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.anthem.com/ca** or by calling **1-800-967-3015**.

For your Pharmacy benefits through Express-Scripts (Medco) go to www.express-scripts.com or call **1-800-711-0917**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$100** Individual / **$300** Family for PPO providers. Does not apply to in network preventive care, physician home and office visits.	See the chart on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes. **$200**/visit for emergency room services.	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. **$1,500** Individual / **$3,000** Family for PPO providers.	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.anthem.com/ca** or call **1-800-967-3015** 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 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 PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	Not Covered	$25 copay/visit for physician home visits.
	Specialist visit	$20 copay/visit	Not Covered	——none——
	Other practitioner office visit	$5 copay/visit	Not Covered	Chiropractic Services limited to 30 visits/calendar year.
	Preventive care/screening/immunization	No copay	Not Covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	No copay	Not Covered	——none——
	Imaging (CT/PET scans, MRIs)	No copay	Not Covered	——none——

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$7 Co-pay (retail) $14 Co-pay (mail order)	$7 Co-pay (retail) Not Covered for mail order scripts	Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription). **Compounded Medications** of which at least one ingredient is a legend drug are covered as follows: 30% with $150.00 out of pocket maximum **For brand drugs that have a generic equivalent available:** Member may pay the generic co-pay plus the difference in cost between the brand and generic drugs. For prepackaged drugs that have more than a 30 day supply, members will be charged up to 3 co-pays at a retail pharmacy per fill. Prior Authorization / Coverage Management programs may apply to some drugs **Retail fill allowance:** The first three times that you purchase a long-term drug at a participating retail pharmacy, you'll pay your retail co-payment. After the third purchase, you'll pay a higher cost if you continue to purchase it at retail.
	Preferred brand drugs	$25 Co-pay (retail) $60 Co-pay (mail order)	$25 Co-pay (retail) Not Covered for mail order scripts	
	Non-preferred brand drugs	Not Covered	Not Covered	

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
	Specialty drugs	20%	Not Covered	Most specialty drugs must be obtained through Accredo Specialty Pharmacy. Specialty meds have a co-pay maximum of $100 per script filled at retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100/occurance	Not Covered	Subject to utilization review.
	Physician/surgeon fees	No copay	Not Covered	——————none——————
If you need immediate medical attention	Emergency room services	No copay	No copay	$200 deductible waived if admitted.
	Emergency medical transportation	$50 copay	Not covered	——————none——————
	Urgent care	$20 copay/visit	Not covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$100/day	Not covered	Subject to utilization review. $100/day for the first three days.
	Physician/surgeon fee	No copay	Not covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay/visit	Not covered	$20 copay applies to physician visits only; preauthorization required after 12 visits. Facility based care is subject to utilization review.
	Mental/Behavioral health inpatient services	$100/day	Not covered	
	Substance use disorder outpatient services	$20 copay/visit	Not covered	
	Substance use disorder inpatient services	$100/day	Not covered	
If you are pregnant	Prenatal and postnatal care	No copay	Not covered	Refer to plan documents for further details of Family Planning benefits.
	Delivery and all inpatient services	No copay	Not covered	——————none——————
If you need help recovering or have other special health needs	Home health care	$20 copay/visit	Not covered	Subject to utilization review. Limited to 100 visits/calendar year, one visit by home health aide equals four hours or less; not covered while member receives hospice care.
	Rehabilitation services	$20 copay/visit	Not covered	——————none——————
	Habilitation services	$20 copay/visit	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
	Skilled nursing care	No copay	Not covered	Subject to utilization review; limited to 100 days/calendar year.
	Durable medical equipment	20% coinsurance	Not covered	——————none——————
	Hospice service	No copay	Not covered	——————none——————
If your child needs dental or eye care	Eye exam	No copay	Not Covered	Medically necessary vision screening.
	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
- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- 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

Pharmacy Benefit Exclusions

- Allergy Serums
- Biologicals
- Blood or blood plasma products
- Drugs labeled "Caution-limited by Federal law to investigational use" or experimental drugs, even though a charge is made to the individual
- Drugs used for cosmetic purposes
- Drugs used to promote or stimulate hair growth
- Insulin Pumps
- Non-Federal Legend Drugs
- Nutritional Supplements
- Ostomy Supplies

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	• Coverage provided outside the United States. See www.BCBS.com/bluecardworldwide	• Infertility treatment (limited)
Other Pharmacy Benefit Inclusions		
• Federal Legend Drugs • Insulin • Needles and Syringes	• OTC Diabetic Supplies (except Insulin Pumps and Glucowatch products) • Specialty Drugs	• State Restricted Drugs • Vaccines

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 1-800-967-3015. 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:

Anthem Blue Cross
P.O. Box 4310
Woodland Hills, CA. 91365-4310

Pharmacy Benefits: For grievances and appeals regarding your drug coverage, call the number on the back of your prescription benefit card or visit www.express-scripts.com.

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:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídííłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

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** $7,370
- **Patient pays** $170

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	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$170
Total	**$170**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $1,940
- **Patient pays** $3,460

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	$100
Copays	$200
Coinsurance	$230
Limits or exclusions	$2,930
Total	**$3,460**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-621-2232.

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.