

# Plan Option 1: City of Tulare

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

Coverage Period: Beginning on or after 1/1/2015

Coverage for: Active Employees | 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.hnas.com](http://www.hnas.com) or by calling 1-877-356-0666.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In-network: \$1,000 person/ \$2,000 family; out-of-network: \$3,000 person/ \$9,000 family.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. In-network \$4,000 person/ \$8,000 family; out-of-network: \$7,500 person/ \$22,500 family.	The <u>out-of-pocket limit</u> , which includes the medical deductible, coinsurance & co-pays, 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 <u>out-of-pocket limit</u> ?	Rx co-pays, premiums, balance-billed charges, penalties & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	See <a href="http://www.blueshieldca.com/networkppo">www.blueshieldca.com/networkppo</a> or call 1-800-810-2583 for a list of in-network providers.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from the 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 document for additional information about <u>excluded services</u> .

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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 **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 **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$10/visit	30%* coinsurance	--none--
	Specialist visit	\$10/visit	30%* coinsurance	--none--
	Other practitioner office visit - chiropractor	10%* coinsurance after \$15/visit	Not covered	Limited to 20 visits/plan year.
	Preventive care/screening/immunization	No charge	40%* coinsurance	Includes all mandated preventive care as required under PPACA.
If you have a test	Diagnostic test (x-ray, blood work)	10%* coinsurance	40%* coinsurance	--none--
	Imaging (CT/PET scans, MRIs)	10%* coinsurance	40%* coinsurance	Precertification required on select procedures.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10%* coinsurance	40%* coinsurance	--none--
	Physician/surgeon fees	10%* coinsurance	40%* coinsurance	Precertification required on select procedures.**
If you need immediate medical attention	Emergency room services (Emergent use)	10% coinsurance after \$75/visit	10% coinsurance after \$75/visit	--none--
	Emergency room services (Non-emergent use)	40%* coinsurance	40%* coinsurance	--none--
	Emergency medical transportation	10%* coinsurance	10%* coinsurance	--none--
	Urgent care	\$10/visit	40%* coinsurance	--none--

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	10%* coinsurance after \$100 copay	40%* coinsurance	Precertification required.**
	Physician/surgeon fee	10%* coinsurance	40%* coinsurance	--none--
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$10/visit	40%* coinsurance	Certain behavioral services are not covered.
	Mental/Behavioral health inpatient services	10%* coinsurance after \$100 copay	40%* coinsurance	Precertification required.** Certain behavioral services are not covered.
	Substance use disorder outpatient services	\$10/visit	40%* coinsurance	Certain behavioral services are not covered.
	Substance use disorder inpatient services	10%* coinsurance after \$100 copay	40%* coinsurance	Precertification required.** Certain behavioral services are not covered.
If you are pregnant	Prenatal & Postnatal care	No charge	40%* coinsurance	Limited to employee or spouse only.
	Delivery and all inpatient services	10%* coinsurance after \$100 copay	40%* coinsurance	Limited to employee or spouse only.
If you need help recovering or have other special health needs	Home health care	10%* coinsurance	40%* coinsurance	Precertification required for out-of-network services.** Limited to 100 visits/plan year.
	Rehabilitation services – physical, occupational, speech & other rehabilitative therapies.	10%* coinsurance after \$10/visit	40%* coinsurance	Precertification required for speech therapy.** Limited to an aggregated 60 in-network visits/plan year & 30 out-of-network visits/plan year.
	Habilitation services	Not Covered	Not Covered	--none--
	Skilled nursing care	10%* coinsurance	40%* coinsurance	Precertification required.** Limited to 100 consecutive days/plan year in-network; 60 consecutive days/plan year out-of-network.
	Durable medical equipment	10%* coinsurance	40%* coinsurance	Precertification required on select items.**
	Hospice service	10%* coinsurance	40%* coinsurance	Precertification required for inpatient care.** Limited to 180 days/lifetime.

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If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	--none--
	Glasses	Not Covered	Not Covered	--none--
	Dental check-up	Not Covered	Not Covered	--none--

\* Deductible applies.

\*\* Precertification is required before certain medical services. Emergency admissions must be certified within 48 hours following the admission. To precertify services, call the phone number indicated on your ID card. **Failure to precertify out-of-network services will result in a 50% penalty.**

Common Medical Event	Services You May Need	Your Cost If You Use a Retail Pharmacy (30 day supply)	Your Cost If You Use a Mail Order Pharmacy (90 day supply)	Limitations & Exceptions
If you need drugs to treat your illness or condition  More information about <a href="http://www.usscript.com">prescription drug coverage</a> is available at <a href="http://www.usscript.com">www.usscript.com</a> .	Individual Maximum Out-Of-Pocket Amount	\$2,000		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.
	Family Maximum Out-Of-Pocket Amount	\$4,000		
	Generic or single-source brand contraceptives	\$0/prescription	\$0/prescription	Contraceptives that are not generic or single-source brand will be payable under the appropriate co-pay level.
	Generic drugs	\$15/prescription	\$30/prescription	The Prescription Drug Plan will pay up to the generic price, less the generic co-payment, whenever a generic drug is dispensed. If a brand name drug is dispensed, and a generic equivalent is available, the covered person must pay the difference between the cost of the brand name drug and the generic equivalent, plus the generic co-payment unless the physician specifies "Dispense as Written".
	Formulary drugs	\$25/prescription	\$50/prescription	
	Non-formulary drugs	\$40/prescription	\$80/prescription	

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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.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (adult)
- 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
- Chiropractic care

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### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on your 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 1-877-356-0666. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa](http://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](http://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 HNAS at 1-877-356-0666, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### 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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-356-0666.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-356-0666.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-356-0666.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-356-0666.

