

# Your Summary of Benefits

## City of Riverside



### 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
<p><b>Preventive Care Services</b></p> <p>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.</p> <p>*This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.</p>	No copay
<p><b>Smoking Cessation Program</b></p>	No copay
<p><b>Physician Medical Services</b></p> <ul style="list-style-type: none"> <li>• Office &amp; home visits</li> <li>• Specialists</li> <li>• Skilled nursing facility visits</li> <li>• Hospital visits</li> <li>• Injectable medications in physician's office (excluding allergy serum and immunization)</li> <li>• Surgeon &amp; Surgical assistant</li> <li>• Anesthesiologist or anesthesiologist</li> </ul>	<p>\$20/visit</p> <p>\$40/visit</p> <p>No copay</p> <p>No copay</p> <p>30%/up to \$150 maximum copay</p> <p>No copay</p> <p>No copay</p>
<p><b>Acupuncture</b></p>	\$20/visit

Covered Services	Per Member Copay
<p><b>Outpatient Medical Services</b> <i>(Services received in a hospital, other than emergency room services, or in any facility that is affiliated with a hospital)</i></p> <ul style="list-style-type: none"> <li>• Outpatient surgery &amp; supplies</li> <li>• Advanced Imaging</li> <li>• All other X-ray &amp; laboratory tests <i>(including genetic testing)</i></li> <li>• Radiation therapy, chemotherapy &amp; hemodialysis treatment &amp; Infusion therapy</li> <li>• Other Outpatient Medical Services including: Rehabilitation Therapy <i>(Physical, Occupational and Speech Therapy limited to a 60-day period of care)</i></li> </ul>	<p>\$125/admit</p> <p>\$100/test</p> <p>No copay</p> <p>\$40/visit</p> <p>\$40/visit</p>
<p><b>General Medical Services</b> <i>(when performed in non-hospital-based facility)</i></p> <ul style="list-style-type: none"> <li>• Advanced Imaging</li> <li>• All other X-ray &amp; laboratory tests <i>(including genetic testing)</i></li> <li>• Allergy testing &amp; treatment <i>(including serums)</i></li> <li>• Radiation therapy, chemotherapy &amp; hemodialysis treatment &amp; Infusion therapy</li> <li>• Rehabilitation Therapy <i>(Physical, Occupational, or Speech Therapy or Chiropractic Care, limited to 60-days period of care)</i></li> </ul>	<p>\$100/test</p> <p>No copay</p> <p>\$20/visit</p> <p>\$40/visit</p> <p>\$20/visit</p>
<p><b>Emergency Care</b></p> <ul style="list-style-type: none"> <li>• Physician &amp; medical services</li> <li>• Outpatient hospital emergency room services</li> </ul>	<p>No copay</p> <p>\$150/visit <i>(waived if admitted inpatient)</i></p>
<p><b>Inpatient Medical Services</b></p> <p>Semi-private room or private room, medically necessary services &amp; supplies</p>	<p>\$250/day, up to 3 day max</p>
<p><b>Urgent Care</b></p>	<p>\$20/visit <i>(copay waived if admitted inpatient and outpatient ER)</i></p>
<p><b>Skilled Nursing Facility</b> <i>(limited to 100 days/calendar year; limit does not apply to mental health and substance abuse)</i></p> <ul style="list-style-type: none"> <li>• All necessary services &amp; supplies <i>(excluding take-home drugs)</i></li> </ul>	<p>No copay</p>
<p><b>Ambulance Services</b></p> <ul style="list-style-type: none"> <li>• Transportation when medically necessary</li> </ul>	<p>\$100/trip</p>

Covered Services	Per Member Copay
<b>Ambulatory Surgical Center</b> <ul style="list-style-type: none"> <li>Outpatient surgery &amp; supplies</li> </ul>	\$125/admit
<b>Pregnancy and Maternity Care</b> Prenatal & postnatal Professional ( <i>physician</i> ) services (For your Inpatient copay, see <i>Inpatient Medical Services</i> . For your Outpatient Services copay, see <i>Outpatient Medical Services</i> ) <ul style="list-style-type: none"> <li>Complications of pregnancy or abortions</li> </ul>	\$20/visit  No copay
<b>Prosthetic devices</b> ( <i>including Orthotics</i> )	No copay
<b>Durable medical equipment</b> <ul style="list-style-type: none"> <li>Rental and Purchase of DME (<i>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</i>)</li> </ul>	50%
<b>Family Planning Services</b> <ul style="list-style-type: none"> <li>Infertility studies &amp; tests</li> <li>Female Sterilization (<i>including tubal ligation and counseling/consultation</i>)</li> <li>Male Sterilization</li> <li>Counseling &amp; consultation</li> </ul>	50% of covered expense <sup>†</sup> No copay \$50 \$20/visit
<b>Mental or Nervous Disorders and Substance Abuse</b> <ul style="list-style-type: none"> <li>Inpatient facility care (<i>subject to utilization review; waived for emergency admissions</i>)</li> <li>Inpatient Physician visits</li> <li>Outpatient facility care</li> <li>Physician office visits (<i>Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review</i>)</li> </ul>	\$250/day, up to 3 day max No copay No copay \$20/visit for non-preventive visits
<b>Home Health Care</b> ( <i>limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less</i> )	\$20/visit
<b>Hospice Care</b> ( <i>Inpatient or outpatient services; family bereavement services</i> )	No copay
<b>Organ and Tissue Transplant</b> <ul style="list-style-type: none"> <li>Inpatient Care</li> <li>Physician office visits</li> <li>Specialist office visits</li> </ul>	\$250/day, up to 3 day max \$20/visit \$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

**For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to [https://le.anthem.com/pdf?x=CA\\_LG\\_HMO](https://le.anthem.com/pdf?x=CA_LG_HMO)**