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 1-800-662-5502.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** Member/**$1,000** Family for PPO providers and Non-PPO providers.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use, unless otherwise noted. 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?	Yes. **$250**/Admission for Non-Anthem Blue Cross PPO hospital or residential treatment center. **$250**/Admission for Non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained. **$100**/Visit for Emergency room services.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$3,000** Member/ **$6,000** Family for PPO providers. **$10,000** Member/**$20,000** Family for Non-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?	Deductibles, Copayments, Non Covered expense.	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.

Questions: Call 1-800-662-5502 or visit us at www.anthem.com/ca.

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 or call 1-800-662-5502 to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Does this plan use a network of providers?	Yes. See www.anthem.com/ca or call **1-800-662-5502** for a list of PPO 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 don't need a referral to see a specialist.	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 6. 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	**$35** Copay/Visit *	**40%** Coinsurance	——————none——————
	Specialist visit	**$35** Copay/Visit *	**40%** Coinsurance	——————none——————
	Other practitioner office visit	**$25** Copay/Visit * for Chiropractor. Acupuncture 20% coinsurance	**40%** Coinsurance for Chiropractor and Acupuncture	Coverage is limited up to 12 visits per calendar year for Chiropractor. Coverage is limited to 20 visits per calendar year for Acupuncture. There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.
	Preventive care/screening/immunization	No Charges *	Not Covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No Charges *	**40%** Coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	**20%** Coinsurance	**40%** Coinsurance	——————none——————
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 network rate minus $10 copay	For up to a 30 day supply
	Preferred brand drugs at Retail pharmacy	$20 Copay	Reimbursed at network rate minus $20 copay	For up to a 30 day supply
	Non-preferred brand drugs at Retail pharmacy	$35 Copay	Reimbursed at network rate minus $35 copay	For up to a 30 day supply
	Specialty drugs (Anthem Blue Cross)	20% Coinsurance	Not Covered	For up to a 30 day supply
Mail Service Drugs	Drugs purchased through Mail Service program	**$20** Generic **$40** Preferred **$60** Non-preferred	Not Covered	For up to a 90 day supply

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**$125** Copay/ Surgery plus **20%** Coinsurance	**40%** Coinsurance	Coverage is limited to $350/day for Non-PPO providers.
	Physician/surgeon fees	**20%** Coinsurance	**40%** Coinsurance	————————none————————
If you need immediate medical attention	Emergency room services	**20%** Coinsurance	**20%** Coinsurance	If admitted $100 copay is waived.
	Emergency medical transportation	**20%** Coinsurance	**20%** Coinsurance	————————none————————
	Urgent care	**$35** Copay/Visit *	**20%** Coinsurance	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	**$250** Copay/ Admission plus **20%** Coinsurance	**40%** Coinsurance	Coverage is limited to $600/day for Non-PPO providers.
	Physician/surgeon fee	**20%** Coinsurance	**40%** Coinsurance	————————none————————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**20%** Coinsurance	**40%** Coinsurance	Coverage is limited to $600/day for Non-PPO providers.
	Mental/Behavioral health inpatient services	**$250** Copay/ Admission plus **20%** Coinsurance	**40%** Coinsurance	Coverage is limited to $600/day for Non-PPO providers.
	Mental/Behavioral health physician services	**$35** Copay/Visit *	**40%** Coinsurance	————————none————————
	Substance use disorder outpatient services	**20%** Coinsurance	**40%** Coinsurance	Coverage is limited to $600/day for Non-PPO providers.
	Substance use disorder physician services	**$35** Copay/Visit *	**40%** Coinsurance	————————none————————
	Substance use disorder inpatient services	**$250** Copay/ Admission plus **20%** Coinsurance	**40%** Coinsurance	Coverage is limited to $600/day for Non-PPO providers.
If you are pregnant	Prenatal and postnatal care	**$35** Copay/Visit *	**40%** Coinsurance	————————none————————
	Delivery and all inpatient services	**$250** Copay/ Admission plus **20%** Coinsurance	**40%** Coinsurance	————————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
Deductible does not apply if *				
If you need help recovering or have other special health needs	Home health care	**20%** Coinsurance	**20%** Coinsurance with authorization	Coverage is limited to 100 prior authorized visits per calendar year; one visit by a home health aide equals four hours or less.
	Rehabilitation services	**$25** Copay/Visit *	**40%** Coinsurance	There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.
	Habilitation services	**$25** Copay/Visit *	**40%** Coinsurance	There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.
	Skilled nursing care	**20%** Coinsurance	**20%** Coinsurance	Coverage is limited to 100 days per calendar year.
	Durable medical equipment	**20%** Coinsurance	**20%** Coinsurance	Hearing Aid benefit is available for one hearing aid per ear every three years.
	Hospice service	No Charges *	No Charges	——————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——————
Deductible does not apply if *				

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
- Weight loss program

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
- Non-emergency care when traveling outside the U.S.
- 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,

P.O 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** $6,540
- **Patient pays** $1,000

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	$500
Copays	$290
Coinsurance	$40
Limits or exclusions	$170
Total	**$1,000**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $1,510
- **Patient pays** $3,890

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	$500
Copays	$250
Coinsurance	$210
Limits or exclusions	$2,930
Total	**$3,890**

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 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.