—————*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 \$5,490
- Patient pays \$1,980

##### 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
<b>Total</b>	<b>\$7,540</b>

##### Patient pays:

Deductibles	\$1,000
Copays	\$220
Coinsurance	\$610
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,980</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$4,000
- Patient pays \$1,480

##### 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
<b>Total</b>	<b>\$5,400</b>

##### Patient pays:

Deductibles	\$380
Copays	\$1,020
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,480</b>

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## 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.

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Important Questions	Answers	Why this Matters:
What is the overall <b><u>deductible</u></b> ?	In-network: \$500 person/ \$1,000 family; out-of-network: \$1,500 person/ \$4,500 family.	You must pay all the costs up to the <b><u>deductible</u></b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b><u>deductible</u></b> 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 <b><u>deductible</u></b> .
Are there other <b><u>deductibles</u></b> for specific services?	No.	You don't have to meet <b><u>deductibles</u></b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <b><u>out-of-pocket limit</u></b> on my expenses?	Yes. In-network \$3,500 person/ \$7,000 family; out-of-network: \$6,000 person/ \$18,000 family.	The <b><u>out-of-pocket limit</u></b> , which includes the medical deductible, coinsurance & co-pays, 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 <b><u>out-of-pocket limit</u></b> ?	Rx co-pays, premiums, balance-billed charges, penalties & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <b><u>network of providers</u></b> ?	See <a href="http://www.blueshieldca.com/networkppo">www.blueshieldca.com/networkppo</a> or call 1-800-810-2583 for a list of in-network providers.	If you use an in-network doctor or other health care <b><u>provider</u></b> , 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 <b><u>provider</u></b> for some services. Plans use the term in-network, <b><u>preferred</u></b> , or participating for <b><u>providers</u></b> in their <b><u>network</u></b> . See the chart starting on page 2 for how this plan pays different kinds of <b><u>providers</u></b> .
Do I need a referral to see a <b><u>specialist</u></b> ?	No.	You can see the <b><u>specialist</u></b> you choose without permission from the plan.
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- 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**.)
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	Other practitioner office visit – chiropractor	10%* coinsurance after \$15/visit	Not covered	Limited to 20 visits/plan year.
	Preventive care/screening/immunization	No charge	40%* coinsurance	Includes all mandated preventive care as required under PPACA.
If you have a test	Diagnostic test (x-ray, blood work)	10%* coinsurance	40%* coinsurance	--none--
	Imaging (CT/PET scans, MRIs)	10%* coinsurance	40%* coinsurance	Precertification required on select procedures.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10%* coinsurance	40%* coinsurance	--none--
	Physician/surgeon fees	10%* coinsurance	40%* coinsurance	Precertification required on select procedures.**
If you need immediate medical attention	Emergency room services (Emergent use)	10% coinsurance after \$75/visit	10% coinsurance after \$75/visit	--none--
	Emergency room services (Non-emergent use)	40%* coinsurance	40%* coinsurance	--none--
	Emergency medical transportation	10%* coinsurance	10%* coinsurance	--none--
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	Substance use disorder inpatient services	10%* coinsurance after \$100 copay	40%* coinsurance	Precertification required.** Certain behavioral services are not covered.
If you are pregnant	Prenatal & Postnatal care	No charge	40%* coinsurance	Limited to employee or spouse only.
	Delivery and all inpatient services	10%* coinsurance after \$100 copay	40%* coinsurance	Limited to employee or spouse only.
If you need help recovering or have other special health needs	Home health care	10%* coinsurance	40%* coinsurance	Precertification required for out-of-network services.** Limited to 100 visits/plan year.
	Rehabilitation services – physical, occupational, speech & other rehabilitative therapies.	10%* coinsurance after \$10/visit	40%* coinsurance	Precertification required for speech therapy.** Limited to an aggregated 60 in-network visits/plan year & 30 out-of-network visits/plan year.
	Habilitation services	Not Covered	Not Covered	--none--
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	Hospice service	10%* coinsurance	40%* coinsurance	Precertification required for inpatient care.** Limited to 180 days/lifetime.

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## Plan Option 2: City of Tulare

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

Coverage Period: Beginning on or after 1/1/2015  
Coverage for: Active Employees | Plan Type: PPO

If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	--none--
	Glasses	Not Covered	Not Covered	--none--
	Dental check-up	Not Covered	Not Covered	--none--

\* Deductible applies.

\*\* Precertification is required before certain medical services. Emergency admissions must be certified within 48 hours following the admission. To precertify services, call the phone number indicated on your ID card. **Failure to precertify out-of-network services will result in a 50% penalty.**

Common Medical Event	Services You May Need	Your Cost If You Use a Retail Pharmacy (30 day supply)	Your Cost If You Use a Mail Order Pharmacy (90 day supply)	Limitations & Exceptions
If you need drugs to treat your illness or condition  More information about <a href="http://www.usscript.com">prescription drug coverage</a> is available at <a href="http://www.usscript.com">www.usscript.com</a> .	Individual Maximum Out-Of-Pocket Amount	\$2,000		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.
	Family Maximum Out-Of-Pocket Amount	\$4,000		
	Generic or single-source brand contraceptives	\$0/prescription	\$0/prescription	Contraceptives that are not generic or single-source brand will be payable under the appropriate co-pay level.
	Generic drugs	\$10/prescription	\$20/prescription	The Prescription Drug Plan will pay up to the generic price, less the generic co-payment, whenever a generic drug is dispensed. If a brand name drug is dispensed, and a generic equivalent is available, the covered person must pay the difference between the cost of the brand name drug and the generic equivalent, plus the generic co-payment unless the physician specifies "Dispense as Written".
	Formulary drugs	\$25/prescription	\$50/prescription	
	Non-formulary drugs	\$40/prescription	\$80/prescription	

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## Plan Option 2: City of Tulare

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

Coverage Period: Beginning on or after 1/1/2015

Coverage for: Active Employees | Plan Type: PPO

### 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
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (adult)
- 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
- Chiropractic care

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

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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 HNAS at 1-877-356-0666, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

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

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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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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 \$5,950**
- **Patient pays \$1,530**

**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
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$500
Copays	\$220
Coinsurance	\$660
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,530</b>

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$4,260**
- **Patient pays \$1,230**

**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
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$380
Copays	\$770
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,230</b>

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### 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.

