Memorandum

To: IVC Pre-65 Retirees

From: Travis Gregory, Administrative Dean of Human Resources

Date: September 16, 2013

Subject: Summary of Benefits and New Health Insurance Marketplace Coverage Information

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Attention All Employees:

Attached, you will find a "Summary of Benefits" regarding our Health Insurance plan options and what the plan covers with important information. You will also find general information about the "New Health Insurance Marketplace Coverage" law that takes effect in 2014 for your review.

We are providing this Notice only because federal law requires us to provide it to you. We can provide you with no further information about its contents. We also cannot provide you with assistance in evaluating your options for exchange coverage or the potential penalties under the law, but the government agencies will have some educational materials and sources for additional information.

You can find more information to help you make your decision at www.healthcare.gov or https://www.cuidadodesalud.gov/es/ (Spanish); starting October 1, you can also call (800) 318-2596."

This Exchange Notice is being furnished to you electronically and describes important information regarding insurance exchanges under health reform law. It does not modify the benefits information you previously received, but you may wish to retain this item for future reference. You have a right to request and obtain a paper version at no charge. Please contact Martha Sanchez, who is distributing this item, at 760.355.6210 or Martha.sanchez@imperial.edu to request a paper version.

Attachments: *Summary of Benefits and Coverage*
New Health Insurance Marketplace Coverage Information

Health Care Reform: What You Need to Know

You've been hearing about the Affordable Care Act (ACA)—often just called health care reform—for several years now. Some health care reform rules have already gone into effect for most plans, such as free preventive care and the option to keep your adult child on your medical plan until age 26.

With even bigger changes scheduled to take place by the end of the year, we want to help you understand what you need to know as an ICSVEBA member.

Our Benefits Program

ICSVEBA will continue to offer a competitive medical benefits package for you and your family utilizing the Anthem Blue Cross JAA Network. For some time, our coverage has been more generous than what the law requires in many respects, and it will continue. As such, many of you will not find the need to go to the exchange. Please keep in mind that if you are eligible for the ICSVEBA health plan and you decide to purchase insurance through the exchange instead, you will not be eligible for a tax credit. Also, when you enroll in your District employer's health plan through the ICSVEBA, your District pays a portion of your premium, and you pay your share with tax-free money – which could make the ICSVEBA plan less expensive for you overall.

Health Insurance Exchanges

When key parts of health care reform take effect on January 1, 2014, insurance will be available through new, state-based health insurance marketplaces called "exchanges." These exchanges will allow people to compare the benefits and costs of all available medical plan options. Financial assistance will be available for those who qualify.

The exchanges will be open for business on October 1, 2013, selling medical coverage that begins January 1, 2014. You will receive information about the exchanges as required by the federal government in the summer or early fall.

We cannot provide you with assistance in evaluating your options for exchange coverage, but the government agencies will have some educational materials and sources for additional information. You can find more information to help you make your decision at www.healthcare.gov or https://www.cuidadodesalud.gov/es/ (Spanish); starting October 1, you can also call (800) 318-2596.

The Individual Mandate: Do Not Worry about the Penalty

Health care reform requires most Americans to have health insurance starting January 1, 2014, or pay a penalty. This doesn't affect you if you and your family members already have insurance—through ICSVEBA , your spouse's employer, or an individual policy, for example.

We are sharing information with you about what is currently known or discussed about health care reform. We cannot guarantee its accuracy, or that there won't be future changes, and many other factors can affect you and your options under the law. If you need to rely on any information about this law, we suggest you speak to your own personal tax or financial advisor.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Martha Sanchez, Human Resources Specialist.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Imperial Valley College	95-6006350
5. Employer address	**6. Employer phone number**
380 East Aten Road / PO Box 158	760-355-6212

7. City	8. State	9. ZIP code
Imperial	CA	92251

10. Who can we contact about employee health coverage at this job?	
Martha Ulloa-Sanchez, Human Resources Specialist	
11. Phone number (if different from above)	**12. Email address**
760-355-6210	martha.sanchez@imperial.edu

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☑ Some employees. Eligible employees are:

    Administrators, Board Members, Classified, Confidentials, Managers, Full-Time Faculty & Pre-65 Retirees

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Spouse, Domestic Partner, Natural Child, Step Child, Adopted Child (eligible dependent coverage to age 26).

