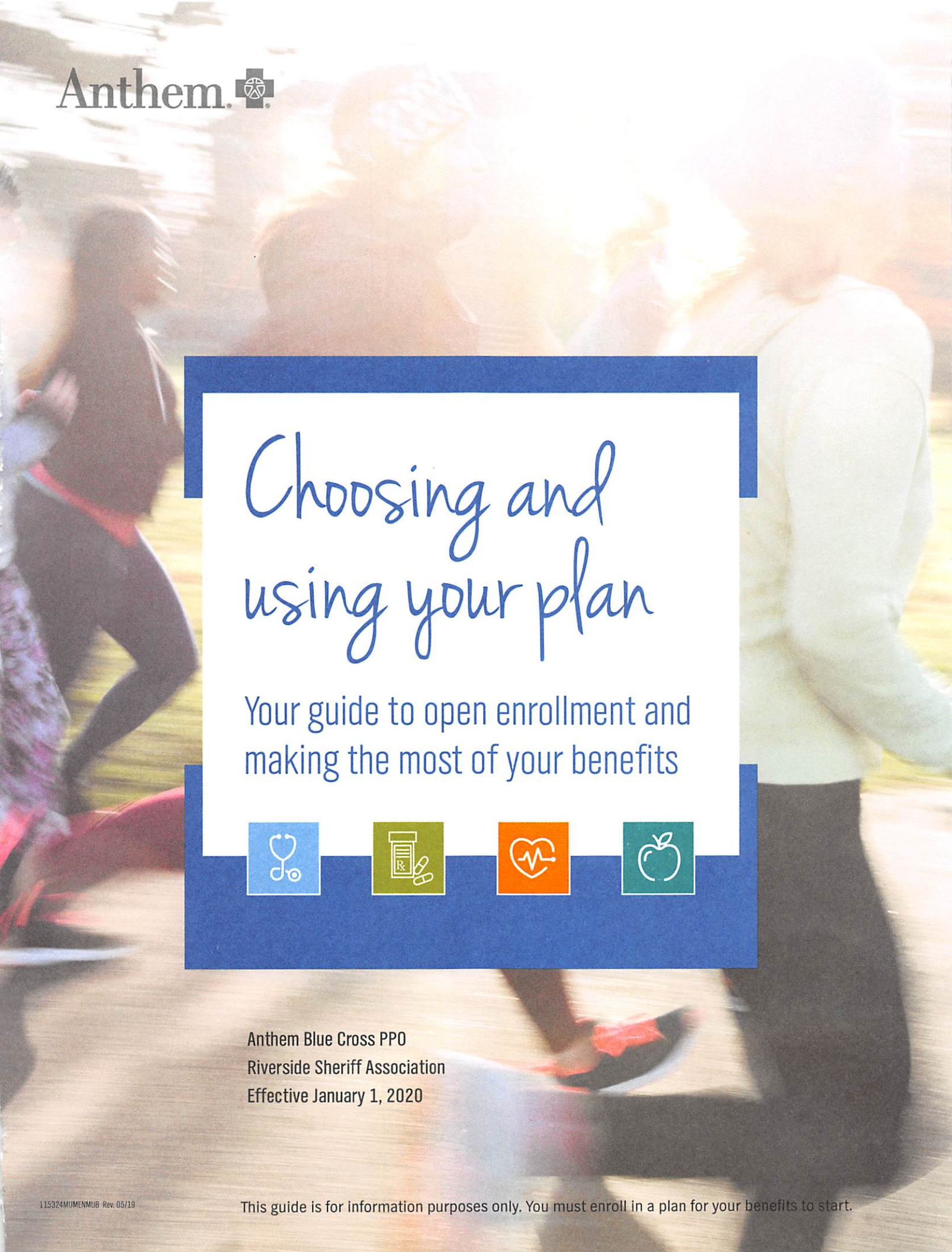

Anthem

Choosing and using your plan

Your guide to open enrollment and making the most of your benefits

Anthem Blue Cross PPO
Riverside Sheriff Association
Effective January 1, 2020

115324MUMENMUB Rev. 05/19

This guide is for information purposes only. You must enroll in a plan for your benefits to start.

It's time to choose your plan

Your trusted health partner

Anthem is committed to being your trusted health care partner. We're developing the technology, solutions, programs and services that give you greater access to care. We also work with doctors to make sure you get affordable, quality health care.

Save this guide

You'll find tips on how to make the most of your benefits and save on health care costs throughout the year.

It's time to choose your plan

Let's get started

This is the perfect time to think about your health — where you are right now and where you want to be tomorrow. It's your opportunity to check out the benefits, programs and resources that can support your health and well-being all year long.

This guide will help you understand our plans. It's also full of tips, tools and resources that can help you reach your health and wellness goals when you become a member. So keep it handy to make the most of your benefits throughout the year.

