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 by calling 1-800-443-4563.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$ 1,500/3,000** Single/Family Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 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. $150** for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	For participating providers **$5,500** person / **$11,000** family For non-participating providers $**10,000** member	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, 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.humboldtipa.com or call 1-800-443-4563 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 4. See your policy or plan document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your cost if you use 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/Podiatrist - visit to treat an injury or illness, first 12 visits	$40 copay, then 100%	50% after deductible	None
	Primary care/Podiatrist - visit to treat an injury or illness, visit 13+	45% no deductible	50% after deductible	None
	Specialist visit	$40 copay, then 100%		First 12 visits. 13+ visits 55% no deductible.
	Preventive care/screening/immunization	No copay, 100%	50% after deductible	Immunizations covered at 100%.
If you have a test	Diagnostic test (x-ray, blood work)	40% after deductible	50% after deductible	None
	Imaging (CT/PET scans, MRIs)	40% after deductible	50% after deductible	None
If you need drugs to treat your illness or condition	Generic drugs	$15 copay	50% copay	None
	Preferred brand drugs	$25 copay	50% copay	$150 deductible applies.
	Non-preferred brand drugs	$25 copay	50% copay	$150 deductible applies.

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
More information about **prescription drug coverage** is available by calling 1-800-443-4563.	Specialty drugs	30% copay	50% copay	Self-Administered Injectables (except insulin).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% after deductible	All charges after plan pays max of $380 per day	None
	Physician/surgeon fees	40% after deductible	50% after deductible	None
If you need immediate medical attention	Emergency room services	$50 copay, then 40% after deductible	$50 copay, then 40% after deductible	Copay waived if admitted. Plan pays 60% after deductible.
	Emergency medical transportation	No copay, 20% after deductible	No copay, 40% after deductible	None
	Urgent care	$50 copay, then 40% after deductible	$50 copay, then 40% after deductible	Copay waived if admitted. Plan pays 60% after deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% after deductible	All charges after plan pays max of $650 per day	None
	Physician/surgeon fee	40% after deductible	50% after deductible	None

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 mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	All charges after plan pays max of $25 per day after deductible	All charges after plan pays max of $25 per day after deductible	Plan pays 100% to maximum $25 after deductible.
	Mental/Behavioral health inpatient services	All charges after plan pays max of $175 per day after deductible	All charges after plan pays max of $175 per day after deductible	Plan pays 100% to maximum of $175 after deductible.
	Substance use disorder outpatient services	All charges after plan pays max of $25 per day after deductible	All charges after plan pays max of $25 per day after deductible	Plan pays 100% to maximum of $25 after deductible.
	Substance use disorder inpatient services	All charges after plan pays max of $175 per day after deductible	All charges after plan pays max of $175 per day after deductible	Plan pays 100% to maximum of $175 after deductible.
If you are pregnant	Prenatal and postnatal care	40% after deductible	50% after deductible	Pregnancy coverage will not include, Lamaze and other charges for education related to pre-natal care and birthing procedures, adoption expenses or expenses of a surrogate mother.
	Delivery and all inpatient services	40% after deductible	All charges after plan pays max of $650 per day after deductible	

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% after deductible	All charges after plan pays max of $75 per day after deductible	Maximum of 90, 4-hour visits per year.
	Rehabilitation services	40% after deductible	All charges after plan pays max of $25 per day after deductible	Limited to 12 visits per plan year.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	40% after deductible	All charges after plan pays max of $150 per day after deductible	Maximum of 100 days per year.
	Durable medical equipment	40% after deductible	50% after deductible	Rental charges that exceed the reasonable purchase price of the equipment are not covered. Replacement of lost, stolen or damaged equipment is not covered.
	Hospice service	Not covered	Not covered	None
If your child needs dental or eye care	Eye exam	Not covered	Not covered	None
	Glasses	Not covered	Not covered	None
	Dental check-up (Maximum Annual Benefit - $1,000 per member)	Preventive services-100%	Preventive services-100%	Deductible - $50 single, $150 family. Basic services - 80% after deductible. Major services - 50% after deductible.

Excluded Services & Other Covered Services:

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

- Cosmetic Surgery
- Weight Control
- Hair Replacement
- Hearing Aids or exams

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

- Acupuncture
- Allergy Testing and Treatment
- Chiropractic Care
- Speech Therapy

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-443-4563. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, call 1-800-443-4563.

Grandfather Status – Statement of Belief

The Cher Ae-Heights Casino plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change form grandfathered health plan status can be directed to the Plan Administrator at (707) 677-0211. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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** $3,640
- **Patient pays** $3,900

Sample care costs:

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

Patient pays:

Deductibles	$1,500
Co-pays	$0
Co-insurance	$2,400
Limits or exclusions	$0
Total	**$3,900**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $2,186
- **Patient pays** $1,932

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$1,500
Co-pays (assuming 4 office visits per year and 1 generic medication per month for well-controlled condition)	$340
Co-insurance	$92
Limits or exclusions	$0
Total	**$1,932**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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