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## Plan Option 3: City of Tulare

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

Coverage Period: Beginning on or after 1/1/2015

Coverage for: Active Employees | 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.hnas.com](http://www.hnas.com) or by calling 1-877-356-0666.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In-network: \$0 person/ \$0 family; out-of-network: \$200 person/ \$600 family.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. In-network \$3,000 person/ \$6,000 family; out-of-network: \$4,700 person/ \$14,100 family.	The <u>out-of-pocket limit</u> , which includes the medical deductible, coinsurance & co-pays, 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 <u>out-of-pocket limit</u> ?	Rx co-pays, premiums, balance-billed charges, penalties & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	See <a href="http://www.blueshieldca.com/networkppo">www.blueshieldca.com/networkppo</a> or call 1-800-810-2583 for a list of in-network providers.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from the 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 document for additional information about <u>excluded services</u> .

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## Plan Option 3: City of Tulare

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

Coverage Period: Beginning on or after 1/1/2015

Coverage for: Active Employees | Plan Type: PPO



- **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 **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$10/visit	30%* coinsurance	--none--
	Specialist visit	\$10/visit	30%* coinsurance	--none--
	Other practitioner office visit - chiropractor	15% coinsurance after \$15/visit	Not covered	Limited to 20 visits/plan year.
	Preventive care/screening/immunization	No charge	30%* coinsurance	Includes all mandated preventive care as required under PPACA.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	30%* coinsurance	--none--
	Imaging (CT/PET scans, MRIs)	15% coinsurance	30%* coinsurance	Precertification required on select procedures.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	30%* coinsurance	--none--
	Physician/surgeon fees	15% coinsurance	30%* coinsurance	Precertification required on select procedures.**
If you need immediate medical attention	Emergency room services (Emergent use)	15% coinsurance after \$75/visit	15% coinsurance after \$75/visit	--none--
	Emergency room services (Non-emergent use)	30% coinsurance	30%* coinsurance	--none--
	Emergency medical transportation	15% coinsurance	15% coinsurance	--none--
	Urgent care	\$10/visit	30%* coinsurance	--none--

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## Plan Option 3: City of Tulare

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

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Coverage for: Active Employees | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance after \$100 copay	30%* coinsurance	Precertification required.**
	Physician/surgeon fee	15% coinsurance	30%* coinsurance	--none--
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$10/visit	30%* coinsurance	Certain behavioral services are not covered.
	Mental/Behavioral health inpatient services	15% coinsurance after \$100 copay	30%* coinsurance	Precertification required.** Certain behavioral services are not covered.
	Substance use disorder outpatient services	\$10/visit	30%* coinsurance	Certain behavioral services are not covered.
	Substance use disorder inpatient services	15% coinsurance after \$100 copay	30%* coinsurance	Precertification required.** Certain behavioral services are not covered.
If you are pregnant	Prenatal & Postnatal care	No charge	30%* coinsurance	Limited to employee or spouse only.
	Delivery and all inpatient services	15% coinsurance after \$100 copay	30%* coinsurance	Limited to employee or spouse only.
If you need help recovering or have other special health needs	Home health care	15% coinsurance	30%* coinsurance	Precertification required for out-of-network services.** Limited to 100 visits/plan year.
	Rehabilitation services – physical, occupational, speech & other rehabilitative therapies.	15% coinsurance after \$10/visit	30%* coinsurance	Precertification required for speech therapy.** Limited to an aggregated 60 in-network visits/plan year & 30 out-of-network visits/plan year.
	Habilitation services	Not Covered	Not Covered	--none--
	Skilled nursing care	15% coinsurance	30%* coinsurance	Precertification required.** Limited to 100 consecutive days/plan year in-network; 60 consecutive days/plan year out-of-network.
	Durable medical equipment	15% coinsurance	30%* coinsurance	Precertification required on select items.**
	Hospice service	15% coinsurance	30%* coinsurance	Precertification required for inpatient care.** Limited to 180 days/lifetime.

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If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	--none--
	Glasses	Not Covered	Not Covered	--none--
	Dental check-up	Not Covered	Not Covered	--none--

\* Deductible applies.

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Common Medical Event	Services You May Need	Your Cost If You Use a Retail Pharmacy (30 day supply)	Your Cost If You Use a Mail Order Pharmacy (90 day supply)	Limitations & Exceptions
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.usscript.com">www.usscript.com</a> .	Individual Maximum Out-Of-Pocket Amount	\$2,000		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.
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	Generic drugs	\$10/prescription	\$20/prescription	The Prescription Drug Plan will pay up to the generic price, less the generic co-payment, whenever a generic drug is dispensed. If a brand name drug is dispensed, and a generic equivalent is available, the covered person must pay the difference between the cost of the brand name drug and the generic equivalent, plus the generic co-payment unless the physician specifies "Dispense as Written".
	Formulary drugs	\$15/prescription	\$30/prescription	
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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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#### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,040
- Patient pays \$1,430

##### 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
<b>Total</b>	<b>\$7,540</b>

##### Patient pays:

Deductibles	\$0
Copays	\$220
Coinsurance	\$1,060
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,430</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$4,330
- Patient pays \$1,160

##### 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
<b>Total</b>	<b>\$5,400</b>

##### Patient pays:

Deductibles	\$0
Copays	\$1,020
Coinsurance	\$60
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,160</b>

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## 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.