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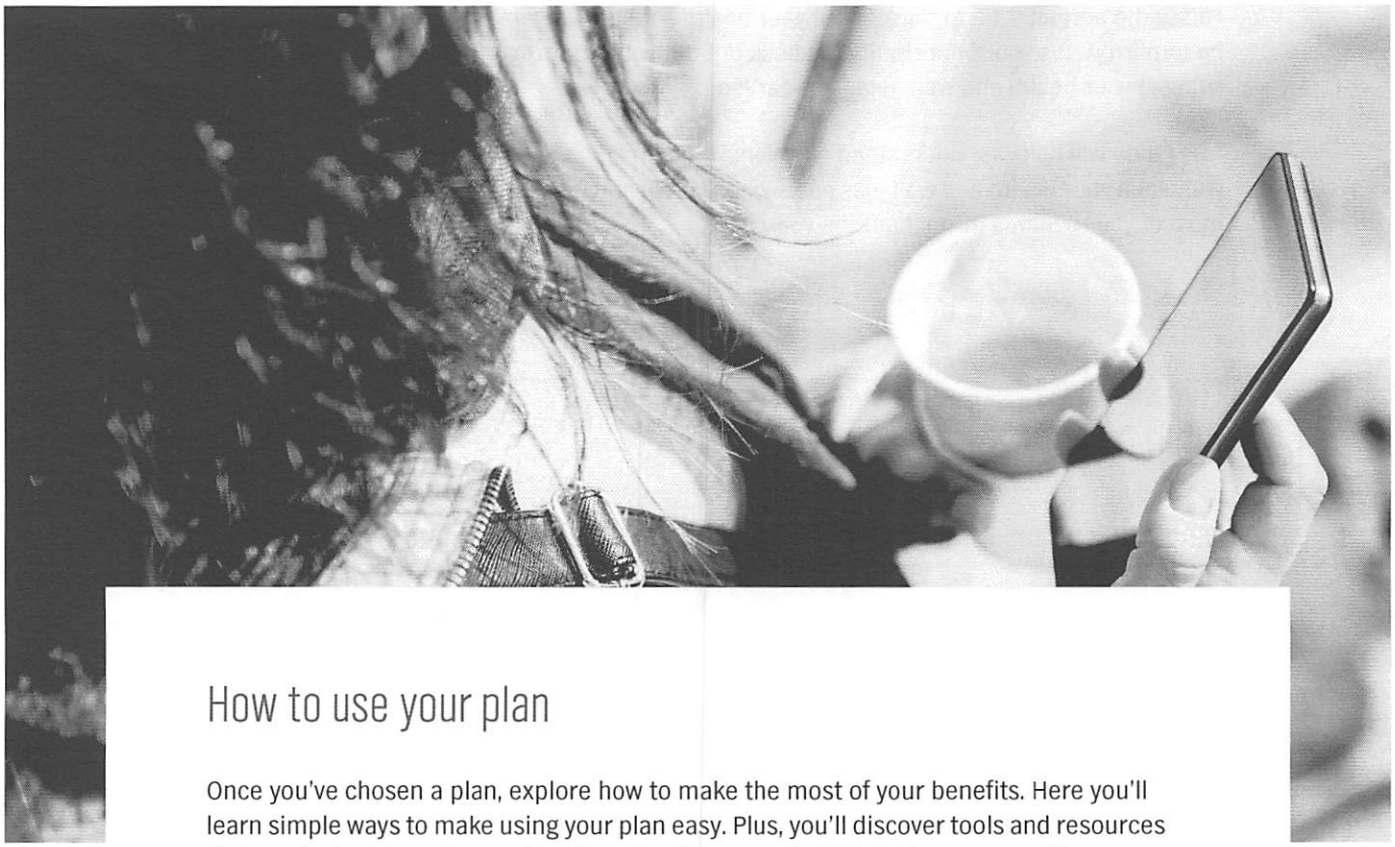

How to use your plan

Once you've chosen a plan, explore how to make the most of your benefits. Here you'll learn simple ways to make using your plan easy. Plus, you'll discover tools and resources that can help you reach your health and wellness goals. With Anthem, supporting your healthiest self is all part of the plan!

How to use your plan

Use your ID card right from your phone

Introducing the **Sydney Health** mobile app. With **Sydney Health** you can find everything you need to know about your benefits – all in one place. You'll have a custom experience that's based on your plan, your specific health care needs and lots more. And you can quickly access your digital ID card to show it to your doctor. You can even use **Sydney Health** to track your health goals, find care, compare costs, and manage your claims.

