Your Summary of Benefits
City of Riverside
Effective 1/1/2016

Anthem Blue Cross

Custom Value HMO 20/40/250/3 day

This Summary of Benefits is a brief overview of your plan's benefits only. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA), except services provided under the "ReadyAccess" program, OB/GYN services received within the member's medical group/IPA, and services for all mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Annual copay maximum: Individual $2,500; Family $5,000

The following copay does not apply to the annual copay maximum: non-covered expenses and infertility services. After an annual copay maximum is met for medical and prescription drugs during a calendar year, the individual member or family will no longer be required to pay a copay or coinsurance for medical and prescription drug covered expenses for the remainder of that year. The member remains responsible for non-covered expenses and infertility services.

Covered Services	Per Member Copay
Preventive Care Services Preventive Care Services including*, physical exams, preventive screenings *(including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing)*, and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay
Smoking Cessation Program	No copay
Physician Medical Services	
∘ Office & home visits	$20/visit
∘ Specialists	$40/visit
∘ Skilled nursing facility visits	No copay
∘ Hospital visits	No copay
∘ Injectable medications in physician's office *(excluding allergy serum and immunization)*	30%/up to $150 maximum copay
∘ Surgeon & Surgical assistant	No copay
∘ Anesthesiologist or anesthetist	No copay
Acupuncture	$20/visit
Outpatient Medical Services (*Services received in a hospital, other than emergency room services, or in any facility that is affiliated with a hospital*)	
∘ Outpatient surgery & supplies	$125/admit
∘ Advanced Imaging	$100/test
∘ All other X-ray & laboratory tests (*including genetic testing*)	No copay
∘ Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy	$40/visit
∘ Other Outpatient Medical Services including:	$40/visit
Rehabilitation Therapy *(Physical, Occupational and Speech Therapy limited to a 60-day period of care)*	

Covered Services	Per Member Copay
General Medical Services (*when performed in non-hospital-based facility*)	
• Advanced Imaging	$100/test
• All other X-ray & laboratory tests (*including genetic testing*)	No copay
• Allergy testing & treatment *(including serums)*	$20/visit
• Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy	$40/visit
• Rehabilitation Therapy *(Physical, Occupational, or Speech Therapy or Chiropractic Care, limited to 60-days period of care)*	$20/visit
Emergency Care	
• Physician & medical services	No copay
• Outpatient hospital emergency room services	$150/visit (*waived if admitted inpatient*)
Inpatient Medical Services	
Smi-private room or private room, medically necessary services & supplies	$250/day, up to 3 day max
Urgent Care	$20/visit *(copay waived if admitted inpatient and outpatient ER)*
Skilled Nursing Facility (*limited to 100 days/calendar year; limit does not apply to mental health and substance abuse*)	
• All necessary services & supplies (*excluding take-home drugs*)	No copay
Ambulance Services	
• Transportation when medically necessary	$100/trip
Ambulatory Surgical Center	
• Outpatient surgery & supplies	$125/admit
Pregnancy and Maternity Care	
Prenatal & postnatal Professional *(physician)* services *(For your Inpatient copay, see Inpatient Medical Services. For your Outpatient Services copay, see Outpatient Medical Services)*	$20/visit
• Complications of pregnancy or abortions	No copay
Prosthetic devices *(including Orthotics)*	No copay
Durable medical equipment	50%
• Rental and Purchase of DME *(hearing aids benefit available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge)*	

Covered Services	Per Member Copay
Family Planning Services	
• Infertility studies & tests	50% of covered expense†
• Female Sterilization *(including tubal ligation and counseling/consultation)*	No copay
• Male Sterilization	$50
• Counseling & consultation	$20/visit
Mental or Nervous Disorders and Substance Abuse	
• Inpatient facility care *(subject to utilization review; waived for emergency admissions)*	$250/day, up to 3 day max
• Inpatient Physician visits	No copay
• Outpatient facility care	No copay
• Physician office visits *(Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)*	$20/visit
Home Health Care (*limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less*)	$20/visit
Hospice Care (*Inpatient or outpatient services; family bereavement services*)	No copay
Organ and Tissue Transplant	
• Inpatient Care	$250/day, up to 3 day max
• Physician office visits	$20/visit
• Specialist office visits	$40/visit

This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).

† Not applicable to the annual copay maximum

Exclusions and Limitations

Care Not Approved. Care from a health care provider without the OK of primary care doctor, except for emergency services or urgent care.

Care Not Covered. Services before the member was on the plan, or after coverage ended.

Care Not Listed. Services not listed as being covered by this plan.

Care Not Needed. Any services or supplies that are not medically necessary.

Crime or Nuclear Energy. Any health problem caused: (1) while committing or trying to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) by nuclear energy, when the government can pay for treatment.

Experimental or Investigative. Any experimental or investigative procedure or medication.
But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may ask that the denial be reviewed by an external independent medical review organization, as described in the Evidence of Coverage (EOC).