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# Plan Option 1: City of Tulare

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

Coverage Period: Beginning on or after 1/1/2015

Coverage for: Pre-65 Retirees | 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.hnas.com](http://www.hnas.com) or by calling 1-877-356-0666.

Important Questions	Answers	Why this Matters:
What is the overall <b>deductible</b> ?	In-network: \$1,000 person/ \$2,000 family; out-of-network: \$3,000 person/ \$9,000 family.	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. In-network \$3,000 person/ \$6,000 family; out-of-network: \$4,500 person/ \$13,500 family.	The <b>out-of-pocket limit</b> 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 <b>out-of-pocket limit</b> ?	Deductible, copayments, premiums, balance-billed charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	See <a href="http://www.blueshieldca.com/networkppo">www.blueshieldca.com/networkppo</a> or call 1-800-810-2583 for a list of in-network providers.	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the <b>specialist</b> you choose without permission from the 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 document for additional information about <b>excluded services</b> .

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# Plan Option 1: City of Tulare

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

Coverage Period: Beginning on or after 1/1/2015

Coverage for: Pre-65 Retirees | Plan Type: PPO



- **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 **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$10/visit	40%* coinsurance	--none--
	Specialist visit	\$10/visit	40%* coinsurance	--none--
	Other practitioner office visit - chiropractor	10%* coinsurance after \$15/visit	Not covered	Limited to 20 visits/plan year.
	Preventive care/screening/immunization	No charge	40%* coinsurance	--none--
If you have a test	Diagnostic test (x-ray, blood work)	10%* coinsurance	40%* coinsurance	--none--
	Imaging (CT/PET scans, MRIs)	10%* coinsurance	40%* coinsurance	Precertification required on select procedures.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10%* coinsurance	40%* coinsurance	--none--
	Physician/surgeon fees	10%* coinsurance	40%* coinsurance	Precertification required on select procedures.**
If you need immediate medical attention	Emergency room services (Emergent use)	10% coinsurance after \$75/visit	10% coinsurance after \$75/visit	--none--
	Emergency room services (Non-emergent use)	40%* coinsurance	40%* coinsurance	--none--
	Emergency medical transportation	10%* coinsurance	10%* coinsurance	--none--
	Urgent care	\$10/visit	40%* coinsurance	--none--

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Coverage for: Pre-65 Retirees | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	10%* coinsurance after \$100 copay	40%* coinsurance	Precertification required.**
	Physician/surgeon fee	10%* coinsurance	40%* coinsurance	--none--
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$10/visit	40%* coinsurance	Certain behavioral services are not covered.
	Mental/Behavioral health inpatient services	10%* coinsurance after \$100 copay	40%* coinsurance	Precertification required.** Certain behavioral services are not covered.
	Substance use disorder outpatient services	\$10/visit	40%* coinsurance	Certain behavioral services are not covered.
	Substance use disorder inpatient services	10%* coinsurance after \$100 copay	40%* coinsurance	Precertification required.** Certain behavioral services are not covered.
If you are pregnant	Prenatal care	No charge	40%* coinsurance	Limited to employee or spouse only.
	Postnatal care	10%* coinsurance	40%* coinsurance	Limited to employee or spouse only.
	Delivery and all inpatient services	10%* coinsurance after \$100 copay	40%* coinsurance	Limited to employee or spouse only.
If you need help recovering or have other special health needs	Home health care	10%* coinsurance	40%* coinsurance	Precertification required for out-of-network services.** Limited to 100 visits/plan year.
	Rehabilitation services – physical, occupational, speech & other rehabilitative therapies.	10%* coinsurance	40%* coinsurance	Precertification required for speech therapy.** Limited to an aggregated 60 visits/plan year.
	Habilitation services	Not Covered	Not Covered	--none--
	Skilled nursing care	10%* coinsurance	40%* coinsurance	Precertification required.** Limited to 100 consecutive days/plan year in-network; 60 consecutive days/plan year out-of-network.
	Durable medical equipment	10%* coinsurance	40%* coinsurance	Precertification required on select items.**
	Hospice service	10%* coinsurance	40%* coinsurance	Precertification required for inpatient care.** Limited to 180 days/lifetime.

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# Plan Option 1: City of Tulare

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

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Coverage for: Pre-65 Retirees | Plan Type: PPO

If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	--none--
	Glasses	Not Covered	Not Covered	--none--
	Dental check-up	Not Covered	Not Covered	--none--

\* Deductible applies.

\*\* Precertification is required before certain medical services. Emergency admissions must be certified within 48 hours following the admission. To precertify services, call the phone number indicated on your ID card. **Failure to precertify out-of-network services will result in a 50% penalty.**

Common Medical Event	Services You May Need	Your Cost If You Use a Retail Pharmacy (30 day supply)	Your Cost If You Use a Mail Order Pharmacy (90 day supply)	Limitations & Exceptions
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="http://www.usscript.com">prescription drug coverage</a> is available at <a href="http://www.usscript.com">www.usscript.com</a> .	Individual Maximum Out-Of-Pocket Amount	\$2,000		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.
	Family Maximum Out-Of-Pocket Amount	\$4,000		
	Generic drugs	\$15/prescription	\$30/prescription	The Prescription Drug Plan will pay up to the generic price, less the generic co-payment, whenever a generic drug is dispensed. If a brand name drug is dispensed, and a generic equivalent is available, the covered person must pay the difference between the cost of the brand name drug and the generic equivalent, plus the generic co-payment unless the physician specifies "Dispense as Written".
	Formulary drugs	\$25/prescription	\$50/prescription	
	Non-formulary drugs	\$40/prescription	\$80/prescription	

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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.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (adult)
- 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
- Chiropractic care

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# Plan Option 1: City of Tulare

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

Coverage Period: Beginning on or after 1/1/2015

Coverage for: Pre-65 Retirees | Plan Type: PPO

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on your 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 1-877-356-0666. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa](http://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](http://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 HNAS at 1-877-356-0666, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

## 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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-356-0666.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-356-0666.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-356-0666.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-356-0666.

