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.healthcomp.com or by calling 1-800-442-7247.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers: **$0** person / **$0** family For out-of-network providers: **$250** person / **$500** 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?	Yes. **$50** person / **$150** family for dental coverage. There are no other specific **deductibles**.	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. For in-network medical providers: **$1,500** person / **$3,000** family For out-of-network medical providers: **$2,500** person / **$5,000** 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. There is a separate in-network **out-of-pocket limit** for the prescription drug benefit of **$7,950** person / **$15,900** family.
What is not included in the out–of–pocket limit?	Non-Network copays, balance-billed charges, premiums, cost containment penalties, chiropractor, and health care this plan does not 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 1-800-888-8288** for a list of in-network 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 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 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	$20 copay/visit	30% coinsurance	---------------none------------
	Specialist visit	$30 copay/visit	30% coinsurance	---------------none------------
	Other practitioner office visit	No charge for chiropractor.	No charge for chiropractor.	Coverage is limited to $20/visit and 30 combined visits per calendar year.
	Preventive care/screening/immunization	No charge	Not covered or 30% coinsurance	No coverage for out-of-network providers for individuals 19 years old and older. Coverage is limited to one gynecological exam and pap smear per year. Coverage is limited to $200 per calendar year for all well child out-of-network provider care.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	---------------none------------
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	---------------none------------

**Note: For Non-Network providers, the co-insurance represents only the coverage levels up to the Plan's "Recognized Charge" amounts, which may be less than the provider's billed charges. Any billed amounts charged by a non-network provider which exceed the Recognized Charge allowance are excluded from coverage and are the sole liability of the member.*

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
	Generic drugs	Retail: $10/prescription Mail order: $20/prescription	Retail: $10/prescription Mail order: $20/prescription	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). The copay for oral contraceptives is $0.
	Preferred brand drugs**	Retail: $20/prescription Mail order: $40/prescription	Retail: $20/prescription Mail order: $40/prescription	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription).
	Non-preferred brand drugs**	Retail: $40/prescription Mail order: $80/prescription	Retail: $40/prescription Mail order: $80/prescription	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay/visit	30% coinsurance	Coverage is limited to $1,000/surgery at out-of-network facilities. Pre-certification is required or coverage may be reduced.
	Physician/surgeon fees	No charge	30% coinsurance	---------------none------------
If you need immediate medical attention	Emergency room services	$100 copay/visit	$100 copay/visit	Copay waived if admitted. Out-of-network deductible waived.
	Emergency medical transportation	No charge	No charge	Out-of-network deductible waived.
	Urgent care	$20 copay/visit	30% coinsurance	---------------none------------

**Note: For Non-Network providers, the co-insurance represents only the coverage levels up to the Plan's "Recognized Charge" amounts, which may be less than the provider's billed charges. Any billed amounts charged by a non-network provider which exceed the Recognized Charge allowance are excluded from coverage and are the sole liability of the member.*

*** If an FDA approved Generic equivalent is available, and the Brand is still requested, you will be responsible for the difference in cost between the Brand and Generic in addition to the brand copay.*

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 a hospital stay	Facility fee (e.g., hospital room)	$150 copay/per day	30% coinsurance	$750 copay maximum per calendar year for in-network providers. Pre-certification is required or coverage may be reduced.
	Physician/surgeon fee	No charge	30% coinsurance	---------------none------------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay/visit	30% coinsurance	---------------none------------
	Mental/Behavioral health inpatient services	$150 copay/per day	30% coinsurance	$750 copay maximum per calendar year for in-network providers. Pre-certification is required or coverage may be reduced.
	Substance use disorder outpatient services	$20 copay/visit	30% coinsurance	---------------none------------
	Substance use disorder inpatient services	$150 copay/per day	30% coinsurance	$750 copay maximum per calendar year for in-network providers. Pre-certification is required or coverage may be reduced.
If you are pregnant	Prenatal and postnatal care	$200 copay/ pregnancy	30% coinsurance	---------------none------------
	Delivery and all inpatient services	$150 copay/per day	30% coinsurance	$750 copay maximum per calendar year for in-network providers.

**Note: For Non-Network providers, the co-insurance represents only the coverage levels up to the Plan's "Recognized Charge" amounts, which may be less than the provider's billed charges. Any billed amounts charged by a non-network provider which exceed the Recognized Charge allowance are excluded from coverage and are the sole liability of the member.*

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% coinsurance	30% coinsurance	Coverage is limited to 40 combined visits per calendar year. Pre-certification is required or coverage may be reduced.
	Rehabilitation services	$20 copay/visit	30% coinsurance	Coverage is limited to 60 visits combined per calendar year.
	Habilitation services	$20 copay/visit	30% coinsurance	Coverage is limited to 60 visits combined per calendar year.
	Skilled nursing care	10% coinsurance	30% coinsurance	Coverage is limited to 120 days per calendar year. Pre-certification is required or coverage may be reduced.
	Durable medical equipment	No charge	30% coinsurance	Pre-certification required for amounts over $500. Pre-certification is required or coverage may be reduced.
	Hospice service	No charge	30% coinsurance	Coverage is limited to $7,500/lifetime for out-of-network facilities. Pre-certification is required or coverage may be reduced.
If your child needs dental or eye care	Eye exam	$20 copay/visit	$20 copay/visit	Coverage is limited to $35 for out-of-network providers. Limited to one exam per year.
	Glasses	$20 copay/pair lenses	$20 copay/pair lenses	Coverage is limited to $200 for frames from an in-network provider. Coverage is limited to $70 for frames, $50 for single lenses, $75 bifocal, $100 trifocal, $75 progressive from an out-of-network provider. Limited to one pair every 24 months.

Note: For Non-Network providers, the co-insurance represents only the coverage levels up to the Plan's "Recognized Charge" amounts, which may be less than the provider's billed charges. Any billed amounts charged by a non-network provider which exceed the Recognized Charge allowance are excluded from coverage and are the sole liability of the member.

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
	Dental check-up	10% coinsurance	30% coinsurance	Coverage limited to 2 check-ups per person per calendar year. Coverage limited to $1,750 per individual per calendar year.

**Note:* For Non-Network providers, the co-insurance represents only the coverage levels up to the Plan's "Recognized Charge" amounts, which may be less than the provider's billed charges. Any billed amounts charged by a non-network provider which exceed the Recognized Charge allowance are excluded from coverage and are the sole liability of the member.*

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
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- 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.)

- Bariatric surgery
- Chiropractic Care
- Dental care
- Routine eye care

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 1-800-442-7247. 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:

HealthComp
P.O. Box 45018
Fresno, CA 93718-5018
Toll Free: (800) 442-7247
www.healthcomp.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.**

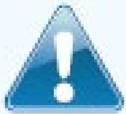
Language Access Services:

Para obtener asistencia en Español, llame al (800)442-7247.

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** $6,800
- **Patient pays** $740

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	$520
Coinsurance	$70
Limits or exclusions	$150
Total	**$740**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,710
- **Patient pays** $690

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	$600
Coinsurance	$10
Limits or exclusions	$80
Total	**$690**

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.