



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 deductible? | 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 deductibles for specific services? | Yes. \$100 Individual/ \$300 Family Brand Pharmacy Deductible. | 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 \$3,000 Individual/ \$6,000 Family For Out-of-Network Providers \$0 Individual/ \$0 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? | Prescription drug copays, Infertility Services 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 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 <i>specific</i> covered services, such as office visits. |
| Does this plan use a network of providers? | 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 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 . |

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Anthem Blue Cross
City of Riverside Custom Value HMO 20/40/250/3 Day

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

Coverage Period: 01/01/2014 – 12/31/2014

Coverage for: Individual/Family | Plan Type: HMO

| | | |
|---|---|---|
| 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</u> office 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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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/provide-r-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 | \$150 Copay/Visit | \$150 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————— |
| | 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. |

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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 |
|---|--|---|---|---|
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$250 Copay/ Day | Not Covered | Up to 3 day max/ \$750 maximum per admission. |
| | 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————— |
| | Delivery and all inpatient services | \$250 Copay/ Day | Not Covered | Up to 3 day max/ \$750 maximum per admission. |

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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 |
|---|---------------------------|---|---|--|
| 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 | 50% 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 Program |

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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 adoolwoł iínizinigo t'áá diné k'éjíggo, t'áá shoodí ba na'aln'íhí ya sidáhí bich'í naabídíłkiid. Eí doo biigha daago ni ba'nija'go ho'aalag'í bich'í hodiilní. Hai'daą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bi'ki si'núilígú 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 \$4,080**
- **Patient pays \$1,320**

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 | \$640 |
| Limits or exclusions | \$80 |
| Total | \$1,320 |

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 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.

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