Government Treatment. Any services the member actually received that were given by a local, state or federal government agency, except when this plan's benefits, must be provided by law.
We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Services Given by Providers Who Are Not With Anthem Blue Cross HMO. We will not cover these services unless primary care doctor refers the member, except for emergencies or urgent care.

Services Not Needing Payment. Services the member is not required to pay for or are given to the member at no charge, except services the member got at a charitable research hospital (not with the government). This hospital must:1. Be known throughout the world as devoted to medical research.2. Have at least 10% of its yearly budget spent on research not directly related to patient care.3. Have 1/3 of its income from donations or grants (not gifts or payments for patient care).4. Accept patients who are not able to pay.5. Serve patients with conditions directly related to the hospital's research (at least 2/3 of their patients).

Work-Related. Care for health problems that are work-related if such health problems are or can be covered by workers' compensation, an employer's liability law, or a similar law. We will provide care for a work-related health problem, but, we have the right to be paid back for that care. See "Third Party Liability" below.

Acupressure. Acupressure, or massage to help pain, treat illness or promote health by putting pressure to one or more areas of the body.

Air Conditioners. Air purifiers, air conditioners, or humidifiers.

Birth Control Devices. Any devices needed for birth control which can be obtained without a doctor's prescription such as condoms.

Blood. Benefits are not provided for the collection, processing and storage of self-donated blood unless it is specifically collected for a planned and covered surgical procedure.

Braces or Other Appliances or Services for straightening the teeth (orthodontic services).

Clinical Trials. Services and supplies in connection with clinical trials, except as specified as covered in the Evidence of Coverage (EOC).

Commercial weight loss programs. Weight loss programs, whether or not they are pursued under medical or doctor supervision, except as specified as covered in the EOC. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or for treatment of anorexia nervosa or bulimia nervosa.

Consultations given by telephone or fax.

Cosmetic Surgery. Surgery or other services done only to make the member: look beautiful; to improve appearance; or to change or reshape normal parts or tissues of the body. This does not apply to reconstructive surgery the member might need to: get back the use of a body part; have for breast reconstruction after a mastectomy; correct or repair a deformity caused by birth defects, abnormal development, injury or illness in order to improve function, symptomatology or create a normal appearance. Cosmetic surgery does not become reconstructive because of psychological or psychiatric reasons.

Custodial Care or Rest Cures. Room and board charges for a hospital stay mostly for a change of scene or to make the member feel good. Services given by a rest home, a home for the aged, or any place like that.

Dental Services or Supplies. Dentures, bridges, crowns, caps, or dental prostheses, dental implants, dental services, tooth extraction, or treatment to the teeth or gums. Cosmetic dental surgery or other dental services for beauty purposes.

Diabetic Supplies. Prescription and non-prescription diabetic supplies, except as specified as covered in the EOC.

Eye Exercises or Services and Supplies for Correcting Vision. Optometry services, eye exercises, and orthoptics, except for eye exams to find out if the member's vision needs to be corrected. Eyeglasses or contact lenses are not covered. Contact lens fitting is not covered.

Eye Surgery for Refractive Defects. Any eye surgery just for correcting vision (like nearsightedness and/or astigmatism). Contact lenses and eyeglasses needed after this surgery.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as specified as covered in the EOC or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

Health Club Membership. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a doctor. This exclusion also applies to health spas.

Hearing Aids. Hearing aids or services for fitting or making a hearing aid, except as specified as covered in the EOC.

Immunizations. Immunizations needed to travel outside the USA.

Infertility Treatment. Any infertility treatment including artificial insemination or in vitro fertilization & sperm bank.

Lifestyle Programs. Programs to help member change how one lives, like fitness clubs, or dieting programs. This does not apply to cardiac rehabilitation programs approved by the medical group.

Mental or nervous disorders. Academic or educational testing, counseling. Remedying an academic or education problem, except as stated as covered in the EOC.

Nicotine Use. Programs to stop smoking or the treatment of nicotine or tobacco use if the program is not affiliated with Anthem.

Non-Prescription Drugs. Non-prescription, over-the-counter drugs or medicines, except as specified as covered in the Evidence of Coverage (EOC).

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC.

Outpatient Drugs. Outpatient prescription drugs or medications including insulin.

Personal Care and Supplies. Services for personal care, such as: help in walking, bathing, dressing, feeding, or preparing food. Any supplies for comfort, hygiene or beauty purposes.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Routine Exams. Routine physical or psychological exams or tests asked for by a job or other group, such as a school, camp, or sports program.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement.

Sexual Problems. Treatment of any sexual problems unless due to a medical problem, physical defect, or disease.

Sterilization Reversal. Surgery done to reverse a sterilization.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Third Party Liability - Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Varicose Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

Coordination of Benefits - The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

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