Have a question? **Sydney Health** acts like a personal health guide, answering your questions and connecting you to the right resources at the right time. And you can use the chatbot to get answers quickly. **Sydney Health** makes it easier to get things done, so you can spend more time focusing on your health. Get started by downloading the **Sydney Health** mobile app.

Register for online tools and resources

Accessing your health plan on your mobile phone or computer makes life so much easier. Register on the **Sydney Health** mobile app and **anthem.com/ca** to get personalized information about your health plan and more. You can:

- Quickly access your digital ID card.
- Find a doctor and estimate your costs before you go.
- View your claims, see what's covered and what you may owe for care.
- Get support managing your health conditions and tracking your goals.
- Update your email and communication preferences.

How to use your plan

Find a doctor in your plan

The right doctor can make all the difference — and choosing one in your plan can save you money, too. So you'll be happy to know your plan includes lots of top-notch doctors. If you decide to get care from doctors outside the plan, it'll cost you more and your care might not be covered at all.

It's easy to find a doctor in your plan. Simply use the **Find a Doctor** tool on the **Sydney Health** mobile app or at **anthem.com/ca** to search for doctors, hospitals, labs and other health care professionals.

Schedule a checkup

Preventive care, like regular checkups and screenings, can help you avoid health problems down the road. Your plan covers these services at little or no extra cost when you see a doctor in your plan:

- Yearly physicals
- Well-child visits
- Flu shot
- Routine shots
- Screenings and tests

Check your plan details on the **Sydney Health** mobile app or **anthem.com/ca** to confirm what preventive care is covered.

Your summary of benefits

Anthem BlueCross

Anthem Blue Cross

Your Plan: Modified Premier PPO 250/20/20

Your Network: Prudent Buyer PPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section. In-Network Providers and Non-Network Providers deductibles are combined. Satisfying one helps satisfy the other.*	$250 single / $750 family	$250 single / $750 family
Copay for non-Anthem Blue Cross PPO hospital or residential treatment center *(waived for emergency admission)*	N/A	$500 copay per admission
Copay for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained *(waived for emergency admission)*	N/A	$500 copay per admission
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum. In-Network Providers and Non-Network Providers out of pocket maximums are combined. Satisfying one helps satisfy the other.*	$3,000 single / $6,000 family	$3,000 single / $6,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. 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 charge	40% coinsurance
Doctor Home and Office Services		
Primary care visit to treat an injury or illness *Deductible does not apply to In-Network providers.*	$20 copay per visit[1]	40% coinsurance
Specialist care visit *Deductible does not apply to In-Network providers.*	$20 copay per visit[1]	40% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care *Deductible does not apply to In-Network providers.*	$10 copay per visit[1]	40% coinsurance
Other practitioner visits:		
Retail health clinic *Deductible does not apply to In-Network providers.*	$20 copay per visit[1]	40% coinsurance
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse. Deductible does not apply to In-Network providers.*	$20 copay per visit	40% coinsurance
Chiropractor services *Coverage for In-Network Provider and Non-Network Provider combined is limited to 20 visit limit per benefit period. Deductible does not apply to In-Network providers.*	$5 copay per visit	$5 copay per visit
Acupuncture[1] *Coverage for In-Network Provider and Non-Network Provider combined is limited to 20 visit limit per benefit period.*	20% coinsurance	40% coinsurance
Other services in an office:		
Allergy testing	20% coinsurance	40% coinsurance
Chemo/radiation therapy	20% coinsurance	40% coinsurance
Hemodialysis	20% coinsurance	40% coinsurance
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection (including allergy serum)*	20% coinsurance	40% coinsurance
Diagnostic Services		
Lab:		
Office	20% coinsurance	40% coinsurance
Freestanding Lab	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
X-ray:		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Advanced diagnostic imaging (For example, MRI/PET/CAT scans):		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Emergency and Urgent Care		
Emergency room doctor and other services	No copay	No copay
Outpatient hospital emergency room services *Copay waived if admitted.*	$25 copay per visit	$25 copay per visit
Inpatient hospital services	No copay	No copay
Ambulance (air and ground) *Ground or air ambulance transportation when medically necessary, including medical services & supplies necessary, including medical services & supplies.*	20% coinsurance[3]	20% coinsurance[3]
Urgent Care (office setting) *Deductible does not apply to In-Network providers.*	$20 copay per visit	40% coinsurance
Mental/Behavioral Health and Substance Abuse		
Inpatient facility care	No copay	40% coinsurance[4]
Inpatient Doctor visit	No copay	40% coinsurance
Outpatient facility care	No copay	40% coinsurance[4]
Outpatient Doctor office visit *Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review. Deductible does not apply to In-Network providers.*	$10 copay per visit	40% coinsurance
Outpatient Surgery		
Facility fees:		
Hospital	20% coinsurance	40% coinsurance[4]
Freestanding Surgical Center *Coverage for Out-of-Network Provider is limited to $1,000 maximum per day.*	20% coinsurance	40% coinsurance
Doctor and other services	20% coinsurance	40% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital Stay (all inpatient stays including maternity)		
Facility fees (for example, room & board)	20% coinsurance	40% coinsurance[4]
Doctor and other services	20% coinsurance	40% coinsurance
Recovery & Rehabilitation		
Home health care *In-Network Provider and Non-Network Provider combined is limited to 100 visit limit per benefit period; one visit by home health aide equals four hours or less.*	20% coinsurance	40% coinsurance
Rehabilitation services (For example, physical/speech/occupational therapy):		
Office *Costs may vary by site of service.*	20% coinsurance	40% coinsurance
Outpatient hospital	20% coinsurance	40% coinsurance
Habilitation services	20% coinsurance	40% coinsurance
Cardiac rehabilitation		
Office	20% coinsurance	40% coinsurance
Outpatient hospital	20% coinsurance	40% coinsurance
Skilled nursing care (in a facility) *In-Network Provider and Non-Network Provider combined is limited to 100 day limit per benefit period; limit does not apply to mental health and substance abuse.*	20% coinsurance	40% coinsurance
Hospice	20% coinsurance[3]	20% coinsurance[3]
Durable Medical Equipment *Hearing aid benefit is available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge.*	20% coinsurance	40% coinsurance
Prosthetic Devices	20% coinsurance	40% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Organ & Tissue Transplants *(Subject to utilization review; specified transplants covered only when performed at Centers of Medical Excellence [CME] or Blue Distinction Centers for Specialty Care [BDCSC].)*		
Inpatient services provided in connection with non-investigative organ or tissue transplants. *Specified organ transplants covered only at Centers of Medical Excellence [CME].*	20% coinsurance	Not covered
Transplant travel expense for an authorized, specified transplant at a *Centers of Medical Excellence [CME])* or Blue Distinction Centers for Specialty Care [BDCSC]. *Transplant travel expense for an authorized, specified transplant (recipient & companion transportation limited to $10,000 per transplant) and unrelated donor search, limited to $30,000 per transplant.*	No copay	Not covered
Bariatric Surgery *(Subject to utilization review; covered only when performed at a Blue Distinction Centers for Specialty Care [BDCSC].)*		
Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity *Bariatric surgery covered only at Centers of Medical Excellence [CME]).*	20% coinsurance	Not covered
Bariatric travel expense when member's home is 50 miles or more from the nearest Blue Distinction Centers for Specialty Care [BDCSC]. *Travel expenses for an authorized, specified surgery (recipient & companion transportation limited to $3,000 per surgery)*	No copay	Not covered
Family planning services		
Infertility studies & tests	Not covered	Not covered
Female sterilization *Including tubal ligation and counseling/consultation. Deductible does not apply to In-Network providers.*	No copay	50% coinsurance[5]
Male Sterilization	20%[5] coinsurance	50%[5] coinsurance
Counseling & consultation	$20 copay per visit	50%[5] coinsurance

