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 by calling Customer Service at **1-800-847-8361**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network **providers** **$500** person/ **$1,000** family. For out-of-network **providers** **$1,000** person/**$2,000** 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. **$250** for prescription drug expenses.	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 **providers** **$4,000** person/**$8,000** family For out-of-network **providers** **$10,000** person/**$20,000** 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.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, pre-authorization penalties 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	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.
Does this plan use a network of providers?	Yes. Call Customer Service at **1-800-847-8361** 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 5. 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 a In-Network Provider	Your Cost If You Use a 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	$25 copay	50% coinsurance	Deductible does not apply to in-network providers.
	Specialist visit	$25 copay	50% coinsurance	Deductible does not apply to in-network providers.
	Other practitioner office visit	For chiropractic care 20% coinsurance For acupuncture Not covered	For chiropractic care 50% coinsurance For acupuncture Not covered	For chiropractic care Limited to 12 visits per year For acupuncture Not covered
	Preventive care/screening/immunization	No charge	Not covered	Deductible does not apply to in-network providers.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Pre-authorization required. A $500 penalty for failure to obtain pre-authorization.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling Customer Service at 1-800-847-8361.	Generic drugs	Retail – $10copay Mail Order – $30 copay	Retail – $10 copay Mail Order – $30 copay	Generic mandatory when available. Deductible waived for generics. Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription)
	Preferred brand drugs	Retail –$30 copay Mail Order – $60 copay	Retail – $30 copay Mail Order – $60 copay	
	Non-preferred brand drugs	Retail – $50 copay Mail Order – $150 copay	Retail – $50 copay Mail Order – $150 copay	
	Specialty drugs	20% coinsurance	50% coinsurance	Covers up to a 34-day supply by mail order only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay, 20% coinsurance	50% coinsurance	————none————
	Physician/surgeon fees	20% coinsurance	50% coinsurance	————none————
If you need immediate medical attention	Emergency room services	$100 copay, 20% coinsurance	$100 copay, 20% coinsurance	Copay waived if admitted. In-network deductible applies.
	Emergency medical transportation	20% coinsurance	20% coinsurance	In-network deductible applies.
	Urgent care	$50 copay	50% coinsurance	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay, 20% coinsurance	50% coinsurance	Pre-authorization required. A $500 penalty for failure to obtain pre-authorization.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	————none————
If you have mental health or behavioral health needs.	Mental/Behavioral health outpatient services	$25 copay/office visit and 20% coinsurance/ other outpatient services.	50% coinsurance	————none————
	Mental/Behavioral health inpatient services	$500 copay, 20% coinsurance	50% coinsurance	Pre-authorization required. A $500 penalty for failure to obtain pre-authorization.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Out-of-Network Provider	Limitations & Exceptions
If you have substance abuse needs	Substance use disorder outpatient services	$25 copay/office visit and 20% coinsurance/ other outpatient services.	50% coinsurance	———————none———————
	Substance use disorder inpatient services	$500 copay, 20% coinsurance	50% coinsurance	Pre-authorization required. A $500 penalty for failure to obtain pre-authorization.
If you are pregnant	Prenatal and postnatal care	$25 copay	50% coinsurance	———————none———————
	Delivery and all inpatient services	$500 copay, 20% coinsurance	50% coinsurance	Pre-authorization is required in excess of 48 hrs (vaginal) and 72 hrs (c-section) births.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	———————none———————
	Rehabilitation services	For inpatient 20% coinsurance For outpatient 20% coinsurance	For inpatient 50% coinsurance For outpatient 50% coinsurance	———————none———————
	Habilitation services	For inpatient 20% coinsurance For outpatient 20% coinsurance	For inpatient 50% coinsurance For outpatient 50% coinsurance	———————none———————
	Skilled nursing care	20% coinsurance	50% coinsurance	———————none———————
	Durable medical equipment	50% coinsurance	50% coinsurance	———————none———————
	Hospice service	20% coinsurance	50% coinsurance	———————none———————
If your child needs dental or eye care	Eye exam	No charge	50% coinsurance	Limited to one exam every year. Deductible does not apply to in-network providers.
	Glasses	Not Covered	Not Covered	Not Covered

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Out-of-Network Provider	Limitations & Exceptions
	Dental check-up	Not Covered	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & child)
- Glasses (Adult & child)
- Hearing aids
- 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.)

- Chiropractic Care
- Routine eye care (Adult & child)

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 1-800-847-8361. 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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or your State Department of Insurance.

Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care Help Center at (888) 466-2219.

Language Access Services:

(Español): Para obtener asistencia en Español, llame al 1-800-378-1179.
(Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.
(Chinese): (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-378-1179.
(Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-378-1179.

———————————*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** $5,520
- **Patient pays** $2,020

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	$15
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$20
Coinsurance	$1,350
Limits or exclusions	$150
Total	**$2,020**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,950
- **Patient pays** $1,450

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	$630
Coinsurance	$240
Limits or exclusions	$80
Total	**$1,450**

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.
- Coverage examples are based on single coverage only.
- 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.