  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much will the employee have to pay in premiums for that plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy):

• An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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.deltahealthsystems.com or by calling **1-866-691-2443**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** individual / **$1,500** family for In-Network and **$700** individual / **$2,100** family for Non-Network. Does not apply to co-pays, emergency room care for an emergency, prescription drugs or preventive care. Covered expenses applied to your in-network deductible do not count toward your non-network deductible and vice versa.	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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,000** individual / **$6,000** family for In-Network and **$6,000** individual / **$18,000** family for Non-Network.	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, co-pays, penalties for failure to obtain preauthorization services, expenses which exceed UCR and health care this plan doesn't cover. Covered expenses applied to your in-network out-of-pocket limit do not count toward your non-network out-of-pocket limit and vice versa.	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. See www.anthem.com/ca or call **1-866-691-2443** for a list of Network 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	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this

specialist?		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**.

- **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 **coinsurance** 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.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25/visit	50% coinsurance	——————none——————
	Specialist visit	$50/visit	50% coinsurance	——————none——————
	Other practitioner office visit	$30/visit	50% coinsurance	Acupuncture and chiropractic have a combined maximum benefit of $1,500 per calendar year.
	Preventive care/screening/immunization	No charge	50% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% coinsurance	When lab services are provided in the doctor's office or at an outpatient lab or x-ray facility.
	Imaging (CT/PET scans, MRIs)	No charge	50% coinsurance	When imaging services are provided in the doctor's office or at an outpatient imaging facility.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	$5/prescription retail and mail order.		Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).
	Preferred Brand Name Drugs	$20/prescription retail and mail order.		
	Non-Preferred Brand Name Drugs	$35/prescription retail and mail order.		
	Specialty Drugs	See above		This category is covered under the appropriate drug tier and all limitations and exceptions apply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Potentially cosmetic or investigative services require pre-authorization.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Potentially cosmetic or investigative services require pre-authorization
If you need immediate medical attention	Emergency room services	$250/visit		——————none——————
	Emergency room services in a non-emergency	20% coinsurance	50% coinsurance	——————none——————
	Emergency medical transportation	20% coinsurance	20%coinsurance	Air ambulance is limited to a maximum benefit of $19,000 per incident.
	Urgent care	$30/visit	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$250/admission then 20% coinsurance		Pre-authorization is required.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not Covered	Not Covered	Benefits for Mental/Behavioral Health and Substance use disorders are covered through a separate plan with **The Holman Group**. Call 1-800-321-2843 or www.holmangroup.com.
	Mental/Behavioral health inpatient services	Not Covered	Not Covered	
	Substance use disorder outpatient services	Not Covered	Not Covered	
	Substance use disorder inpatient services	Not Covered	Not Covered	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	——————none——————
	Delivery and all inpatient services	$250/admission then 20% coinsurance		Services must be pre-authorized for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Services must be pre-authorized.
	Rehabilitation services	$15/visit	50% coinsurance	The services must be specifically prescribed by a physician as to type and duration and must be for improvement of bodily function.
	Habilitation services	$15/visit	50% coinsurance	The services must be specifically prescribed by a physician as to type and duration and must be for improvement of bodily function.
	Skilled nursing care	20% coinsurance	$500/admission, then 50% coinsurance	Services must be pre-authorized. Limited to 90 days per confinement.
	Durable medical equipment	20% coinsurance	50% coinsurance	Limited to a $10,000 lifetime benefit per person.
	Hospice service	20% coinsurance	50% coinsurance	Terminal prognosis of life-expectancy is 6 months or less. Limited to a $10,000 lifetime benefit per person.
If your child needs dental or eye care	Eye exam	Not covered		Not covered.
	Glasses	Not covered		Not covered.
	Dental check-up	Not covered		Not covered.