Your summary of benefits

FOOTNOTES:

[1] *The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery, etc.), after any applicable deductible.*

[2] *Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).*

[3] *These providers are not represented in the Anthem Blue Cross PPO network.*

[4] *For California facilities, a discount applies if the facility has a contract with Anthem Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher out-of-pocket costs for members.*

[5] *The member's percentage copay is not applicable to the annual out-of-pocket maximum.*

Your summary of benefits

Notes:

- 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).
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual Out-of-Pocket Maximums includes deductible, copays, coinsurance and prescription drug.
- In network and out of network out of pocket maximum are exclusive of each other.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- If your plan includes out of network benefit and you use a non-network provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense '&' actual charges, as well as any deductible '&' percentage copay.
- Non-emergency, out-of-network air ambulance services are limited to Anthem maximum payment of $50,000 per trip.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.

Your summary of benefits

- Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 consecutive days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- 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 coverage do not exceed 100% of the covered expense
- 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_PPO
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://eoc.anthem.com/eocdps/ca/fi. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (855) 333-5730 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$250**/single or **$750**/family. All Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, Primary Care visit, and Specialist visit for In-Network Providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$3,000**/single or **$6,000**/family. All Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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.
Will you pay less if you use a network provider?	Yes, Prudent Buyer PPO. See www.anthem.com/ca or call (855) 333-5730 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

