Ca L SeePlans
CALIFORNIA • LARGE GROUP
Benefits shown as member portion of costs.

SeeChange HEALTH INSURANCE

FAMILY DENTAL PLANS			
Plan Name	**DENTAL 1000**	**DENTAL 1500**	**DENTAL 2000**
Annual Maximum Benefit	$1,000	$1,500	$2,000
Calendar Year Deductible	$50 per covered person. Maximum of 3 covered family members including in and out-of-network. *Waived for Preventive & Diagnostic Services*		
Preventive & Diagnostic Services	In-Network/Out-of-Network		
Includes: Oral exams, x-rays, cleanings, fluoride, sealants and space maintainers (subject to frequency limitations)	0% / 20% *Deductible waived*	0% / 20% *Deductible waived*	0% / 10% *Deductible waived*
Basic Services	In-Network/Out-of-Network		
Includes: Palliative care, fillings, stainless steel crowns, pulpotomies, oral surgery, endodontics, periodontics	30% / 50% *After deductible*	20% / 40% *After deductible*	10% / 30% *After deductible*
Major Services	In-Network/Out-of-Network		
Includes: Other crowns, bridges and dentures	50% / 50% *After deductible*	50% / 50% *After deductible*	40% / 50% *After deductible*
Orthodontic Services	Optional orthodontic coverage for dependent children to age 19, or adults and children.		
Lifetime maximum benefit	Additional orthodontic coverage is not available on the Dental 1000	$1,500	$2,000

This is a high-level overview; refer to Certificate of Insurance and Schedule of Benefits for comprehensive description of coverage, benefits, special circumstances, and limitations.

In-Network/Out-of-Network Calendar Year Deductible is combined.

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**In-Network/Out-of-Network Annual Deductible Amounts and Out-Of-Pocket Maximum Amounts are both combined.

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Questions?
Contact your Broker
or visit us at
SeeChangeHealth.com

Exclusions & Limitations

Following is an abbreviated list of exclusions and limitations. Please see the Group Policy, ("Policy"), the Certificate of Insurance ("COI"), the Schedule of Benefits ("SOB"), and any Riders or Amendments for comprehensive details. Defined terms are "Capitalized" and can be found in the COI. Please note that in listing services or examples, we do not intend to limit a list of services or examples unless we state specifically that the list "is limited to".

