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/sisc or by calling 1-855-333-5730.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For In-Network Providers **$5,000** Individual/**$10,000** Family	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. For In-Network Providers **$6,350** Individual/**$12,700** 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, 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. This policy has no overall annual limit on the amount it will pay each year.	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 **providers**, see www.anthem.com/ca/sisc or call **1-855-333-5730.**	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 8. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-855-333-5730 or visit us at www.anthem.com/ca/sisc . If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.anthem.com/ca/sisc or call 1-855-333-5730 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 **in-network 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	$60 / visit for the 1st 3 visits, thereafter **30% coinsurance**	Billed charges exceeding out of network fee schedule.	--------none--------
	Specialist visit	$60 / visit for the 1st 3 visits, thereafter **30% coinsurance**	Billed charges exceeding out of network fee schedule.	--------none--------
	Other practitioner office visit	Chiropractor: **30% coinsurance** Acupuncturist: **30% coinsurance**	Billed charges exceeding out of network fee schedule.	Acupuncturist: Coverage is limited to 12 visits with **$25** max per visit for In-Network and Non-Network Providers/per calendar year.
	Preventive care/screening/immunization	No Cost Share	Not Covered	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	**30% coinsurance**	Billed charges exceeding out of network fee schedule.	--------none--------
	Imaging (CT/PET scans, MRIs)	**30% coinsurance**	Billed charges exceeding out of network fee schedule.	Coverage limited to $800 for **out-of-network** providers.

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 https://www.anthem.com/ca/health-insurance/provider-directory/searchcriteria?branding=ABC&provtype=Rx	Generic drugs (*includes diabetic supplies)*	**$9** Copay/ prescription (retail) **$18** Copay/ prescription (home delivery)	**$9** Copay/ prescription plus **50%** of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount	For Non-Participating Pharmacies: Member pays the retail pharmacy copay plus **50%**. Covers up to a 30 day supply for Retail pharmacy or a 90 day supply for Home Delivery. For Non-Participating Pharmacies, compound drugs & certain specialty pharmacy drugs may require preauthorization or are not covered. 30-day supply; 60-day supply for Federally Classified Schedule II Attention Deficit Disorder drugs that require a triplicate prescription require double copay available only at a Retail Pharmacy.
	Brand name formulary drugs (*includes self-injectable drugs)*	**$35** Copay/ prescription (retail) **$90** Copay/ prescription (home delivery)	**$35** Copay/ prescription plus **50%** of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount	
	Brand name non-formulary drugs (*includes compound drugs; retail only; includes self-injectable drugs)*	**$35** Copay/ prescription (retail) **$90** Copay/ prescription (home delivery)	**$35** Copay/ prescription plus **50%** of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount	
	Specialty drugs (*includes self- injectable drugs)*	**$9** Copay/ prescription for Generic drugs **$35** Copay/ prescription for Brand name drugs	Not Covered	For Non-Network: Member pays the retail pharmacy copay plus **50%**. For Non-Participating Pharmacies, compound drugs & certain specialty pharmacy drugs require preauthorization or are not covered 30-day supply for Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**30%** **coinsurance**	Billed charges exceeding out of network fee schedule.	Coverage is limited to **$350**/Admit for Non-Network Ambulatory Surgery Center. Outpatient Facility subject to utilization review