⚠ All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit deductible does not apply	40% coinsurance	--------none--------
	Specialist visit	$20/visit deductible does not apply	40% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/ca/pharmacyinformation/ National	Generic Drugs	$5/prescription (retail) and $10/prescription (home delivery)	50% coinsurance of the prescription drug covered expense and costs in excess of the maximum amount allowed up to a $250 maximum/ prescription	Most home delivery is 90-day supply. *See Prescription Drug section of the plan or policy document (e.g. evidence of coverage or certificate).
	Brand Name Formulary Drugs	$10/prescription (retail) and $20/prescription (home delivery)	50% coinsurance of the prescription drug covered expense and costs in excess of the maximum amount allowed up to a $250 maximum/ prescription	
	Brand Name Non-Formulary Drugs	$40/prescription (retail) and $80/prescription (home delivery)	50% coinsurance of the prescription drug covered expense and costs in excess of the maximum amount allowed up to a $250 maximum/ prescription	

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/ca/fi.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Specialty Pharmacy Drugs	20% coinsurance of prescription drug covered expense up to $100/prescription	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	--------none--------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	$25/visit deductible does not apply	Covered as In-Network	If directly admitted to a hospital, ER copay is waived. 0% coinsurance for Emergency Room Physician Fee.
	Emergency medical transportation	20% coinsurance	Covered as In-Network	--------none--------
	Urgent care	$20/visit deductible does not apply	40% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	$500/admission then 40% coinsurance	--------none--------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $10/visit deductible does not apply Other Outpatient 0% coinsurance	Office Visit 40% coinsurance Other Outpatient 40% coinsurance	Office Visit --------none-------- Other Outpatient --------none--------
	Inpatient services	0% coinsurance	$500/admission then 40% coinsurance	0% coinsurance for Inpatient Physician Fee In-Network Providers. 40% coinsurance for Inpatient Physician Fee Non-Network Providers.
If you are pregnant	Office visits	$10/visit deductible does not apply	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	$500/admission then 40% coinsurance	
If you need help recovering or have	Home health care	20% coinsurance	40% coinsurance	100 visits/benefit period. One visit by home health aide equals four hours or less.

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/ca/fi.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
other special health needs	Rehabilitation services	20% coinsurance	40% coinsurance	*See Therapy Services section
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	100 days limit/benefit period.
	Durable medical equipment	20% coinsurance	40% coinsurance	--------none--------
	Hospice services	20% coinsurance	20% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	*See Dental Services section

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (adult)
- Dental Check-up
- Eye exams for a child
- Glasses for a child
- Infertility treatment
- Long- term care
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture 20 visits/benefit period.
- Bariatric surgery for In-Network Providers
- Chiropractic care 20 visits/benefit period.
- Hearing aids one hearing aid/ear every three years.
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/ca/fi.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) HMO-2219. Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310

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

Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) HMO-2219

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

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/ca/fi.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$250
Specialist *copayment*	$20
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$60
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,870**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$250
Specialist *copayment*	$20
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$800
Coinsurance	$30
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,140**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$250
Specialist *copayment*	$20
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 333-5730

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 333-5730 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 333-5730.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 333-5730:

Bassa (Bàsɔ̀ɔ̀ Wùdù): Ǹ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bèdɛ̀ìn-dɛ̀ bé m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùŭn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (855) 333-5730.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 333-5730 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အသံဖိုင် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (855) 333-5730 သို့ ခေါ်ဆိုပါ။

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (855) 333-5730。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (855) 333-5730.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 333-5730.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 333-5730 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 333-5730.

Language Access Services:

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 333-5730.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 333-5730.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (855) 333-5730.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 333-5730.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (855) 333-5730 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855) 333-5730.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (855) 333-5730.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (855) 333-5730.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (855) 333-5730.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 333-5730

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 333-5730 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (855) 333-5730 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (855) 333-5730.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 333-5730 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (855) 333-5730.

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídiłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h ílínígóó. Ata' halne'igíí ła' bich'į' hadeesdzih ninízingo kojį' hodiilnih (855) 333-5730.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (855) 333-5730

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (855) 333-5730 bilbilla.

Pennsylvania Dutch (Deitsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (855) 333-5730 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (855) 333-5730.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (855) 333-5730.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 333-5730 ਤੇ ਕਾਲ ਕਰੋ।

Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (855) 333-5730.

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 333-5730.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (855) 333-5730.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (855) 333-5730.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 333-5730.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (855) 333-5730.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (855) 333-5730 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером: (855) 333-5730.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (855) 333-5730 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (855) 333-5730.

Yiddish (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט 333-5730 (855).

Yoruba (Yorùbá): Tí o bá ní èyíkéyìí ibèrè nípa àkọsílẹ̀ yìí, o ní ẹ̀tọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lọ́fẹ̀ẹ́. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe (855) 333-5730.

Language Access Services:

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Anthem Blue Cross — Modified Rx 19 Three Tier Prescription Drug Benefits

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 proposed benefit summary is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care.