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	• Glasses (Child)	• Routine Eye Care (Adult)
• Dental Care (Adult)	• Infertility Treatment	• Routine foot care unless for treatment of a peripheral or metabolic disease
• Dental Care (Child)	• Long-term care	• Weight loss programs
	• Non emergency care when traveling outside the U.S.	

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	• Private Duty Nursing
• Bariatric Surgery (must be medically necessary)	• Hearing Aids (maximum benefit of $600 per ear per 60 month period)	

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 1-866-691-2443. 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: 1-.866-691-2443**.** You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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:** $7,400
- **Plan pays:** $5,470
- **Patient pays:** $2,070

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	$500
Copays	$260
Coinsurance	$1,160
Limits or exclusions	$150
Total	**$2,070**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,700
- **Patient pays:** $700

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	$0
Copays	$620
Coinsurance	$0
Limits or exclusions	$80
Total	**$700**

*Limits or exclusions include possible over-the-counter items that may be needed to manage the condition.

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.

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.deltahealthsystems.com or by calling **1-866-691-2443**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** individual / **$4,500** family for In-Network and **$2,000** individual / **$6,000** family for Non-Network. Does not apply to co-pays, emergency room care for an emergency, prescription drugs or preventive care. Covered expenses applied to your in-network deductible do not count toward your non-network deductible and vice versa.	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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,000** individual / **$15,000** family for In-Network and **$10,000** individual / **$30,000** family for Non-Network.	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, co-pays, penalties for failure to obtain preauthorization services, expenses which exceed UCR and health care this plan doesn't cover. Covered expenses applied to your in-network out-of-pocket limit do not count toward your non-network out-of-pocket limit and vice versa.	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. See www.anthem.com/ca or call **1-866-691-2443** for a list of Network 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	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this

specialist?		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**.

- **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 **coinsurance** 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.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35/visit	50% coinsurance	——————none——————
	Specialist visit	$70/visit	50% coinsurance	——————none——————
	Other practitioner office visit	$30/visit	50% coinsurance	Acupuncture and chiropractic have a combined maximum benefit of $1,500 per calendar year.
	Preventive care/screening/immunization	No charge	50% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	When lab services are provided at an outpatient lab or x-ray facility.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	When imaging services are provided at an outpatient imaging facility.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	$5/prescription retail and mail order.		Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).
	Preferred Brand Name Drugs	$20/prescription retail and mail order.		
	Non-Preferred Brand Name Drugs	$35/prescription retail and mail order.		
	Specialty Drugs	See above		This category is covered under the appropriate drug tier and all limitations and exceptions apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Potentially cosmetic or investigative services require pre-authorization.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Potentially cosmetic or investigative services require pre-authorization
If you need immediate medical attention	Emergency room services	$250/visit		——————none——————
	Emergency room services in a non-emergency	20% coinsurance	50% coinsurance	——————none——————
	Emergency medical transportation	20% coinsurance	20%coinsurance	Air ambulance is limited to a maximum benefit of $19,000 per incident.
	Urgent care	$30/visit	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$250/admission then 20% coinsurance		Pre-authorization is required.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not Covered	Not Covered	Benefits for Mental/Behavioral Health and Substance use disorders are covered through a separate plan with **The Holman Group**. Call 1-800-321-2843 or www.holmangroup.com.
	Mental/Behavioral health inpatient services	Not Covered	Not Covered	
	Substance use disorder outpatient services	Not Covered	Not Covered	
	Substance use disorder inpatient services	Not Covered	Not Covered	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	——————none——————
	Delivery and all inpatient services	$250/admission then 20% coinsurance		Services must be pre-authorized for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Services must be pre-authorized.
	Rehabilitation services	$15/visit	50% coinsurance	The services must be specifically prescribed by a physician as to type and duration and must be for improvement of bodily function.
	Habilitation services	$15/visit	50% coinsurance	The services must be specifically prescribed by a physician as to type and duration and must be for improvement of bodily function.
	Skilled nursing care	20% coinsurance	$500/admission, then 50% coinsurance	Services must be pre-authorized. Limited to 90 days per confinement.
	Durable medical equipment	20% coinsurance	50% coinsurance	Limited to a $10,000 lifetime benefit per person.
	Hospice service	20% coinsurance	50% coinsurance	Terminal prognosis of life-expectancy is 6 months or less. Limited to a $10,000 lifetime benefit per person.
If your child needs dental or eye care	Eye exam	Not covered		Not covered.
	Glasses	Not covered		Not covered.
	Dental check-up	Not covered		Not covered.

