



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.mcsig.com or by calling 1-800-287-1442 or 831-755-8055.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$ 0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes. \$1,200 person / \$2,400 family, cumulative annual for all hospital services and all medical and diagnostic procedures.	You must pay all of the costs for these services up to the specific cumulative annual deductible amount before this plan begins to pay for these services unless otherwise noted. All non-participating services are subject to this deductible unless otherwise noted. There are other services subject to this cumulative deductible. See Evidence of Coverage booklet.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers \$6,000 person / \$12,000 family. For non-participating providers \$12,000 person / \$24,000 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 (co-insurance). This limit helps you plan for health care expenses. Amounts you pay over Reasonable & Customary (balance billing) for non-participating provider care does not accrue toward the out-of-pocket limits.
What is not included in the out-of-pocket limit?	Premiums, non-participating balance billed charges, co-payments, 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.	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 1-800-287-1442 for a list of participating providers.	If you use a participating doctor or other health care provider this plan will pay some or all of the costs of covered services. Be aware, your participating doctor or hospital may use a non-participating 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 4. See your policy or plan document for additional information about excluded services.

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- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 co-pay/visit	50% co-ins. + balance billing	Participating exam/consults not subject to deductible. Medical <i>procedures</i> and all non-participating services subject to deductible.
	Specialist visit	\$50 co-pay/visit	50% co-ins. + balance billing	
	Other practitioner office visit	\$10 co-pay/visit for Chiropractor.	Not covered.	Plan utilizes Chiropractic Health Plan of California network. Number of visits limited to CHPC authorized treatment plan. No deductible.
		All amounts over \$65/visit for Acupuncture.	All amounts over \$65/visit for Acupuncture.	
Preventive care/screening/immunization	Nothing.	50% co-ins. + balance billing	Benefit limited to the recommended services and guidelines found at http://www.HealthCare.gov/center/regulations/prevention.html (the list).	
If you have a test	Diagnostic test (x-ray, blood work)	30% co-ins/visit.	50% co-ins. + balance billing	Non-participating subject to deductible.
	Imaging (CT/PET scans, MRIs)	30% co-ins/visit.		Advanced imaging requires pre-authorization.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mcsig.com .	Generic drugs	\$0/mail order; \$10/retail; \$13 retail maintenance.	20% co-ins. + balance billing.	Outpatient drug coverage provided through Express Scripts. No outpatient drug coverage through Anthem network. Mail order is 90 day supply; retail and retail maintenance are 30 day supply. Specialty drug coverage provided exclusively through CuraScript.
	Preferred brand drugs	\$25/retail; \$35 retail maintenance; \$40 mail order.		
	Non-preferred brand drugs	\$40 retail; \$50 retail maintenance; \$80 mail order.		
	Specialty drugs	\$21/generic; \$60 brand; \$100 non-preferred brand.	No coverage	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-insurance	50% co-ins. + balance billing	All procedures subject to deductible.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room (ER) services	\$250 co-pay. 30% co-insurance.	\$250 co-pay. 30% co-insurance + balance billing.	Co-pay may be reimbursable, see EOC. Deductible applies. Non-participating ER physician services in Participating facility covered as Participating.
	Emergency medical transportation	30% co-insurance.	50% co-ins. based on R&C + balance billing. 50% co-ins. based on billed charges if true emergency	Deductible applies.
	Urgent care	\$35 co-pay/visit. No deductible.	50% co-ins. + balance billing	Medical <i>procedures</i> and non-participating svcs subject to deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance.	50% co-ins. + balance billing	All hospitalizations subject to deductible.
	Physician/surgeon fee			

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15 co-pay/visit.	40% co-ins. + balance billing	Mental, Behavioral health & substance abuse coverage provided through MHN. No coverage under Anthem network. Participating provider services not subject to deductible. All non-participating provider services subject to deductible.
	Mental/Behavioral health inpatient services	\$0		
	Substance use disorder outpatient services	\$15 co-pay/visit.		
	Substance use disorder inpatient services	\$0		
If you are pregnant	Prenatal and postnatal care	30% co-insurance.	50% co-ins. + balance billing	All Maternity services subject to deductible.
	Delivery and all inpatient services	30% co-insurance.		
If you need help recovering or have other special health needs	Home health care	30% co-insurance.	50% co-insurance + balance billing.	Subject to deductible. 120 day limit per illness.
	Rehabilitation services	30% co-insurance.	50% co-ins. + balance billing	Subject to deductible. Visit limits may apply. See Evidence of Coverage document.
	Habilitation services			
	Skilled nursing care	30% co-insurance.	50% co-ins. + balance billing.	Subject to deductible. 365 day lifetime limit.
	Durable medical equipment	30% co-insurance.	50% co-ins. + balance billing	Items costing \$2,000 or more require pre-authorization. All services subject to deductible.
	Hospice service	Nothing, after deductible.		Subject to deductible.
If your child needs dental or eye care	Eye exam	No coverage.		Separate coverage through VSP.
	Glasses	No coverage.		
	Dental check-up	No coverage.		Separate coverage through Delta Dental.

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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
- Hearing Aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine vision 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 (if performed at an Anthem Center of Excellence). Requires pre-authorization.
- Chiropractic Care (only when utilizing a Chiropractic Health Plan of California participating provider).
- Non-emergency care when traveling outside the U.S. See www.mcsig.com
- Routine foot care

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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 1-800-287-1442. 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 and Blue Shield, ATTN: Appeals, P.O. Box 54159, Los Angeles, CA 90054; 1-800-627-8797.

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.**

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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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 \$4,510**
- **Patient pays \$ 3,030**

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	\$1,200
Co-pays (assumes 90 day generics at mail order for Rx)	\$
Co-insurance	\$1,830
Limits or exclusions	\$
Total	\$3,030

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

- **Amount owed to providers: \$4,100**
- **Plan pays \$2,279**
- **Patient pays \$1,821**

Sample care costs:

Prescriptions	\$1,500
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$730
Education	\$290
Laboratory tests	\$140
Vaccines, other preventive	\$140
Total	\$4,100

Patient pays:

Deductibles (in-office procedures subject to deductible)	\$1,200
Co-pays (assumes 4 office visits in a year) (\$30 per office visit co-pay applies) (assumes 90 day generics at mail order for Rx)	\$200
Co-insurance	\$231
Limits or exclusions (Education benefit limited to \$100)	\$190
Total	\$1,821

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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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.

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