PLEASE NOTE: ***This is only a summary of your benefits. Please refer to your Combined Evidence of Coverage and Disclosure Form ("EOC")/Certificate of Insurance ("Certificate") which explains your plan's Exclusions and Limitations as well as the full range of your covered services in detail.***

At Anthem Blue Cross, we know that prescription drugs are the fastest-rising item of your total health care benefits cost. Reasons for the spiraling costs of prescription drugs are varied: a general increase of prescription medication use, an aging population, research and development of new medications and the expense of direct to consumer advertising. With prescription drug costs increasing at twice the rate of medical care, we developed ways to contain costs so your copays remain affordable, while maintaining your access to safe, effective prescription drugs. Our Prescription Drug Program provides you with choice, flexibility, affordability and access to an extensive network of retail pharmacies.

Getting a Prescription Filled at a Participating Pharmacy
To get a prescription filled, you need only take your prescription to a participating pharmacy and present your member ID card. The amount you pay for a covered prescription – your copay – will be determined by whether the drug is a brand-name or generic medication and whether it is a formulary or non-formulary medication.

A generic drug contains the same effective ingredients, meets the same standards of purity as its brand-name counterpart and typically costs less. In many situations, you have a choice of filling your prescription with a generic medication or a brand-name medication.

The formulary is a list of approximately 600 recommended brand and generic medications. These medications have undergone extensive review for therapeutic value for a particular medical condition, safety and cost. Copies of our formulary are furnished to your providers and are available online at anthem.com/ca/ under the Pharmacy section. You or your provider may also contact our Pharmacy Customer Service at **(800) 700-2541**.

The following chart illustrates the relation between drug type and your copay amount at a participating pharmacy:

Drug Type	Copay Amount
Generic	$5.00
Brand name formulary	$10.00
Brand name non-formulary	$40.00

Finding a Participating Pharmacy
Because our huge pharmacy network includes major drugstore chains plus a wide variety of independent pharmacies, it is easy for you to find a participating pharmacy. You can also find a participating pharmacy by going to our website at anthem.com/ca/.

An Extensive Network
Besides saving you money, our extensive network of pharmacies offers you easy accessibility.

- In California there are over 5,100 retail pharmacies. This accounts for nearly 95% of retail pharmacies in the state, including all major chains.
- Nationwide there are more than 61,000 chain and independent pharmacies.

Using a Participating Pharmacy
You can substantially control the cost of your prescription drugs by using our extensive network of participating pharmacies. Participating pharmacies have agreed to charge a discounted price or "negotiated rate" and pass along this savings to you.

Using a Non-Participating Pharmacy
If you choose to fill your prescription at a non-participating pharmacy, your costs will increase. You will likely need to pay for the entire amount of the prescription and then submit a prescription drug claim form for reimbursement. The pharmacist must sign and complete the appropriate section of the claim form to ensure proper processing of the claim for reimbursement.

Members that submit claims from non-participating pharmacies are reimbursed based on a **limited fee schedule**. The fee schedule may be considerably less than the cost of the medication. You are responsible for paying any difference.

The following chart illustrates potential increased out-of-pocket expenses for going to a non-participating pharmacy:

	Out-of-pocket costs using a participating pharmacy	Out-of-pocket costs using a non-participating pharmacy
Pharmacy's normal charge for brand-name formulary drug	$50.00	$50.00
You are responsible for:	$10.00 copay	50% of the limited fee schedule plus any amounts exceeding the fee schedule up to $250
Total out-of-pocket expenses	**$10.00**	**Expense varies based on the cost of the medication**

You may obtain a prescription drug claim form by calling Pharmacy Customer Service at the toll-free number printed on your member ID card or by going to our website at anthem.com/ca/.

Home Delivery Prescription Drug Program
If you take a prescription drug on a regular basis, you may want to take advantage of our home delivery program. Ordering your medications by mail is convenient, saves time and depending on your plan design, may even save you money. Besides enjoying the convenience of home delivery, you will also receive a greater supply of medications. To fill a prescription through the mail, simply complete the Home Delivery Prescription form. You may obtain the form by calling Customer Service, at the toll-free number listed on your ID card or by going to our website at anthem.com/ca/. Once you complete the form, simply mail it with your copay and prescription in the envelope attached to the Home Delivery brochure. Please note that not all medications are available through the Home Delivery Program. Specialty pharmacy drugs are not available through the home delivery program, see Specialty Pharmacy Program below.

Out-Of-State Prescription Benefits
Our national network of participating pharmacies is available to members when outside California. To find a participating pharmacy, a member can check our Web site or call the toll-free number printed on the ID card. When using a non-participating pharmacy outside of California, the member will follow the same procedures for using a non-participating pharmacy in California as outlined above.