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 • Dental Care (Adult) • Dental Care (Child)	• Glasses (Child) • Infertility Treatment • Long-term care • Non emergency care when traveling outside the U.S.	• Routine Eye Care (Adult) • Routine foot care unless for treatment of a peripheral or metabolic disease • 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 • Bariatric Surgery (must be medically necessary)	• Chiropractic care • Hearing Aids (maximum benefit of $600 per ear per 60 month period)	• Private Duty Nursing

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 1-866-691-2443. 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: 1-.866-691-2443**.** You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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:** $4,530
- **Patient pays:** $3,010

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	$1,500
Copays	$260
Coinsurance	$1,100
Limits or exclusions	$150
Total	**$3,010**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,800
- **Patient pays:** $1,600

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	$1,150
Copays	$370
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,600**

*Limits or exclusions include possible over-the-counter items that may be needed to manage the condition.

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.

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.simnsa.com or by calling 1-800-424-4652.

NOTE: SIMNSA's Network is in Mexico. All routine care must be provided by SIMNSA Providers in Mexico. SIMNSA coverage in the USA is limited to bona fide emergency or urgent care services.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$6,350** person and **$12,700** family	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, prescription drug copayments, durable medical equipment cost-sharing and payments for 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 participating providers, see www.simnsa.com or call 1-800-424-4652 or 619-407-4082 (in the U.S.), or 683 29 02 (in Mexico)	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?	Yes. All services outside of primary care with the exception of obstetrics and gynecology, mental health, chemical dependency, and optometry require a referral.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call SIMNSA at 619-407-4082 (in the U.S.) or 683 29 02 (in Mexico) or visit www.simnsa.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformglossary.pdf or call 619-407-4082 (U.S.) to request a copy.

- **Co-payments** 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 coinsurance payment of 20% would be $200.
- 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 **preferred providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

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 visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay/visit	Not Covered	none
	Specialist visit	$5 copay/visit	Not Covered	Prior Authorization for services other than OB/GYN required or the service may not be covered. Chiropractic and acupuncture are not covered.
	Other practitioner office visit	Not Covered	Not Covered	
	Preventive care/screening/ immunization	No charge.	Not Covered	none
If you have a test	Diagnostic test (x-ray, blood work)	No charge.	Not Covered	none
	Imaging (CT/PET scans, MRIs)	No charge.	Not Covered	none
If you need drugs to treat your illness or condition For more information about **prescription drug**	Generic drugs	$5 copay/prescrip tion	Not Covered	Drugs, supplies, and supplements are covered when prescribed by a Plan **provider** and in accordance with Plan guidelines. Certain drugs are covered only for a 30-day supply in a 30 day period.
	Preferred brand drugs	$5 copay/prescrip tion	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	

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
coverage call 683-29-02 (in Mexico) or 619-407-4082 (U.S.)	Specialty drugs	$5 copay/prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge.	Not Covered	Copay is per procedure and includes the outpatient facility fee and the outpatient surgery physician and surgical service fee.
	Physician/surgeon fees	No charge.	Not Covered	none
If you need immediate medical attention	Emergency room services	$100 copay/visit	$100 copay/visit	Copay is waived if you are admitted to the hospital.
	Emergency medical transportation	No charge.	No charge.	none
	Urgent care	$25 copay/visit	$50 copay/visit	none
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge.	Not Covered	Copay is per day and includes inpatient hospital services fee and inpatient physician and surgical services fee.
	Physician/surgeon fee	No charge.	Not Covered	none