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
	Physician/surgeon fees	**30% coinsurance**	Billed charges exceeding out of network fee schedule.	--------none--------
If you need immediate medical attention	Emergency room services	**$100 / visit + 30% coinsurance**	**$100 / visit + 30% coinsurance**	$100 Copayment waived if admitted. You are responsible for billed charges exceeding maximum allowed amount for **out-of-network** providers.
	Emergency medical transportation	**30% coinsurance**	**30% coinsurance**	--------none--------
	Urgent care	**30% coinsurance**	Billed charges exceeding out of network fee schedule.	Costs may vary by site of service. You should refer to your formal contract of coverage for details.
If you have a hospital stay	Facility fee (e.g., hospital room)	**30% coinsurance**	0% **coinsurance** with $600/day max	The maximum **plan** payment for non-emergency hospital services received from a **out-of-network** hospital is $600 per day. Members are responsible for all charges in excess of $600. Failure to prior authorize may result in reduced or nonpayment of benefits.
	Physician/surgeon fee	**30% coinsurance**	Billed charges exceeding out of network fee schedule.	--------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	Office Visit: $60 / visit for the 1st 3 visits, thereafter **30% coinsurance** Facility Visit: **30% coinsurance**	Billed charges exceeding out of network fee schedule.	--------none--------
	Mental/Behavioral health inpatient services	**30% coinsurance**	Billed charges exceeding out of network fee schedule.	This is for facility professional services only. Please refer to your hospital stay for facility fee.
	Substance use disorder outpatient services	Office Visit: $60 / visit for the 1st 3 visits, thereafter **30% coinsurance** Facility Visit: **30% coinsurance**	Billed charges exceeding out of network fee schedule.	--------none--------
	Substance use disorder inpatient services	**30% coinsurance**	Billed charges exceeding out of network fee schedule.	This is for facility professional services only. Please refer to your hospital stay for facility fee.
If you are pregnant	Prenatal and postnatal care	**30% coinsurance**	Billed charges exceeding out of network fee schedule.	--------none--------
	Delivery and all inpatient services	**30% coinsurance**	0% **coinsurance** with $600/day max	**out-of-network** facility are subject to a maximum benefit payment up to $600 per day.

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	**30% coinsurance**	Billed charges exceeding out of network fee schedule.	Subject to utilization review. Coverage is limited to a total of 100 visits, In-Network Provider and Non-Network Provider combined per calendar year (one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care). Services from In-Network Provider and Non-Network Provider count towards your limit.
	Rehabilitation services	**30% coinsurance**	Billed charges exceeding out of network fee schedule.	Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Habilitation services	**30% coinsurance**	Billed charges exceeding out of network fee schedule.	Habilitation visits count toward your rehabilitation visit limit. Costs may vary by site of service. Please refer to your formal contract.
	Skilled nursing care	**30% coinsurance**	0% **coinsurance** with $600/day max	Subject to utilization review. Coverage is limited to a combined total of 100 days per calendar year for services received from In-Network & Non-Network Providers. Benefit limited to **$600**/Day.
	Durable medical equipment	**30% coinsurance**	Billed charges exceeding out of network fee schedule.	Subject to utilization review.
	Hospice service	**30% coinsurance**	Billed charges exceeding out of network fee schedule.	--------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	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.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine Foot Care (unless you have been diagnosed with diabetes. Consult your formal contract of coverage)
- Weight loss programs

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
- Bariatric surgery (For morbid obesity. Consult your formal contract of coverage)
- Chiropractic care
- Hearing aids (limited to **$700** per 24 months)
- Most coverage provided outside the United States. See www.BCBS.com/bluecardworldwide
- Routine eye care (Adult) (as part of routine physical exam)

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 1-855-333-5730. 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 BlueCross
ATTN: Appeals
P.O. Box 4310
Woodland Hills, CA 91365-4310

Or Contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform

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 naabídíiłkiid. 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.

아직 가입하지 않았거나 한국어로 된 도움말이 필요한 경우 영업 관리자나 그룹 관리자에게 문의하시기 바랍니다. 이미 가입한 경우 ID 카드에 있는 번호를 사용하여 고객 서비스에 문의하시기 바랍니다.

Nếu quý vị chưa phải là một hội viên và cần được giúp đỡ bằng Tiếng Việt, xin liên lạc với đại diện thương mãi của quý vị hoặc quản trị viên nhóm. Nếu quý vị đã ghi danh, xin liên lạc với dịch vụ khách hàng qua việc dùng số điện thoại ghi trên thẻ ID của quý vị.

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** $1,540
- **Patient pays** $6,000

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	$5,000
Copays	$200
Coinsurance	$600
Limits or exclusions	$200
Total	**$6,000**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $400
- **Patient pays** $5,000

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	$4,700
Copays	$200
Coinsurance	$0
Limits or exclusions	$100
Total	**$5,000**

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 fromnit 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.