Additional Features That are Part of your Plan

Prior authorization as the term implies, is similar to prior authorization for medical services. Prior authorization applies to a select pool of medications that are often a second line of therapy. To require prior authorization, a drug must meet specific criteria. This criteria is based, among other things, on FDA-approved drug indications, targeted populations and the current availability of effective drug therapies. Prior authorization drugs are not covered unless you receive an approval from Anthem Blue Cross.

We distribute instructions on how to obtain prior authorization to physicians and pharmacies so that you may obtain prior authorization for required medications. You may call Pharmacy Customer Service, at the toll-free number printed on your member ID card, to receive a prior authorization form and/or list of medications requiring prior authorization.

Supply limits are the proper FDA recommendations for prescription medication dosage coupled with our determination of specific quantity supply limits to prescription medications. Although our standard pharmacy plans offer a 30-day supply for medications at a retail pharmacy, the supply limit can vary based on the medication, dosage and usage prescribed by your physician. For example, the supply limit for antibiotics used to treat an infection (e.g., 14 pills to be taken twice a day for one week) is different than blood pressure medication taken on a routine basis (e.g., 120 pills to be taken twice a day for 60 days). By adhering to specified supply limits, members are assured of receiving the appropriate amount of medication.

Specialty Pharmacy Program
Specialty medications are usually dispensed as an injectable drug, but may be available in other forms, such as a pill or inhalant. They are used to treat complex conditions. Prescriptions for a specialty pharmacy drug are covered only when ordered through the specialty pharmacy program unless you are given an exception from the specialty drug program (see your EOC for details). The specialty pharmacy program will deliver your medication to you by mail or common carrier (you cannot pick up your medication). You may have to pay the full cost of a specialty pharmacy drug if it is not obtained from the specialty pharmacy program. Specialty drugs are limited to a 30-day supply for each fill.

Programs for Member's Special Health Needs
We recognize that some of our members have unique health care needs requiring special attention. That's why we developed programs exclusively for them. Our additional medical management programs work in synergy with our pharmacy drug program to help members better manage their health care on an ongoing basis.

Diabetic members can receive **free glucometers** so that they can effectively and conveniently monitor their glucose levels.

Seniors can better monitor their chronic diseases and multiple medications through our **seniors-at-risk program.** This program reduces the possibility of toxic drug interactions, and curtails distribution of medications that may adversely affect the senior's chronic condition.

Asthmatic members and their families can take advantage of our program to better control the frequency and severity of the disease.

Members who take multiple prescription medications can take advantage of our pharmacy utilization management programs that encourage the safe, effective distribution of prescription medications. We have a program that protects the welfare of members with multiple prescription medications by carefully monitoring their prescription therapy to help reduce the danger of toxic drug interaction. For additional information regarding your prescription drug benefits, please call Pharmacy Customer Service at the toll-free number printed on your member ID card. Please refer to your Combined Evidence of Coverage and Disclosure Form which explains your plan's Exclusions and Limitations as well as the full range of your covered services in detail.

Covered Services (outpatient prescriptions only)	Per Member Cost Share for Each Prescription or Refill
Prescription Drug Coverage	
This plan uses a National Drug List. Drugs not on the list are not covered.	
Retail Pharmacy	
➢ Preventive immunizations administered by a retail pharmacy	No copay
➢ Female oral contraceptives generic and single source brand	No copay
➢ Generic drugs	$5
➢ Brand name formulary drugs	$10
➢ Brand name non-formulary drugs[1]	$40
➢ Compound drugs	$10
➢ Self-administered injectable drugs, except insulin	20% of prescription drug covered expenses *(maximum $100copay per fill)*
Home Delivery	
➢ Female oral contraceptives generic and single source brand	No copay
➢ Generic drugs	$10
➢ Brand name formulary drugs	$20
➢ Brand name non-formulary drugs[1]	$80
➢ Self-administered injectable drugs, except insulin	20% of prescription drug covered expenses *(maximum $100 copay)*
Specialty Pharmacy Drugs *(obtained through specialty pharmacy program)*	
➢ Generic drugs	$5
➢ Brand name drugs	$10
➢ Brand name non-formulary drugs[1]	$40
➢ Self-administered injectable drugs, except insulin	20% of prescription drug covered expenses *(maximum $ 100 copay per fill)*
Non-participating Pharmacies *(compound drugs & specialty pharmacy drugs not covered)*	*Member pays:* 50% of the remaining prescription drug covered expense & costs in excess of the maximum amount allowed up to $250 per prescription
Supply Limits[2]	
➢ Retail Pharmacy *(participating and non-participating)*	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies); 90-day supply for eligible prescriptions obtained through a retail pharmacy, but will require a triple copay.
➢ Home Delivery	90-day supply
➢ Specialty Pharmacy	30-day supply

[1] When the member's physician has specified "dispense as written" (DAW) for non-formulary drugs, the copay for brand name formulary drugs will apply. When the member's physician has not specified DAW for non-formulary drugs, the higher copay will apply.

