



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.anthem.com/ca or by calling 1-855-333-5730.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	For In-Network Providers \$0 Individual/ \$0 Family For Out-of-Network Providers \$0 Individual/ \$0 Family	See the chart starting on page 2 for your costs for services this plan covers.
Are there other <u>deductibles</u> for specific services?	Yes. \$100 Member/ \$300 Family for Brand Prescription drugs.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For In-Network Providers \$2,000 Individual/ \$4,000 Family For Out-of-Network Providers \$0 Individual/ \$0 Family	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Infertility services copay, Prescription drug copay, Premiums, Balance-billed charges and Health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.anthem.com/ca or call 1-855-333-5730 for a list of In-Network providers.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .

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Do I need a referral to see a <u>specialist</u>?	Yes. You need a referral to see a specialist.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan’s permission before you see the specialist .
Are there services this plan doesn’t cover?	Yes.	Some of the services this plan doesn’t cover are listed on page 8. 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 <u>provider’s office</u> or clinic	Primary care visit to treat an injury or illness	\$20 Copay/Visit	Not Covered	—————none—————
	Specialist visit	\$40 Copay/Visit	Not Covered	—————none—————
	Other practitioner office visit	<u>Chiropractor</u> \$20 Copay/Visit <u>Acupuncture</u> \$20 Copay/Visit	<u>Chiropractor</u> Not Covered <u>Acupuncture</u> Not Covered	<u>Chiropractor</u> Coverage is limited to 60-days period of care. Chiropractic visits count towards your physical and occupational therapy limit. <u>Chiropractic Rider Plan</u> Additional 30 chiropractic visits per calendar year: \$10 Copay/Visit.
	Preventive care/screening/immunization	No Cost Share	Not Covered	—————none—————

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Anthem Blue Cross

City of Riverside Custom Classic HMO 20/40/250 Admit/125 OP Coverage Period: 01/01/2014 - 12/31/2014

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

Coverage for: Individual/Family | Plan Type: HMO

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 test	Diagnostic test (x-ray, blood work)	<u>Lab-Office</u> No Cost Share <u>X-Ray-Office</u> No Cost Share	<u>Lab-Office</u> Not Covered <u>X-Ray-Office</u> Not Covered	—————none—————
	Imaging (CT/PET scans, MRIs)	\$100 Copay/Test	Not Covered	Costs may vary by site of service. You should refer to your formal contract of coverage for details.

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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
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.anthem.com/ca/health-insurance/provider-directory/searchcriteria?branding=ABC&provtype=Rx</p>	<p>Generic drugs (<i>includes diabetic supplies</i>)</p>	<p>\$10 Copay/prescription (retail and home delivery)</p>	<p>\$10 Copay/prescription plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount</p>	<p>For Non-Participating Pharmacies: Member pays the retail pharmacy copay plus 50%. Covers up to a 30 day supply for Retail pharmacy or a 90 day supply for Home Delivery. For Non-Participating Pharmacies, compound drugs & certain specialty pharmacy drugs may require preauthorization or are not covered. 30-day supply; 60-day supply for Federally Classified Schedule II Attention Deficit Disorder drugs that require a triplicate prescription require double copay available only at a Retail Pharmacy.</p>
	<p>Brand name formulary drugs</p>	<p>\$25 Copay/prescription (retail) \$50 Copay/prescription (home delivery)</p>	<p>\$25 Copay/prescription plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount</p>	
	<p>Brand name non-formulary drugs (<i>includes compound drugs; retail only</i>)</p>	<p>\$40 Copay/prescription (retail) \$80 Copay/prescription (home delivery)</p>	<p>\$40 Copay/prescription plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount</p>	

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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
	Specialty Drugs <i>(includes self-administered injectable drugs, except insulin)</i>	\$10 Copay/ prescription for Generic drugs \$25 Copay/ prescription for Brand name formulary drugs \$40 Copay/ prescription for Brand name non- formulary drugs 20% Coinsurance (retail only) with \$150 max and 20% Coinsurance (home delivery) with \$300 max	50% Coinsurance	For Non-Network: Member pays the retail pharmacy copay plus 50% . For Non-Participating Pharmacies, compound drugs & certain specialty pharmacy drugs require preauthorization or are not covered 30-day supply for Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$125 Copay/Admit	Not Covered	_____none_____
	Physician/surgeon fees	No Cost Share	Not Covered	_____none_____
If you need immediate medical attention	Emergency room services	\$100 Copay/Visit	\$100 Copay/Visit	This is for the hospital/facility charge only. The ER physician charge may be separate; copay waived if admitted.
	Emergency medical transportation	\$100 Copay/Trip	\$100 Copay/Trip	_____none_____

