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 1-800-888-8288

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**None**	There is no deductible on this plan.
Are there other deductibles for specific services?	$100/Visit for Emergency Room	You are required to pay the first $100 for each Emergency Room visit (waived if admitted)
Is there an out–of–pocket limit on my expenses?	**$1,000** Individual/**$2,000** Family Copay limit for In Network providers.	The **out-of-pocket copay 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	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 and chiropractic/acpuncture services.
Does this plan use a network of providers?	Yes. See www.anthem.com/ca or call **1-800-662-5502** for a list of In Network HMO providers.	You **must** 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, all services must be approved by your PCP/IPA or Medical Group. 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 PCP/IPA or Medical Groups 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 4. 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

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- **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**.
- Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician (PCP) and authorized by the participating medical group or independent practice association (IPA), except services provided under the "ReadyAccess" program, OB/GYN services received within the member's medical group/IPA, and services for all mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.
- This plan requires 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	**$15** Copay/Visit	Not Covered	————————none————————
	Specialist visit	**$15** Copay/Visit	Not Covered	With referral from the Primary Care physician, Medical Group or IPA
	Other practitioner office visit	**$10** Copay/Visit for Chiropractor and Acupuncture	Not Covered	Coverage is limited to **40** visits (Chiropractor & Acupuncture combined) per calendar year. Chiropractic appliances are limited to **$50** per calendar year. Services must be from an ASH Plan Provider.
	Preventive care/screening/immunization	No Charges	Not Covered	Must be done by your primary care physician, IPA or Medical Group.
If you have a test	Diagnostic test (x-ray, blood work)	No Charges	Not Covered	With referral from the Primary Care physician, Medical Group or IPA
	Imaging (CT/PET scans, MRIs)	No Charges	Not Covered	With referral from the Primary Care physician, Medical Group or IPA

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 www.USscript.com	Generic drugs at Retail pharmacy	$10 Copay	Reimbursed at the network rate minus $10 copay	For up to a 30 day supply
	Preferred brand drugs at Retail pharmacy	$20 Copay	Reimbursed at the network rate minus $20 copay	For up to a 30 day supply
	Non-preferred brand drugs at Retail pharmacy	$35 Copay	Reimbursed at the network rate minus $35 copay	For up to a 30 day supply
	Specialty drugs (Anthem Blue Cross)	10%	Not Covered	For up to a 30 day supply
Mail Service Drugs	Drugs purchased through the Mail Service Program	$20 Generic $40 Preferred $60 Non-preferred	Not Covered	For up to a 90 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charges	Not Covered	With referral from the Primary Care physician, Medical Group or IPA
	Physician/surgeon fees	No Charges	Not Covered	With referral from the Primary Care physician, Medical Group or IPA
If you need immediate medical attention	Emergency room services	**$100** Copay/Visit	Not Covered	If admitted, the $100 copay is waived.
	Emergency medical transportation	No Charges	Not Covered	Notify your Primary Care physician, Medical Group or IPA
	Urgent care	**$15** Copay/ Visit		Notify your Primary Care physician, Medical Group or IPA
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charges	Not Covered	With referral from the Primary Care physician, Medical Group or IPA
	Physician/surgeon fee	No Charges	Not Covered	With referral from the Primary Care physician, Medical Group or IPA

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	No Charge	Not Covered	With referral from the Primary Care physician, Medical Group or IPA
	Mental/Behavioral health inpatient services	No Charge	Not Covered	With referral from the Primary Care physician, Medical Group or IPA
	Mental/Behavioral health physician services	$15 Copay/Visit	Not Covered	With referral from the Primary Care physician, Medical Group or IPA
	Substance use disorder physician services	$15 Copay/Visit	Not Covered	With referral from the Primary Care physician, Medical Group or IPA
	Substance use disorder outpatient services	No Charge	Not Covered	With referral from the Primary Care physician, Medical Group or IPA
	Substance use disorder inpatient services	No Charge	Not Covered	With referral from the Primary Care physician, Medical Group or IPA
If you are pregnant	Prenatal and postnatal care	No Charges	Not Covered	With referral from the Primary Care physician, Medical Group or IPA
	Delivery and all inpatient services	No Charges	Not Covered	With referral from the Primary Care physician, Medical Group or IPA

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	**$15** Copay/Visit	Not Covered	Coverage is limited to 100 visits per calendar year; one visit by a home health aide equals four hours or less. With referral from the Primary Care physician, Medical Group or IPA
	Rehabilitation services	**$15** Copay/Visit	Not Covered	Coverage is limited to 60 day period of care after an illness or injury for each Occupational, Physical and Speech therapy. With referral from the Primary Care physician, Medical Group or IPA
	Habilitation services	**$15** Copay/Visit	Not Covered	Coverage is limited to 60 day period of care after an illness or injury for each Occupational, Physical and Speech therapy. With referral from the Primary Care physician, Medical Group or IPA
	Skilled nursing care	No Charges	Not Covered	Coverage is limited to 100 days per calendar year. With referral from the Primary Care physician, Medical Group or IPA
	Durable medical equipment	No Charges	Not Covered	With referral from the Primary Care physician, Medical Group or IPA. Hearing aids covered for 1 aid per ear every three years.
	Hospice service	No Charges	Not Covered	With referral from the Primary Care physician, Medical Group or IPA
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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- 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
- Chiropractic care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Private-duty nursing
- Hearing Aids

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 [1-800-662-5502]. 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 Life and Health Insurance Company,

Attn: Appeals,

PO Box 54159,

Los Angeles,

CA 90054.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-662-5502.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-662-5502.]

[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-662-5502.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-662-5502.]

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** $1,460
- **Patient pays** $3,940

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	$1,000
Copays	$10
Coinsurance	$0
Limits or exclusions	$2,930
Total	**$3,940**

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 go online to www.anthem.com/ca.

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.