## Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the chart starting on page 2 for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don't have to meet <strong>deductibles</strong> for specific services, but see the chart</td>
</tr>
<tr>
<td></td>
<td></td>
<td>starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes; $500 single / $1,500 family for In-Network Providers.</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay during a coverage period</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(usually one year) for your share of the cost of covered services. This limit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Infertility services, Premiums, Balance-Billed charges, and Health Care</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>specific covered services</strong>, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes, California Care HMO. For a list of In-Network providers, see</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.anthem.com/ca/cityofla">www.anthem.com/ca/cityofla</a> or call (855) 333-5730.</td>
<td>some or all of the costs of covered services. Be aware, your in-network doctor or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>hospital may use an out-of-network provider for some services. Plans use the term</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>in-network</strong>, preferred, or participating for providers in their network. See</td>
</tr>
<tr>
<td></td>
<td></td>
<td>the chart starting on page 2 for how this plan pays different kinds of providers.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>Yes; you need written approval to see a specialist. There may be some</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>providers or services for which referrals are not required. Please see the formal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>contract of coverage for details.</td>
</tr>
<tr>
<td>Important Questions</td>
<td>Answers</td>
<td>Why this Matters:</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
<td>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.</td>
</tr>
</tbody>
</table>

- **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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost if You Use an In-Network Provider</th>
<th>Your Cost if You Use an Non-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 copay per visit</td>
<td>Not covered</td>
<td>No cost share for members under 5 In-network.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$15 copay per visit</td>
<td>Not covered</td>
<td>No cost share for members under 5 In-network.</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>Chiropractor</td>
<td>Chiropractor</td>
<td>Chiropractor Care &amp; Acupuncture Rider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$15 copay per visit</td>
<td>Not covered</td>
<td>A combined total of 60 additional visits per benefit year: <strong>$15</strong> Copay/Visit</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening /immunization</td>
<td>No cost share</td>
<td>Not covered</td>
<td>---none---</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Lab – Office</td>
<td>Lab – Office</td>
<td>Lab – Office</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No cost share</td>
<td>Not covered</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No cost share</td>
<td>Not covered</td>
<td>Costs may vary by site of service.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Typically Generic</td>
<td>$10 copay per prescription (retail only)</td>
<td>$10 copay plus 50% of the</td>
<td>Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply</td>
</tr>
</tbody>
</table>

Common Medical Event

- **If you visit a health care provider’s office or clinic**
  - Primary care visit to treat an injury or illness: $15 copay per visit
  - Specialist visit: $15 copay per visit
  - Other practitioner office visit:
    - Chiropractor: $15 copay per visit
    - Acupuncture: $15 copay per visit
  - Preventive care/screening /immunization: No cost share

- **If you have a test**
  - Diagnostic test (x-ray, blood work):
    - Lab – Office: No cost share
    - X-Ray – Office: No cost share
  - Imaging (CT/PET scans, MRIs):
    - No cost share

- **If you need drugs to treat your illness or condition**
  - Tier 1 - Typically Generic:
    - $10 copay per prescription (retail only)

Important Questions

- **Are there services this plan doesn’t cover?**
  - Yes.

Answers

- **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.
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<th>Limitations &amp; Exceptions</th>
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</thead>
<tbody>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.anthem.com/ca/pharmacyinformation/">http://www.anthem.com/ca/pharmacyinformation/</a></td>
<td>and $20 copay per prescription (home delivery only)</td>
<td>remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum (retail only)</td>
<td>(home delivery program)</td>
<td></td>
</tr>
</tbody>
</table>

Tier 2 - Typically Preferred / Brand

- $20 copay per prescription (retail only) and $40 copay per prescription (home delivery only)
- $20 copay plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum (retail only)

Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost of that type of prescription drug. The preferred generic program does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.

Tier 3 - Typically Non-Preferred / Specialty Drugs

- $40 copay per prescription (retail only) and $80 copay per prescription (home delivery only)
- $40 copay plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum (retail only)

Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost of that type of prescription drug. The preferred generic program does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost if You Use an In-Network Provider</th>
<th>Your Cost if You Use an Non-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Applicable retail drug tier copay</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Typically Specialty Drugs</td>
<td></td>
<td></td>
<td>has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No cost share</td>
<td>Not covered</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No cost share</td>
<td>Not covered</td>
<td>---none---</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$100 copay per visit</td>
<td>Covered as In-Network</td>
<td>If directly admitted to a hospital, ER copay is waived.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge per trip for ground and air</td>
<td>Covered as In-Network</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$15 copay per visit</td>
<td>Covered as In-Network</td>
<td>Copay waived if admitted. No cost share for members under 5 In-network.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No cost share</td>
<td>Not covered</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No cost share</td>
<td>Not covered</td>
<td>---none---</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>Office Visit $15 copay per visit Facility Charges No cost share</td>
<td>Office Visit Not covered Facility Charges Not covered</td>
<td>Office Visit No cost share for members under 5 In-network. Facility Charges ---none---</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>No cost share</td>
<td>Not covered</td>
<td>This is for facility professional services only. Refer to hospital stay for facility fees.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>Office Visit $15 copay per visit Facility Charges No cost share</td>
<td>Office Visit Not covered Facility Charges Not covered</td>
<td>Office Visit No cost share for members under 5 In-network. Facility Charges ---none---</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>No cost share</td>
<td>Not covered</td>
<td>This is for facility professional services only. Refer to hospital stay for facility fees.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal</td>
<td>No cost share</td>
<td>Not covered</td>
<td>In network preventive, prenatal and</td>
</tr>
</tbody>
</table>