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

Coverage for: Individual/Family | Plan Type: HMO

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
	Urgent care	\$40 Copay/Visit	\$40 Copay/Visit	Copay waived if admitted inpatient and outpatient ER. Out-of-network only covered when out of area. For in area, contact your PCP or medical group. You should refer to your formal contract of coverage for details.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 Copay/Admit	Not Covered	—————none—————
	Physician/surgeon fee	No Cost Share	Not Covered	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	<u>Mental/Behavioral Health Office Visit</u> \$20 Copay/Visit <u>Mental/Behavioral Health Facility Visit-Facility Charges</u> No Cost Share	<u>Mental/Behavioral Health Office Visit</u> Not Covered <u>Mental/Behavioral Health Facility Visit-Facility Charges</u> Not Covered	—————none—————
	Mental/Behavioral health inpatient services	No Cost Share	Not Covered	This is for facility professional services only. Please refer to your hospital stay for facility fee.
	Substance use disorder outpatient services	<u>Substance Abuse Office Visit</u> \$20 Copay/Visit <u>Substance Abuse Facility Visit-Facility Charges</u> No Cost Share	<u>Substance Abuse Office Visit</u> Not Covered <u>Substance Abuse Facility Visit-Facility Charges</u> Not Covered	—————none—————
	Substance use disorder inpatient services	No Cost Share	Not Covered	This is for facility professional services only. Please refer to your hospital stay for facility fee.
If you are pregnant	Prenatal and postnatal care	\$20 Copay/Visit	Not Covered	—————none—————

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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
	Delivery and all inpatient services	\$250 Copay/Admit	Not Covered	—————none—————
If you need help recovering or have other special health needs	Home health care	\$20 Copay/Visit	Not Covered	Coverage is limited to 100 visits/calendar year (one visit by a home health aide equals four hours or less).
	Rehabilitation services	\$40 Copay/Visit	Not Covered	Coverage is limited to 60 day period of care for Occupational, Physical and Speech therapy including Chiropractor.
	Habilitation services	\$40 Copay/Visit	Not Covered	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	No Cost Share	Not Covered	Coverage is limited to 100 days per calendar year.
	Durable medical equipment	20% Coinsurance	Not Covered	—————none—————
	Hospice service	No Cost Share	Not Covered	—————none—————
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	—————none—————
	Glasses	Not Covered	Not Covered	—————none—————
	Dental check-up	Not Covered	Not Covered	—————none—————

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 <u>excluded services</u>.)		
<ul style="list-style-type: none"> • Cosmetic Surgery • Dental care (Adult) • Infertility treatment 	<ul style="list-style-type: none"> • Long-term care • Private-duty nursing • Routine eye care(Adult) 	<ul style="list-style-type: none"> • Routine foot care (unless you have been diagnosed with diabetes. Consult your formal contract of coverage) • Weight loss programs

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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. Consult your formal contract of coverage)
- Chiropractic Care
- Hearing Aids (1 per ear/every 3 years)
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide

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 1-855-333-5730. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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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
Grievance and Appeals
P.O. Box 4310
Woodland Hills, CA 91367

Department of Labor's Employee Benefits Security Administration
1-866-444-EBSA (3272)
www.dol.gov/ebsa/healthreform

California Department of Insurance
300 South Spring St.
Los Angeles, CA 90013
1-800-927-4357
www.insurance.ca.gov

Additionally, a consumer assistance program can help you file your appeal. Contact:

California Department of Managed Care
California Help Center
980 9th St., Suite 500
Sacramento, CA 95814-2725
1-888-466-2219
www.dmhc.ca.gov
www.healthhelp.ca.gov
helpline@dmhc.ca.gov

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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:

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.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

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.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwol únizinigo t'áa diné k'éjígó, t'áa shoodí ba na'alníhí ya sidáhí bich'í naabídílkíid. Eí doo biigha daago ni ba'nija'go ho'aalagíí bich'í hodiilní. Hai'daqá iini'taago eíya, t'áa shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'í hodiilní.

—————*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 \$7,000
- Patient pays \$540

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	\$390
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$540

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

- Amount owed to providers: \$5,400
- Plan pays \$4,470
- Patient pays \$930

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	\$250
Limits or exclusions	\$80
Total	\$930

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.anthem.com/ca or call 1-855-333-5730.

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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, copayments, and coinsurance can add up. It also helps you see what expenses might be left

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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.