



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. \$1,500 person / \$3,000 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 \$6,350 person / \$12,700 family. For non-participating providers \$12,700 person / \$25,400 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 | \$40 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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MCSIG: PPO \$40

Coverage Period: Beginning on/after 01/01/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: PPO

| 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 | Part of balance billing may be covered, see Evidence of Coverage document. Deductible applies. |
| | Urgent care | \$40 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 \$4,300**
- **Patient pays \$ 3,240**

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 | \$1,500 |
| Co-pays (assumes 90 day generics at mail order for Rx) | \$ |
| Co-insurance | \$1,740 |
| Limits or exclusions | \$ |
| Total | \$3,240 |

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

- **Amount owed to providers: \$4,100**
- **Plan pays \$2,069**
- **Patient pays \$2,031**

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) | \$1,500 |
| 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 | \$141 |
| Limits or exclusions (Education benefit limited to \$100) | \$190 |
| Total | \$2,031 |

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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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