% / 10% co-insurance	none
	Delivery and all inpatient services	20% / 30% co-insurance	0% / 10% co-insurance	Preauthorization required

SeeChange Health Insurance : California HSA 4000 2-50

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: _____ - _____

Coverage for: Family

| Plan Type: PPO

	Home health care	20% / 30% co-insurance	0% / 10% co-insurance	60 visits per year Preauthorization required
	Rehabilitation services	20% / 30% co-insurance	0% / 10% co-insurance	30 visits per year Preauthorization required
	Skilled nursing care	20% / 30% co-insurance	0% / 10% co-insurance	60 days per year Preauthorization required
	Durable medical equipment	20% / 30% co-insurance	0% / 10% co-insurance	\$2,000 per year max per single equipment purchase
	Hospice service	20% / 30% co-insurance	0% / 10% co-insurance	Preauthorization required
	Eye exam	20% co-insurance / Not covered	0% co-insurance / Not covered	1 exam per covered person per year. Out-of-network benefits NC
	Glasses	Not covered	Not covered	none
	Dental check-up	Not covered	Not covered	none

Questions: Call 1-866-218-6009 or visit us at www.MySeeChangeHealth.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.MySeeChangeHealth.com

4 of 7

CA SBC 2-50 HSA 4000 20130501b

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (Services that are not Medically Necessary): This isn't a complete list.
Check your policy or plan document for other excluded services.

- | | | |
|---------------------|--|--------------------------|
| • Bariatric surgery | • Cosmetic surgery | • Dental care (Adult) |
| • Long-term care | • Non-emergency care while traveling outside of the U.S. | • Private-duty nursing |
| • Routine foot care | • Weight-loss programs | • Alternative treatments |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|-------------------------|----------------------------|---------------------------|
| • Acupuncture | • Chiropractic care | • Hearing aids |
| • Infertility treatment | • Routine eye care (Adult) | • Voluntary sterilization |

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-218-6009. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Member Services toll free at 1-866-218-6009. Additionally, a consumer assistance program can help you file your appeal. Please go to <http://www.insurance.ca.gov/contact-us/0200-file-complaint/index.cfm> for more information.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays:** \$40
- **Patient pays:** \$7,500

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions – Outpatient Generic	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$7,500
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$0
Total	\$7,500

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$4,100
- **Plan pays:** \$140
- **Patient pays:** \$3,960

Sample care costs:

Prescriptions – Specialty/Injectable	\$1,500
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures – 1 visit	\$730
Education	\$290
Laboratory tests	\$140
Vaccines, other preventive	\$140
Total	\$4,100

Patient pays:

Deductibles	\$3,960
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$0
Total	\$3,960

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.