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 by calling 707-443-4563 or toll free 866-443-4563.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** Individual **$3,000** Family **Does not apply to preventive care**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$50** for dental coverage, except bi-annual cleanings & exam. There are no other specific **deductibles**.	You must pay all of the costs, except for bi-annual preventive care cleaning and exams, for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	**$5,300** Individual **$16,050** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits
Does this plan use a network of providers?	Yes. See www.humbodltipa.com or call 1-866-443-4563 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term

		in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **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 provider's office or clinic	Primary care visit to treat an injury or illness	40%	40%	
	Specialist visit	40%	40%	
	Other practitioner office visit	40%	40%	
	Preventive care/screening/immunization	$0	$0	
If you have a test	Diagnostic test (x-ray, blood work)	40%	40%	
	Imaging (CT/PET scans, MRIs)	40%	40%	

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.parnersrx.com.	Generic drugs	$10	$10	
	Preferred brand drugs	$25	$25	
	Non-preferred brand drugs	$40	$40	
	Specialty drugs	30%	30%	Co-insurance to $250 max
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40%	40%	
	Physician/surgeon fees	40%	40%	
If you need immediate medical attention	Emergency room services	$100 or $500 +40%	$100 or $500 +40%	$100 copay for emergency, $500 copay for non-emergency
	Emergency medical transportation	40%	40%	
	Urgent care	40%	40%	
If you have a hospital stay	Facility fee (e.g., hospital room)	40%	40%	
	Physician/surgeon fee	40%	40%	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	40%	40%	Hypnotherapy, sex counseling or therapy, vocational testing or training
	Mental/Behavioral health inpatient services	40%	40%	
	Substance use disorder outpatient services	40%	40%	Tobacco dependence or dependence on ordinary drinks containing caffeine.
	Substance use disorder inpatient services			
If you are pregnant	Prenatal and postnatal care	40%	40%	
	Delivery and all inpatient services	40%	40%	

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 need help recovering or have other special health needs	Home health care	40%	40%	100 visits per calendar year
	Rehabilitation services	30%	30%	$1000 benefit per calendar year, Deductible does not apply,
	Habilitation services	40%	40%	
	Skilled nursing care	40%	40%	100 days per calendar year
	Durable medical equipment	40%	40%	
	Hospice service	40%	40%	
If your child needs dental or eye care	Eye exam	$10	$10	1 exam every 12 months
	Glasses	$50 + balance after lens/frame allowance	$50 + balance after lens/frame allowance	1 pair of lenses and frames every 24 months
	Dental check-up	$0	$0	1 exam and cleaning every 6 months

Excluded Services & Other Covered Services:

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

- Cosmetic and Reconstructive surgery
- Bariatric Surgery for weight loss
- Infertility Treatment

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.)

- Chiropractic, Acupuncture and Massage
- Gleevec
- Infertility Testing

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan administrator at 1-866-443-4563. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-566-444-32-72 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov .

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Humboldt IPA, 2662 Harris St., Eureka, CA 95503. A Claimant whose claim for benefits or authorization is denied by the Contract Administrator may, within sixty (60) days after receipt of denial of the claim: require a review upon written request to Contract Administrator; review pertinent documents; and submit issues and comments in writing.

The Plan shall notify the Claimant of its decision on review within sixty (60) days after receipt of a request for review. Notice of the decision on review shall be in writing and shall include specific reasons for the decision with specific references to the pertinent Plan provision on which the decision is based. Such decision shall be final and binding upon all persons involved and upon the Employer.

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 not meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-528-5888.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-528-5888.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-528-5888.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-528-5888.

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

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,925
- **Patient pays** $3,615

Sample care costs:

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

Patient pays:

Deductibles	$1,000
Copays	$25
Coinsurance	$2,590
Limits or exclusions	$0
Total	**$3,615**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,840
- **Patient pays** $2,560

Sample care costs:

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

Patient pays:

Deductibles	$1,000
Copays	$600
Coinsurance	$960
Limits or exclusions	$0
Total	**$2,560**

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.