—————*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 \$5,490
- Patient pays \$1,980

##### 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
<b>Total</b>	<b>\$7,540</b>

##### Patient pays:

Deductibles	\$1,000
Copays	\$220
Coinsurance	\$610
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,980</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$4,000
- Patient pays \$1,480

##### 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
<b>Total</b>	<b>\$5,400</b>

##### Patient pays:

Deductibles	\$380
Copays	\$1,020
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,480</b>

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## 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.

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## Plan Option 2: City of Tulare

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

Coverage Period: Beginning on or after 1/1/2015

Coverage for: Pre-65 Retirees | Plan Type: PPO



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Important Questions	Answers	Why this Matters:
What is the overall <b>deductible</b> ?	In-network: \$500 person/ \$1,000 family; out-of-network: \$1,500 person/ \$4,500 family.	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. In-network \$3,000 person/ \$6,000 family; out-of-network: \$4,500 person/ \$13,500 family.	The <b>out-of-pocket limit</b> 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 <b>out-of-pocket limit</b> ?	Deductible, copayments, premiums, balance-billed charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	See <a href="http://www.blueshieldca.com/networkppo">www.blueshieldca.com/networkppo</a> or call 1-800-810-2583 for a list of in-network providers.	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the <b>specialist</b> you choose without permission from the 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 document for additional information about <b>excluded services</b> .

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## Plan Option 2: City of Tulare

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Coverage Period: Beginning on or after 1/1/2015

Coverage for: Pre-65 Retirees | Plan Type: PPO



- **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 **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$10/visit	40%* coinsurance	--none--
	Specialist visit	\$10/visit	40%* coinsurance	--none--
	Other practitioner office visit - chiropractor	10%* coinsurance after \$15/visit	Not covered	Limited to 20 visits/plan year.
	Preventive care/screening/immunization	No charge	40%* coinsurance	--none--
If you have a test	Diagnostic test (x-ray, blood work)	10%* coinsurance	40%* coinsurance	--none--
	Imaging (CT/PET scans, MRIs)	10%* coinsurance	40%* coinsurance	Precertification required on select procedures.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10%* coinsurance	40%* coinsurance	--none--
	Physician/surgeon fees	10%* coinsurance	40%* coinsurance	Precertification required on select procedures.**
If you need immediate medical attention	Emergency room services (Emergent use)	10% coinsurance after \$75/visit	10% coinsurance after \$75/visit	--none--
	Emergency room services (Non-emergent use)	40%* coinsurance	40%* coinsurance	--none--
	Emergency medical transportation	10%* coinsurance	10%* coinsurance	--none--
	Urgent care	\$10/visit	40%* coinsurance	--none--

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Coverage Period: Beginning on or after 1/1/2015

Coverage for: Pre-65 Retirees | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	10%* coinsurance after \$100 copay	40%* coinsurance	Precertification required.**
	Physician/surgeon fee	10%* coinsurance	40%* coinsurance	--none--
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$10/visit	40%* coinsurance	Certain behavioral services are not covered.
	Mental/Behavioral health inpatient services	10%* coinsurance after \$100 copay	40%* coinsurance	Precertification required.** Certain behavioral services are not covered.
	Substance use disorder outpatient services	\$10/visit	40%* coinsurance	Certain behavioral services are not covered.
	Substance use disorder inpatient services	10%* coinsurance after \$100 copay	40%* coinsurance	Precertification required.** Certain behavioral services are not covered.
If you are pregnant	Prenatal care	No charge	40%* coinsurance	Limited to employee or spouse only.
	Postnatal care	10%* coinsurance	40%* coinsurance	Limited to employee or spouse only.
	Delivery and all inpatient services	10%* coinsurance after \$100 copay	40%* coinsurance	Limited to employee or spouse only.
If you need help recovering or have other special health needs	Home health care	10%* coinsurance	40%* coinsurance	Precertification required for out-of-network services.** Limited to 100 visits/plan year.
	Rehabilitation services – physical, occupational, speech & other rehabilitative therapies.	10%* coinsurance	40%* coinsurance	Precertification required for speech therapy.** Limited to an aggregated 60 visits/plan year.
	Habilitation services	Not Covered	Not Covered	--none--
	Skilled nursing care	10%* coinsurance	40%* coinsurance	Precertification required.** Limited to 100 consecutive days/plan year in-network; 60 consecutive days/plan year out-of-network.
	Durable medical equipment	10%* coinsurance	40%* coinsurance	Precertification required on select items.**
	Hospice service	10%* coinsurance	40%* coinsurance	Precertification required for inpatient care.** Limited to 180 days/lifetime.

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## Plan Option 2: City of Tulare

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

Coverage Period: Beginning on or after 1/1/2015

Coverage for: Pre-65 Retirees | Plan Type: PPO

If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	--none--
	Glasses	Not Covered	Not Covered	--none--
	Dental check-up	Not Covered	Not Covered	--none--

\* Deductible applies.

