**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?** | **$0** per individual/ **$0** per family<br>Does not apply to preventative care and prescription drugs. | See the chart starting on page 2 for your costs for services this plan covers. |
| **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. **$1,500** per individual / **$3,000** per family for medical only. | 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?** | Infertility services, Premiums, Balance-Billed Charges, Costs Related to Prescription Drugs Covered Under the Prescription Drug Plan, 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 Select Network **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?** | Yes. | This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 9. 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 **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 | $10 / visit | Not Covered | --------none-------- |
| | Specialist Visit | $10 / visit | Not Covered | --------none-------- |
| | Other practitioner office Visit | $10/visit for chiropractic and acupuncture | Not Covered | Up to 30 combined visits per calendar year. |
| | Preventive care/screening/immunization | No Cost Share | Not Covered | --------none-------- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Cost Share | Not Covered | --------none-------- |
| | Imaging (CT/PET scans, MRIs) | $100 Copay/Test | Not Covered | Costs may vary by site of service. You should refer to your formal contract of coverage for details. |

| 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**<br><br>**More information about prescription drug coverage is available at www.navitus.com** | Generic drugs | Retail 30-Days:<br>Costco: $0/Rx<br>Other: $7/Rx<br>Mail 90-Days:<br>$0/Rx | Member must pay the entire cost up front and apply for reimbursement. Net cost may be greater than if member uses an In-network provider. | Some narcotic pain medications and cough medications require the regular retail copay at Costco and 3 times the regular copay at Mail. |
| | Brand drugs | Brand:<br>Retail 30-Days:<br>Costco: $25/Rx<br>Other: $25/Rx<br>Mail 90-Days:<br>$60/Rx<br><br>Specialty:<br>30-Days: $25/Rx | | If a brand drug is dispensed when a generic equivalent is available, then the member will be responsible for the generic copayment plus the cost difference between the generic and brand. |
| | Specialty drugs | | Not Covered | Member must use Navitus Specialty Rx. Supplies of more than 30 days are not allowed |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No Charge | Not Covered | --------none-------- |
| | Physician/surgeon fees | No Cost Share | Not Covered | --------none-------- |
| **If you need immediate medical attention** | Emergency room services | $100 / visit | $100 / visit | This is for the hospital/facility charge only; copay waived if admitted. Failure to prior authorize **out-of-network provider** services may result in reduced or nonpayment of benefits. The ER physician charge may be separate. |

| 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 |
|---|---|---|---|---|
| | Emergency medical transportation | $100 Copay/Trip | $100 Copay/Trip | --------none-------- |
| | Urgent care (outside of service area) | $10 / visit | Not Covered | Copay waived if admitted inpatient or outpatient ER. If you are within the service area (less than 15 miles or 30 minutes away from your medical group or their hospital), contact your PCP or medical group. Costs may vary by site of service. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No Charge | Not Covered | --------none-------- |
| | Physician/surgeon fee | No Cost Share | Not Covered | --------none-------- |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Office Visit: $10 / visit<br><br>Facility Charges: No Charge | Not Covered | --------none-------- |
| | Mental/Behavioral health inpatient services | No Charge | Not Covered | This is for facility professional services only. Please refer to your hospital stay for facility fee. |
| | Substance use disorder outpatient services | Office Visit: $10 / visit<br><br>Facility Charges: No Charge | Not Covered | --------none-------- |
| | Substance use disorder inpatient services | No Charge | Not Covered | This is for facility professional services only. Please refer to your hospital stay for facility fee. |
| **If you are pregnant** | Prenatal and postnatal care | $10 / visit | Not Covered | --------none-------- |
| | Delivery and all inpatient services | No Charge | Not Covered | --------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 need help recovering or have other special health needs** | Home health care | $10 / visit | Not Covered | Coverage is limited to 100 visits/calendar year (one visit by a home health aide equals four hours or less). |
| | Rehabilitation services | $10 / visit | Not Covered | Coverage is limited to 60 day period of care for Occupational, Physical and Speech therapy including Chiropractor. Costs may vary by site of service. Please refer to your formal contract. |
| | Habilitation services | $10 / visit | Not Covered | All rehabilitation and habilitation visits count toward your rehabilitation visit limit. Costs may vary by site of service. Please refer to your formal contract. |
| | Skilled nursing care | No Cost Share | Not Covered | Coverage is limited to 100 days per calendar year. |
| | Durable medical equipment | 20% | Not Covered | --------none-------- |
| | Hospice service | No Cost Share | 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 | 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 eye care (Adult)
- 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.)**

- Bariatric surgery (For morbid obesity. Consult your formal contract of coverage)
- Hearing Aid Rider (**50%** Coinsurance)
- Acupuncture or Chiropractic Care Through Self-Referral
- Most coverage provided outside the United States. See www.BCBS.com/bluecardworldwide

## 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 Life & Health Insurance Company
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 naabídíílkiid. 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** $7,140
- **Patient pays** $400

**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 | $200 |
| Coinsurance | $0 |
| Limits or exclusions | $200 |
| **Total** | **$400** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,480
- **Patient pays** $920

**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 | $800 |
| Coinsurance | $20 |
| Limits or exclusions | $100 |
| **Total** | **$920** |

# 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.