New Health Insurance Marketplace Coverage Options and Your Health Coverage

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PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Cynthia Lindholm cindylindholm@sbcglobal.net 949-492-3574.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Behavioral Systems Southwest, Inc.		4. Employer Identification Number (EIN) 95-3238991
5. Employer address 118 Avenida Victoria		6. Employer phone number 949-492-3574
7. City San Clemente	8. State CA	9. ZIP code 92672
10. Who can we contact about employee health coverage at this job? Cynthia Lindholm		
11. Phone number (if different from above)	12. Email address cindylindholm@sbcglobal.net	

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

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☑ Some employees. Eligible employees are:
    Fulltime employees working 40 hours per week
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:
    Spouse, children from birth to age 26 regardless of student status
  - ☐ We do not offer coverage.

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

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

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

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

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

☐ **Yes** (Continue)

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

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

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

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

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

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

Date of change (mm/dd/yyyy):

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

Health Net Life Ins. Co., AZ: AZ PPO: (7HU)

Coverage Period: 09/01/2013 – 08/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** All Covered Members | **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.healthnet.com or by calling 1-800-289-2818.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$6,000 person/$12,000 family In-Network $12,000 person /$24,000 family Out-of-Network per calendar year.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $0 per person/$0 family In-Network $12,000 person/$24,000 family Out-of-Network per calendar year.	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?	Prescription drug costs, premiums, deductibles, 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. For a list of **preferred providers**, see www.healthnet.com or call 1-800-289-2818.	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 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**.

Questions: Call the number on your Health Net ID card (current members) or **1-800-289-2818** or visit us at **www.healthnet.com.**
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov or call **1-800-289-2818** or the number on your Health Net ID card to request a copy.

- **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 **participating 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 PPO 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	$30	50% co-ins	none
	Specialist visit	$60	50% co-ins	none
	Other practitioner office visit	Chiropractic - $60 Acupuncture – Not covered	Chiropractic– 50% co-ins Acupuncture – Not covered	Requires prior authorization.
	Preventive care/screening/immunization	No charge	50% co-ins	none
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% co-ins	none
	Imaging (CT/PET scans, MRIs)	CT-$250 MRI- $400 PET- $400	50% co-ins	Requires prior authorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Low cost, Preferred generic or brand drugs	$20/retail $60/mail	Not covered	Supply/order: 31 day (retail/specialty); 35-93 day (mail). Prior authorization is required for select drugs.
	Moderate cost, Preferred generic or brand drugs, or Preferred insulin	$40/retail $120/mail	Not covered	
	High cost, Preferred generic or brand drugs	$50/retail $150/mail	Not covered	
	Non-preferred generic or brand drugs	$60/retail $180/mail	Not covered	

www.healthnet.com	Specialty drugs	$75/$100/$150/ $300/ order	Not covered	Supply/order: up to 31 day supply filled by specialty pharmacy. Prior authorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	50% co-ins	Requires prior authorization.
	Physician/surgeon fees	No charge	50% co-ins	——none——
If you need immediate medical attention	Emergency room services	$450	$450	Copay waived if admitted to Hospital.
	Emergency medical transportation	No charge	No charge	——none——
	Urgent care	$50	50% co-ins	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% co-ins	Requires prior authorization.
	Physician/surgeon fee	No charge	50% co-ins	Included with inpatient hospital charges
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30	50% co-ins	May require prior authorization.
	Mental/Behavioral health inpatient services	No charge	50% co-ins	Requires prior authorization.
	Substance abuse disorder outpatient services	$30	50% co-ins	Limited to Detoxification, when medically necessary. Requires prior authorization.
	Substance abuse disorder inpatient services	No charge	50% co-ins	Limited to Detoxification, when medically necessary. Requires prior authorization.
If you are pregnant	Prenatal and postnatal care	PCP-$30 Specialist-$60	50% co-ins	Copay waived after initial diagnosis of pregnancy
	Delivery and all inpatient services	No charge	50% co-ins	Requires prior authorization.

If you need help recovering or have other special health needs	Home health care	No charge	50% co-ins	Limited to part-time and intermittent nursing care. May require prior authorization.
	Rehabilitation services	No charge	50% co-ins	Limited to 60 visits per calendar year. (all therapy services combined) May require prior authorization.
	Habilitation services	Not covered	Not covered	——none——
	Skilled nursing care	No charge	50% co-ins	Limited to 100 days per calendar year in-network and out-of-network. Requires prior authorization.
	Durable medical equipment	No charge	50% co-ins	Limited to a benefit maximum of $2,500 per calendar year in-network and out-of-network combined. (DME and Oxygen combined) May require prior authorization.
	Hospice service	No charge	50% co-ins	May require prior authorization.
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——

Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric Surgery
- Cosmetic surgery
- Dental care (child & adult)
- Glasses
- Habilitation services
- 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 program

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 care

Your Rights to Continue Coverage:

If you lose coverage under this 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 1-800-289-2818. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Health Net's Customer Contact Center at 1-800-289-2818, submit a grievance form through www.healthnet.com, or file your complaint in writing to, Commercial Appeals and Grievances Department, Attn: Appeals & Grievances Manager, Health Net of Arizona, P.O. Box 277610, Sacramento, CA 95827. You may also call the Consumer Services Division of the Arizona Department of Insurance at 602-364-2499 or 1-800-325-2548 (outside the Metro Phoenix area). For information about group health care coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444 (EBSA (3272) or www.dol.gov / ebsa / healthreform.

Language Access Services:

Spanish (Espanol): Para obtener asistencia en Espanol, llame al 1-800-223-7691.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-223-7691.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-223-7691.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-223-7691.

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** $3,750
- **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
Total	**$7,540**

Patient pays:

Deductibles	$3,620
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$3,790**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,790
- **Patient pays** $2,610

Sample care costs:

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

Patient pays:

Deductibles	$0
Copays	$2,530
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,610**

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.

Questions: Call the number on your Health Net ID card (current members) or **1-800-289-2818** or visit us at **www.healthnet.com.**
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov or call **1-800-289-2818** or the number on your Health Net ID card to request a copy.