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 have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	$5 copay/visit	Not Covered	none
	Mental/behavioral health inpatient services	No charge.	Not Covered	none
	Substance use disorder outpatient services	$5 copay/visit	Not Covered	none
	Substance use disorder inpatient services	No charge.	Not Covered	none
If you are pregnant	Prenatal and postnatal care	$5 copay/visit	Not Covered	Normal prenatal visits and first post-natal visit is $0 cost-share.
	Delivery and all inpatient services	No charge.	Not Covered	none
If you need help recovering or have other special health needs	Home health care	No Charge.	Not Covered	Since this Plan's Service Area is in Mexico, Home Health, Rehabilitation and Skilled Nursing services are only available in limited situations; please consult your plan document (also available at www.simnsa.com). Skilled Nursing Facilities are not available in the Plan's Service Area.
	Rehabilitation services	No Charge.	Not Covered	
	Habilitation services	No Charge.	Not Covered	
	Skilled nursing care	No Charge.	Not Covered	
	Durable medical equipment	No Charge.	Not Covered	Must be in accordance with durable medical equipment formulary guidelines. 50% coverage limit applies.
	Hospice service	No Charge.	Not Covered	Since this Plan's Service Area is in Mexico, Hospice Services are only available in limited situations; please consult your plan document (also available at www.simnsa.com) for more information.
If your child needs dental or eye care	Eye exam	$5 copay/visit	Not Covered	Eye exams for the purpose of obtaining or maintaining contact lenses are not covered.
	Glasses	Not Covered	Not Covered	none

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
	Dental check-up	Not Covered	Not Covered	May be covered if dental policy is purchased by your employer. For more information please contact your employer or call us at (619) 407-4082 (in U.S.) or 683-29-02 (in Mexico).

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.)

- Acupuncture
- Bariatric surgery
- Chiropractic Care
- Cosmetic surgery
- Dental Care
- Hearing aids
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the Plan's Service Area in Mexico.
- Non-formulary brand drugs
- Non-medically necessary services/treatment
- Private-duty nursing
- 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.)

- Bariatric Surgery
- Routine eye examination (Adult) with limits.
- Routine Foot Care with limits.

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 Trust's/your employer's office at 1-800-633-2683. You may also contact your state insurance department at 1-888-466-2219, 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 619-407-4082 (U.S.), 683-29-02 (Mexico) or at www.simnsa.com. You may also contact your state consumer assistance program at 1-888-466-2219 (1-888-HMO-HELP).

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Español: Para obtener asistencia en Español, llame al 619-407-4082 (U.S.) o al 683-29-02 (Mexico).

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.

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Having a baby
(normal delivery)

- **Amount owed to providers:** $3,600
- **Plan pays** $3,600
- **Patient pays** $0

Sample care costs:

Hospital charges (mother)	$1,850
Routine obstetric care	$900
Hospital charges (baby)	$150
Anesthesia	$300
Laboratory tests	$125
Prescriptions	$125
Radiology	$100
Vaccines, other preventive	$50
Total	**$3,600**

Patient pays:

Deductibles	$0
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$0
Total	**$0**

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

- **Amount owed to providers:** $2,400
- **Plan pays** $2,150
- **Patient pays** $250

Sample care costs:

Prescriptions	$970
Medical Equipment and Supplies	$250
Office Visits and Procedures	$780
Education	$100
Laboratory tests	$50
Vaccines, other preventive	$0
Total	**$2,150**

Patient pays:

Deductibles	$0
Co-pays	$250
Co-insurance	$0
Limits or exclusions	$0
Total	**$250**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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- 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?

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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.

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You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformglossary.pdf or call 619-407-4082 (U.S.) to request a copy.