- **Tier 4 - Typically Specialty Drugs**: Typically Specialty Drugs are covered up to a 30 day supply (retail pharmacy) Covers up to a 30 day supply (home delivery program) Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost if You Use an In-Network Provider</th>
<th>Your Cost if You Use an Non-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
</table>
| postnatal services   | No cost share         | Not covered                                |                                             | postnatal services covered at 100%.
| Delivery and all     |                      |                                            |                                             | ------------------------|
| inpatient services   |                      |                                            |                                             | ------------------------|
| Home health care      | No cost share         | Not covered                                |                                             | Coverage for In-Network Providers is limited to 100 visits per benefit period. |
| Rehabilitation services | $15 copay per visit | Not covered                                |                                             | Coverage for In-Network Providers is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Chiropractor visits count towards your physical and occupational therapy limit. |
| Habilitation services | $15 copay per visit | Not covered                                | Habilitation visits count towards your rehabilitation limit. |
| Skilled nursing care | No cost share         | Not covered                                | Coverage for In-Network Providers is limited to 100 days limit per benefit period. |
| Durable medical      | No cost share         | Not covered                                |                                             | ------------------------|
| equipment            |                      |                                            |                                             | ------------------------|
| Hospice service      | No cost share         | Not covered                                |                                             | ------------------------|
| If your child needs  | Eye exam              | Not covered                                | Not covered                                | ------------------------|
| dental or eye care   | Glasses               | Not covered                                | Not covered                                | ------------------------|
| Dental check-up      | Not covered           | Not covered                                |                                             | ------------------------|
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
- Non-emergency care outside US
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care unless you have been diagnosed with diabetes.
- 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 only.
- Chiropractic care
- Hearing Aid Rider - Coverage limited to one hearing aid every 24 months/No cost share.

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 (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](http://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](http://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:

**ATTN: Grievances and Appeals**
P.O. Box 4310
Woodland Hills, CA 91365-4310

Department of Labor, Employee Benefits Security Administration
(866) 444-EBSA (3272)
[www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Department of Managed Health Care California Help Center
980 9th Street
Suite 500
Sacramento, CA 95814-2725
(888) HMO-2219

California Department of Managed Health Care Help Center
980 9th Street, Suite 500
Sacramento, CA 95814
(888) 466-2219
[http://www.healthhelp.ca.gov](http://www.healthhelp.ca.gov)
helpline@dmhc.ca.gov
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:
如果您是非会员并需要中文协助，请联络您的销售代表或小组管理员。如果您已参保，则请使用您 ID 卡上的号码联络客户服务人员。

Doo bee a’th ni’liigoo eí dooda’í, shikáa adoolwoł íinizìngígo t’áá diné k’číígo, t’áá shoodí ba na’ałníhí ya sidáhí bich’j naabídíílkid. Eí doo biqha daago ni ba’nija’go ho’aalagíí bich’j hodiilní. Hai’dąą iini’taago eíya, t’áá shoodí diné ya atáh halne’ígíí ní béésh bee hane’í wólt’a’ bi’ki si’iilíígí bi’kéhgo bich’j hodiilní.

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.

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.

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 mại 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:** $7,260
- **Patient pays:** $280

#### 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: $130
- Coinsurance: $0
- Limits or exclusions: $150
- **Total:** $280

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)
- **Amount owed to providers:** $5,400
- **Plan pays:** $4,820
- **Patient pays:** $580

#### 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: $360
- Coinsurance: $140
- Limits or exclusions: $80
- **Total:** $580
Questions and answers about the Coverage Examples:

<table>
<thead>
<tr>
<th>What are some of the assumptions behind the Coverage Examples?</th>
<th>What does a Coverage Example show?</th>
<th>Can I use Coverage Examples to compare plans?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Costs don’t include <strong>premiums</strong>.</td>
<td>For each treatment situation, the Coverage Example helps you see how <strong>deductibles</strong>, <strong>copayments</strong>, and <strong>coinsurance</strong> 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.</td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
<td>✓ <strong>Yes.</strong> 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.</td>
</tr>
<tr>
<td>• The patient’s condition was not an excluded or preexisting condition.</td>
<td></td>
<td>✓ <strong>Yes.</strong> An important cost is the <strong>premium</strong> you pay. Generally, the lower your <strong>premium</strong>, the more you’ll pay in out-of-pocket costs, such as <strong>copayments</strong>, <strong>deductibles</strong>, and <strong>coinsurance</strong>. 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.</td>
</tr>
<tr>
<td>• All services and treatments started and ended in the same coverage period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• There are no other medical expenses for any member covered under this plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Out-of-pocket expenses are based only on treating the condition in the example.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The patient received all care from in-network <strong>providers</strong>. If the patient had received care from out-of-network <strong>providers</strong>, costs would have been higher.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

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