ColCal Colorado, Inc.: Employee Benefit $1,000 Plan

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

Coverage Period: Beginning on or after 1/1/2015
Coverage for: Individual/Family | **Plan Type:** PPO

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.cnichs.com or http://secure.healthx.com/cnic_new.aspx or by calling 1-800-426-7453.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000/**person **$3,000/**family for participating providers. **$2,500/**person **$7,500/**family for non-participating providers. Doesn't apply to in-network preventive care or pharmacy charges.	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 1st). 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?	Yes. **$50/**person **$150/**family for dental coverage. There are no other specific deductibles.	You must pay all 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?	Yes. For network providers **$3,300/**person **$8,400/**family. For non-network providers **$4,000/**person **$10,300/**family. Network and non-network out-of-pocket maximums cross accumulate.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, cost containment penalties, health care 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?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of network providers in Colorado, see www.rmhp.org or call **(800) 426-7453.** For California employees, see www.ahappo.com or call **(800) 870-6252**.	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 6. See your policy or plan document for additional information about **excluded services**

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	40% coinsurance	----------None----------
	Specialist visit	$45 copay/visit	40% coinsurance	----------None----------
	Other practitioner office visit	20% coinsurance for chiropractic	40% coinsurance for chiropractic	$1,000 calendar year maximum for chiropractic
	Preventive care/screening/immunization	No charge	40% coinsurance	----------None----------
If you have a test	Diagnostic test (X-ray, blood work)	$20 copay/lab test $35 copay/X-ray in physician office; $55 copay plus 20% coinsurance all other locations	40% coinsurance after $35 copay/lab test or $65 copay/X-ray in physician office; 40% coinsurance after $105 copay all other locations	----------None----------
	Imaging (CT/PET scans, MRIs)	$35 copay/test in physician office; $55 copay plus 20% coinsurance all other locations	40% coinsurance after $65 copay/test in physician office; 40% coinsurance after $105 copay all other locations	----------None----------

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welldynerx.com.	Generic drugs	$15 copay/Rx (retail) $25 copay/Rx (mail order)	Not covered	Covers up to a 34-day supply (retail prescription); 31-90 day supply (mail order prescription) If a preferred or non-preferred brand name drug is chosen instead of available generic, the covered person is responsible for copay plus any cost difference between brand and generic drugs. Limited exceptions exist for prescriptions filled at non-participating pharmacies. See plan document for exceptions.
	Preferred brand drugs	$30 copay/Rx (retail) $55 copay/Rx (mail order)	Not covered	
	Non-preferred brand drugs	$55 copay/Rx (retail) $105 copay/Rx (mail order)	Not covered	
	Specialty drugs	$250 copay/Rx (retail)	Not covered	Covers up to a 30-day supply. Mail order not available.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	----------None----------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	----------None----------
If you need immediate medical attention	Emergency room services	$250 copay/visit and 20% coinsurance	$250 copay/visit and 20% coinsurance	Copay is waived if patient is admitted to hospital from ER.
	Emergency medical transportation	20% coinsurance	20% coinsurance	----------None----------
	Urgent care	$65 copay/visit and 20% coinsurance	$125 copay/visit and 40% coinsurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification is required. If not precertified, the deductible will increase by $500 and benefits will be paid at 70%.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	----------None----------

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$45 copay/office visit; 20% coinsurance other outpatient services	40% coinsurance	----------None----------
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Precertification is required. If not precertified, the deductible will increase by $500 and benefits will be paid at 70%.
	Substance use disorder outpatient services	$45 copay/office visit; 20% coinsurance other outpatient services	40% coinsurance	----------None----------
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Precertification is required. If not precertified, the deductible will increase by $500 and benefits will be paid at 70%.
If you are pregnant	Prenatal and postnatal care	No charge for prenatal services, 20% coinsurance for postnatal care	40% coinsurance	In-network routine prenatal visits (to include certain lab services, tobacco cessation counseling and certain immunizations as required by applicable regulations) – **no cost share (if billed in office visit setting)**.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Hospitalization of a newborn beyond the mother's discharge date must be precertified. If precertification is not obtained, the deductible will increase by $500 and benefits will be paid at 70%.

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If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	60-visit calendar year maximum
	Rehabilitation services	20% coinsurance	40% coinsurance	Includes therapy services such as physical and speech therapies.
	Habilitation services			
	Skilled nursing care	20% coinsurance	40% coinsurance	Within 14 days of a 3-day hospital stay.
	Durable medical equipment	20% coinsurance	40% coinsurance	----------None----------
	Hospice service	20% coinsurance	40% coinsurance	Includes bereavement counseling.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	----------None----------
	Glasses	Not covered	Not covered	----------None----------
	Dental check-up	No charge	No charge	Oral exams covered once every 6 months. Maximum of $1,500 per person per year

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Excluded Services & Other Covered Services: Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services).

- Cosmetic surgery, except for symmetrical reconstruction as provided under the reconstructive surgery benefit
- Hearing aids
- Infertility treatment, except for initial testing for diagnosis
- Long-term care
- Non-emergency care when traveling outside the U.S. (if sole purpose is for obtaining medical services)
- Routine eye care
- Routine foot care
- Weight loss programs

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 (when medically necessary to treat a covered illness or injury
- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Private duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on 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 970-255-0898. 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.cciio.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 the plan at 970-255-0898 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-426-7453.

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

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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:** $5,250
- **Patient pays:** $2,290

Sample care costs:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient Pays:	
Deductibles	$1,000
Copays	$170
Coinsurance	$1,120
Limits or exclusions	$0
Total	**$2,290**

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,400
- **Patient pays:** $2,000

Sample care costs:	
Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient Pays:	
Deductibles	**$1,000**
Copays	**$880**
Coinsurance	**$120**
Limits or exclusions	**$0**
Total	**$2,000**

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**, **copayments** and **coinsurance** 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 **copayments**, **deductibles** and **coinsurance**. 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.