\*\* Precertification is required before certain medical services. Emergency admissions must be certified within 48 hours following the admission. To precertify services, call the phone number indicated on your ID card. **Failure to precertify out-of-network services will result in a 50% penalty.**

Common Medical Event	Services You May Need	Your Cost If You Use a Retail Pharmacy (30 day supply)	Your Cost If You Use a Mail Order Pharmacy (90 day supply)	Limitations & Exceptions
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="http://www.usscript.com">prescription drug coverage</a> is available at <a href="http://www.usscript.com">www.usscript.com</a> .	Individual Maximum Out-Of-Pocket Amount	\$2,000		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.
	Family Maximum Out-Of-Pocket Amount	\$4,000		
	Generic drugs	\$10/prescription	\$20/prescription	The Prescription Drug Plan will pay up to the generic price, less the generic co-payment, whenever a generic drug is dispensed. If a brand name drug is dispensed, and a generic equivalent is available, the covered person must pay the difference between the cost of the brand name drug and the generic equivalent, plus the generic co-payment unless the physician specifies "Dispense as Written".
	Formulary drugs	\$25/prescription	\$50/prescription	
	Non-formulary drugs	\$40/prescription	\$80/prescription	

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## Plan Option 2: City of Tulare

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

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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.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (adult)
- 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
- Chiropractic care

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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 \$5,940
- Patient pays \$1,530

##### 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
<b>Total</b>	<b>\$7,540</b>

##### Patient pays:

Deductibles	\$500
Copays	\$220
Coinsurance	\$660
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,530</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$4,260
- Patient pays \$1,230

##### 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
<b>Total</b>	<b>\$5,400</b>

##### Patient pays:

Deductibles	\$380
Copays	\$770
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,230</b>

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### 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.

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## Plan Option 3: City of Tulare

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

Coverage Period: Beginning on or after 1/1/2015

Coverage for: Pre-65 Retirees | 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.hnas.com](http://www.hnas.com) or by calling 1-877-356-0666.

Important Questions	Answers	Why this Matters:
What is the overall <b>deductible</b> ?	In-network: \$0 person/ \$0 family; out-of-network: \$200 person/ \$600 family.	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. In-network \$3,000 person/ \$6,000 family; out-of-network: \$4,500 person/ \$13,500 family.	The <b>out-of-pocket limit</b> 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 <b>out-of-pocket limit</b> ?	Deductible, copayments, premiums, balance-billed charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	See <a href="http://www.blueshieldca.com/networkppo">www.blueshieldca.com/networkppo</a> or call 1-800-810-2583 for a list of in-network providers.	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the <b>specialist</b> you choose without permission from the 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 document for additional information about <b>excluded services</b> .

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## Plan Option 3: City of Tulare

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

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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 **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 **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$10/visit	30%* coinsurance	--none--
	Specialist visit	\$10/visit	30%* coinsurance	--none--
	Other practitioner office visit - chiropractor	15% coinsurance after \$15/visit	Not covered	Limited to 20 visits/plan year.
	Preventive care/screening/immunization	No charge	30%* coinsurance	--none--
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	30%* coinsurance	--none--
	Imaging (CT/PET scans, MRIs)	15% coinsurance	30%* coinsurance	Precertification required on select procedures.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	30%* coinsurance	--none--
	Physician/surgeon fees	15% coinsurance	30%* coinsurance	Precertification required on select procedures.**
If you need immediate medical attention	Emergency room services (Emergent use)	15% coinsurance after \$75/visit	15% coinsurance after \$75/visit	--none--
	Emergency room services (Non-emergent use)	30% coinsurance	30%* coinsurance	--none--
	Emergency medical transportation	15% coinsurance	15% coinsurance	--none--
	Urgent care	\$10/visit	30%* coinsurance	--none--

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance after \$100 copay	30%* coinsurance	Precertification required.**
	Physician/surgeon fee	15% coinsurance	30%* coinsurance	--none--
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$10/visit	30%* coinsurance	Certain behavioral services are not covered.
	Mental/Behavioral health inpatient services	15% coinsurance after \$100 copay	30%* coinsurance	Precertification required.** Certain behavioral services are not covered.
	Substance use disorder outpatient services	\$10/visit	30%* coinsurance	Certain behavioral services are not covered.
	Substance use disorder inpatient services	15% coinsurance after \$100 copay	30%* coinsurance	Precertification required.** Certain behavioral services are not covered.
If you are pregnant	Prenatal care	No charge	30%* coinsurance	Limited to employee or spouse only.
	Postnatal care	15% coinsurance	30%* coinsurance	Limited to employee or spouse only.
	Delivery and all inpatient services	15% coinsurance after \$100 copay	30%* coinsurance	Limited to employee or spouse only.
If you need help recovering or have other special health needs	Home health care	15% coinsurance	30%* coinsurance	Precertification required for out-of-network services.** Limited to 100 visits/plan year.
	Rehabilitation services – physical, occupational, speech & other rehabilitative therapies.	15% coinsurance	30%* coinsurance	Precertification required for speech therapy.** Limited to an aggregated 60 visits/plan year.
	Habilitation services	Not Covered	Not Covered	--none--
	Skilled nursing care	15% coinsurance	30%* coinsurance	Precertification required.** Limited to 100 consecutive days/plan year in-network; 60 consecutive days/plan year out-of-network.
	Durable medical equipment	15% coinsurance	30%* coinsurance	Precertification required on select items.**
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	Glasses	Not Covered	Not Covered	--none--
	Dental check-up	Not Covered	Not Covered	--none--

\* Deductible applies.