- Any amounts in excess of maximum amounts stated in the SOB.
- Charges in excess of Eligible Expenses as detailed in the SOB.
- Services or supplies that are not medically necessary.
- Services received before your effective date.
- Services received after your coverage ends.
- Any conditions for which benefits can be recovered under any workers' compensation law or similar law.
- Services provided by a local, state or federal government agency, unless you have to pay for them.
- Services you receive for which you are not legally obligated to pay.
- Services for which no charge is made to you in the absence of insurance coverage.
- Services not listed as covered in the COI, the SOB, or any Riders or Amendments.
- Services performed by a Provider who is a family member by birth or
- marriage or resides at same residence.
- Alternative Treatments such as acupressure, aromatherapy, hypnotism, Rolfing and art therapy.
- Cosmetic Procedures.
- Custodial care.
- Dental and orthodontic services except as specifically stated in the
- COI, the SOB, or any Riders or Amendments.
- Devices, appliances and prosthetics except as specifically stated in the COI, the SOB, or any Riders or Amendments. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo esophageal voice prosthetics.
- Replacement of prosthetics and Durable Medical Equipment ("DME") due to misuse, malicious damage, gross neglect or when lost or stolen.
- Domiciliary care.
- Experimental or Investigational Services, except for services for persons who have been accepted into an approved clinical trial for cancer, or a life threatening Sickness or condition.
- Eye surgery performed solely for the purpose of correcting refractive errors (such as intact corneal implants). Also, Surgery that is intended to allow you to see better without glasses or other vision correction such as LASIK.
- Eyewear including the purchase cost and fitting charge for eyeglasses and contact lenses unless specifically stated in the COI.
- Food or dietary supplements, except for formulas and special food products to prevent complications of phenylketonuria (PKU).
- Foot care that is routine. Examples include the cutting and removal of corns or calluses; hygienic and preventive maintenance foot care; treatment of flat feet; shoe orthotics; shoe inserts; and arch supports. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which benefits are provided under the diabetes services in the COI, the SOB, or any Riders or Amendments. This exclusion does not apply to preventive foot care for those who are at risk of neurological or vascular disease arising from diseases such as diabetes.
- Foreign language and sign language interpreters, except as required by law.
- Genetic testing, except as specifically stated in the COI.
- Growth hormone therapy.
- Health club memberships.
- Infertility services (including sterilization reversal) except as specifically stated in the COI, the SOB, or any Riders or Amendments.
- Medical supplies, except as specifically listed in the COI, the SOB, or any Riders or Amendments.
- Non-injectable medications given in an outpatient or office setting.
- Nutritional counseling except as specified listed as covered in the COI, the SOB, or any Riders or Amendments.
- Obesity reduction services through surgical and non-surgical treatment, except as specifically stated in the COI.
- Over-the-counter medications and treatments.
- Pain management services using multi-disciplinary pain management programs provided on an inpatient basis.
- Personal care attendant's services.
- Personal comfort items.
- Pharmaceutical products and prescription medication products beyond the specified supply limits and/or specifically excluded in the COI and/or SOB.
- Pharmaceutical Products or prescription medication products for outpatient use that are filled by a prescription order or refill except as specifically stated in the COI.
- Pregnancy through a surrogate and any services or supplies provided in connection with a surrogate Pregnancy.
- Private duty nursing.
- Psychosurgery.
- Respite care.
- Sex transformation operations.
- Smoking cessation programs that are stand-alone multi-disciplinary smoking cessation programs, except as covered in the COI, the SOB, or any Riders or Amendments.
- Snoring treatments, both medical and surgical treatment, except as when provided as part of treatment for documented obstructive sleep apnea. Also limited is upper and lower jawbone surgery including that for obstructive sleep apnea.
- Travel or transportation expenses, even if prescribed by a Physician.
- Weight loss programs.
- Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. This exclusion does not apply to mammography.
- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
- Health services while on active military duty.
- Health services for organ and tissue transplants, except those described under Transplantation Services in the COI, the SOB, or any Riders or Amendments.
- Out-of-Network health services provided in a foreign country, unless as required as Emergency Health Services.
- Out-of-Network Preventive Care except as required by law.
- Medicare eligibility results in Benefit payment pursuant to Medicare rules.
- Claims submitted for health services beyond 12 months from the date of service, except as required by law.
- Services performed by a Provider who is a family member by birth or marriage or resides at same residence.
- Dental and orthodontic services except as specifically stated in the COI, the SOB, or any Riders or Amendments.

Value-based benefit plans enable a unique partnership between you, your Physicians and SeeChange Health. To make this partnership effective, however, we need to work a specified Network of Physicians, Hospitals and other Providers of medical services. At the same time we recognize that you may wish to obtain treatment from a Provider outside of this Network. Therefore, we provide some coverage for the Out-of- Network Providers, but much less than the coverage provided when you remain in our Network. Specifically, the Out-of-Network Benefits have separate deductibles and Out-of-Pocket Maximums than the Network Benefits. The allowed amount for Out-of-Network Claims is equal to 110% of Medicare allowable rates. Only the allowed amount is applied to the Out-of-Network deductible and/or Out-of-Pocket Maximum. You will be responsible for any billed charges in excess of the Medicare allowed rate. The difference in billed charges from a Network Provider compared to an Out-of-Network Provider can be substantial and these excess amounts are the responsibility of the insured. These amounts are NOT SUBJECT to any Out-of-Pocket Maximum limitations. Please be sure to verify if your Provider is in the SeeChange Health Network prior to receiving services.

For complete Benefits information visit www.SeeChangeHealth.com.

This brochure provides abridged information about benefits, exclusions, and limitations. For costs and complete information on coverage, you must refer to the Certificate of Insurance, Group Policy, and Schedule of Benefits about how SeeChange plans work, accessing benefits, benefit limits, service area benefit limitations, pre-service benefit confirmation, compliance rules, and eligible expenses. SeeChange Health Insurance Company offers value-based group health insurance coverage in all counties in California.