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Common Medical Event	Services You May Need	Your Cost If You Use a Retail Pharmacy (30 day supply)	Your Cost If You Use a Mail Order Pharmacy (90 day supply)	Limitations & Exceptions
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.usscript.com">www.usscript.com</a> .	Individual Maximum Out-Of-Pocket Amount	\$2,000		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.
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#### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,040
- Patient pays \$1,430

##### 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
<b>Total</b>	<b>\$7,540</b>

##### Patient pays:

Deductibles	\$0
Copays	\$220
Coinsurance	\$1,060
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,430</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$4,580
- Patient pays \$910

##### 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
<b>Total</b>	<b>\$5,400</b>

##### Patient pays:

Deductibles	\$0
Copays	\$770
Coinsurance	\$60
Limits or exclusions	\$80
<b>Total</b>	<b>\$910</b>

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### 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.

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## Plan Option 4: City of Tulare

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

Coverage Period: Beginning on or after 1/1/2015

Coverage for: Pre-65 Retirees | 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.hnas.com](http://www.hnas.com) or by calling 1-877-356-0666.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In-network: \$3,000 person/ \$6,000 family; out-of-network: \$5,950 person/ \$11,900 family.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. In-network \$5,950 person/ \$11,900 family; out-of-network: \$5,950 person/ \$11,900 family.	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Copayments, premiums, balance-billed charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	See <a href="http://www.blueshieldca.com/networkppo">www.blueshieldca.com/networkppo</a> or call 1-800-810-2583 for a list of in-network providers.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from the 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 document for additional information about <u>excluded services</u> .

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## Plan Option 4: City of Tulare

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

Coverage Period: Beginning on or after 1/1/2015

Coverage for: Pre-65 Retirees | Plan Type: PPO



- **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 **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	15%* coinsurance	30%* coinsurance	--none--
	Specialist visit	15%* coinsurance	30%* coinsurance	--none--
	Other practitioner office visit - chiropractor	15%* coinsurance	Not covered	Limited to 20 visits/plan year.
	Preventive care/screening/immunization	No charge	30%* coinsurance	--none--
If you have a test	Diagnostic test (x-ray, blood work)	15%* coinsurance	30%* coinsurance	--none--
	Imaging (CT/PET scans, MRIs)	15%* coinsurance	30%* coinsurance	Precertification required on select procedures.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15%* coinsurance	30%* coinsurance	--none--
	Physician/surgeon fees	15%* coinsurance	30%* coinsurance	Precertification required on select procedures.**
If you need immediate medical attention	Emergency room services (Emergent use)	15%* coinsurance	15%* coinsurance	--none--
	Emergency room services (Non-emergent use)	30%* coinsurance	30%* coinsurance	--none--
	Emergency medical transportation	15%* coinsurance	15%* coinsurance	--none--
	Urgent care	15%* coinsurance	30%* coinsurance	--none--
If you have a hospital stay	Facility fee (e.g., hospital room)	15%* coinsurance	30%* coinsurance	Precertification required.**
	Physician/surgeon fee	15%* coinsurance	30%* coinsurance	--none--

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## Plan Option 4: City of Tulare

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

Coverage Period: Beginning on or after 1/1/2015

Coverage for: Pre-65 Retirees | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	15%* coinsurance	30%* coinsurance	Certain behavioral services are not covered.
	Mental/Behavioral health inpatient services	15%* coinsurance	30%* coinsurance	Precertification required.** Certain behavioral services are not covered.
	Substance use disorder outpatient services	15%* coinsurance	30%* coinsurance	Certain behavioral services are not covered.
	Substance use disorder inpatient services	15%* coinsurance	30%* coinsurance	Precertification required.** Certain behavioral services are not covered.
<b>If you are pregnant</b>	Prenatal care	No charge	30%* coinsurance	Limited to employee or spouse only.
	Postnatal care	15%* coinsurance	30%* coinsurance	Limited to employee or spouse only.
	Delivery and all inpatient services	15%* coinsurance	30%* coinsurance	Limited to employee or spouse only.
<b>If you need help recovering or have other special health needs</b>	Home health care	15%* coinsurance	30%* coinsurance	Precertification required for out-of-network services.** Limited to 100 visits/plan year.
	Rehabilitation services – physical, occupational, speech & other rehabilitative therapies.	15%* coinsurance	30%* coinsurance	Precertification required for speech therapy.** Limited to an aggregated 60 visits/plan year.
	Habilitation services	Not Covered	Not Covered	--none--
	Skilled nursing care	15%* coinsurance	30%* coinsurance	Precertification required.** Limited to 100 consecutive days/plan year in-network; 60 consecutive days/plan year out-of-network.
	Durable medical equipment	15%* coinsurance	30%* coinsurance	Precertification required on select items.**
	Hospice service	15%* coinsurance	30%* coinsurance	Precertification required for inpatient care.** Limited to 180 days/lifetime.

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## Plan Option 4: City of Tulare

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

Coverage Period: Beginning on or after 1/1/2015

Coverage for: Pre-65 Retirees | Plan Type: PPO

If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	--none--
	Glasses	Not Covered	Not Covered	--none--
	Dental check-up	Not Covered	Not Covered	--none--

\* Deductible applies.

\*\* Precertification is required before certain medical services. Emergency admissions must be certified within 48 hours following the admission. To precertify services, call the phone number indicated on your ID card. **Failure to precertify out-of-network services will result in a 50% penalty.**

Common Medical Event	Services You May Need	Your Cost If You Use a Retail Pharmacy (30 day supply)	Your Cost If You Use a Mail Order Pharmacy (90 day supply)	Limitations & Exceptions
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.usscript.com">www.usscript.com</a> .	Individual Maximum Out-Of-Pocket Amount	\$2,000		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.
	Family Maximum Out-Of-Pocket Amount	\$4,000		
	Generic drugs	15%* coinsurance	15%* coinsurance	The Prescription Drug Plan will pay up to the generic price, less the generic co-payment, whenever a generic drug is dispensed. If a brand name drug is dispensed, and a generic equivalent is available, the covered person must pay the difference between the cost of the brand name drug and the generic equivalent, plus the generic co-payment unless the physician specifies "Dispense as Written".
	Formulary drugs	15%* coinsurance	15%* coinsurance	
	Non-formulary drugs	15%* coinsurance	15%* coinsurance	

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## Plan Option 4: City of Tulare

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

Coverage Period: Beginning on or after 1/1/2015

Coverage for: Pre-65 Retirees | Plan Type: PPO

### 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
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (adult)
- 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
- Chiropractic care

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## Plan Option 4: City of Tulare

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

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### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on your 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 1-877-356-0666. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa](http://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](http://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 HNAS at 1-877-356-0666, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### 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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-356-0666.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-356-0666.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-356-0666.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-356-0666.

—————*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 \$3,670
- Patient pays \$3,790

##### 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
<b>Total</b>	<b>\$7,540</b>

##### Patient pays:

Deductibles	\$3,000
Copays	\$0
Coinsurance	\$640
Limits or exclusions	\$150
<b>Total</b>	<b>\$3,790</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$2,070
- Patient pays \$3,420

##### 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
<b>Total</b>	<b>\$5,400</b>

##### Patient pays:

Deductibles	\$3,000
Copays	\$0
Coinsurance	\$340
Limits or exclusions	\$80
<b>Total</b>	<b>\$3,420</b>

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### 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.

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# Delta Dental PPO<sup>SM</sup> – Easy, Friendly, Accessible

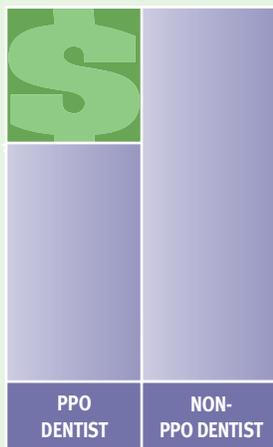


We'll do whatever it takes and then some.

## Save with a PPO dentist

### YOUR COSTS

SAVE MORE    SAVE LESS



 AMOUNT YOU SAVE  
 AMOUNT YOU PAY

Illustration showing sample enrollee share of cost for information purposes only. Actual dentist fees and contract allowances will vary by region, procedure and group contract.

We're pleased to be your partner in maintaining great oral health. The Delta Dental PPO<sup>†</sup> plan makes it easy for you to find a dentist and control your costs when you visit a network dentist. Here are some of the great things you'll need to know about enrolling with Delta Dental:

- **Save with a PPO dentist.** Our PPO network dentists accept reduced fees for covered services, so you'll usually pay the least when you visit a PPO network dentist. Non-Delta Dental dentists may balance bill you the difference between the contracted fee and their usual fee.
- **Large dentist network.** Since Delta Dental offers access to some of the largest dentist networks in the U.S.,<sup>‡</sup> chances are there's a wide choice of PPO dentists near your home or office. Use your desktop or mobile device to search for a dentist at [deltadentalins.com](http://deltadentalins.com).
- **Visit the dentist of your choice.** Want to visit a non-Delta Dental dentist? No problem. You can visit any licensed dentist, but your costs are usually lowest with a PPO dentist.
- **Log in to Online Services.** Check benefits, eligibility and claims status, view or print an ID card and use our "Fee Finder" tool to check average costs in your area. You can also change your Profile preference to go paperless. Use your mobile device to access many of these tools on the go; show the dental office your ID card information instead of carrying a printed card.

Visit the *SmileWay*<sup>®</sup> Wellness section of our site for dental health articles, videos, quizzes and a risk assessment tool. You can also subscribe to our free dental health e-newsletter.

<sup>†</sup> In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

<sup>‡</sup> Netminder Dental Network Trend Report, March 2013.



Socialize with us: [deltadentalins.com/enrollees](http://deltadentalins.com/enrollees)



**Plan Benefit Highlights for: City of Tulare**

**Group No: 16763**

**Effective Date: 01/01/14**

**Delta Dental PPO<sup>SM</sup>**  
**Benefit Highlights**

<b>Eligibility</b>	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to age <b>26</b>		
<b>Maximums</b>	The maximum benefit paid is <b>\$1,500</b> per person each calendar year		
<b>Waiting Period(s)</b>	Basic Benefits None	Major Benefits None	Orthodontics None

<b>Benefits and Covered Services*</b>	<b>Delta Dental PPO dentists**</b>	<b>Non-Delta Dental PPO dentists**</b>
<b>Diagnostic &amp; Preventive Services (D &amp; P)</b> Exams, cleanings, x-rays	100 %	100 %
<b>Basic Services</b> Fillings, simple tooth extractions, sealants	80 %	80 %
<b>Endodontics</b> (root canals) Covered Under Basic Services	80 %	80 %
<b>Periodontics</b> (gum treatment) Covered Under Basic Services	80 %	80 %
<b>Oral Surgery</b> Covered Under Basic Services	80 %	80 %
<b>Major Services</b> Crowns, inlays, onlays and cast restorations	80 %	80 %
<b>Prosthodontics</b> Bridges, dentures, implants	80 %	80 %
<b>Orthodontic Benefits</b> Adults and dependent children	80 %	80 %
<b>Orthodontic Maximums</b>	Separate <b>\$1,000</b> Lifetime maximum per person	

\* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

\*\* Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California 100 First St. San Francisco, CA 94105	<b>Customer Service</b> 800-765-6003	<b>Claims Address</b> P.O. Box 997330 Sacramento, CA 95899-7330
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**deltadentalins.com**

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.