[2] Supply limits for certain drugs may be different. Please refer to the Evidence of Coverage and Disclosure form (EOC) for complete information.

The Prescription Drug Benefit covers the following:

- All eligible immunizations administered by a participating retail pharmacy.
- Outpatient prescription drugs and medications which the law restricts to sale by prescription.
- Formulas prescribed by a physician for the treatment of phenylketonuria. These formulas are subject to the copay for brand name drugs.
- Folic acid supplementation prescribed by a physician for women planning to become pregnant (folic acid supplement or a multivitamin prescribed by a physician).
- Aspirin prescribed by a physician for the reduction of heart attack or stroke prescribed by a physician.
- Smoking cessation products and over-the-counter nicotine replacement products (limited to nicotine patches and gum) as prescribed by a physician.
- Prescription drugs prescribed by a physician to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products.
- Insulin.
- Syringes when dispensed for use with insulin and other self-injectable drugs or medications
- All FDA-approved contraceptives for women, including oral contraceptives; contraceptive diaphragms and over-the-counter contraceptives prescribed by a doctor.
- Injectable drugs which are self-administered by the subcutaneous route (under the skin).
- Drugs that have Food and Drug Administration (FDA) labeling for self-administration.
- All compound prescription drugs that contain at least one covered prescription ingredient.
- Diabetic supplies (i.e., test strips and lancets).
- Prescription drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
- Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copay for brand name drugs.
- Certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

Prescription drug cost shares are included in the medical out-of-pocket maximum. See medical plan summary of benefits for details.

Prescription Drug Exclusions & Limitations

Hypodermic syringes &/or needles, except when dispensed for use with insulin & other self-injectable drugs or medications
Drugs & medications used to induce spontaneous & non-spontaneous abortions
Drugs & medications dispensed or administered in an outpatient setting, including outpatient hospital facilities and physicians' offices
Professional charges in connection with administering, injecting or dispensing drugs
Drugs & medications that may be obtained without a physician's written prescription, except insulin or niacin for cholesterol lowering and certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.
Drugs & medications dispensed by or while confined in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility
Durable medical equipment, devices, appliances & supplies, even if prescribed by a physician, except contraceptive diaphragms, as specified as covered in the EOC
Services or supplies for which the member is not charged
Oxygen
Cosmetics & health or beauty aids.
Drugs labeled "Caution, Limited by Federal Law to Investigational Use," or Non-FDA approved investigational drugs. Any drugs or medications prescribed for experimental indications
Any expense for a drug or medication incurred in excess of (a) the drug limited fee schedule for drugs dispensed by non-participating pharmacies; or (b) the prescription drug negotiated rate for drugs dispensed by participating pharmacies or through the mail service program
Drugs which have not been approved for general use by the State of California Department of Health Services or the Food and Drug Administration. This does not apply to drugs that are medically necessary for a covered condition.
Prescription drugs that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material, thus treating a disease or abnormal medical condition.
Over-the-counter smoking cessation drugs. This does not apply to medically necessary drugs that the member can only get with a prescription under state and federal law.
Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of drug for medically necessary treatment of a medical condition other than one that is cosmetic.
Drugs used primarily to treat infertility (including, but not limited to, Clomid, Pergonal and Metrodin), unless medically necessary for another covered condition.
Anorexiants and drugs used for weight loss, except when used to treat morbid obesity (e.g., diet pills & appetite suppressants)
Drugs obtained outside the U.S., unless they are furnished in connection with urgent care or an emergency.
Allergy desensitization products or allergy serum
Infusion drugs, except drugs that are self-administered subcutaneously
Herbal supplements, nutritional and dietary supplements, except for formulas for the treatment of phenylketonuria.
Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was in effective.
Compound medications obtained from other than a participating pharmacy. **Member will have to pay the full cost of the compound drugs if member obtains drug at a non-participating pharmacy.**
Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy are not covered by this plan. **Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that member should have obtained from the specialty pharmacy program.**
Third Party Liability
Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.
Any service, drug, drug regimen, treatment, or supply furnished, ordered or prescribed by a provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to an emergency medical condition.

Please refer to the Certificate or EOC for details and complete list of exclusions and limitations. Exclusion does not apply to the medically necessary treatment as specifically stated as covered in the EOC/Certificate.

anthem.com/ca Anthem Blue Cross SC6753 Effective 01-2020 Printed 09-2019

Get help in your language

Notice of Language Assistance

Anthem.

Curious to know what all this says? We would be too. Here's the English version: No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357. (TTY/TDD:711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
Servicios lingüísticos sin costo. Puede tener un intérprete. Puede solicitar que le lean los documentos y algunos puede recibirlos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-254-2721. Para obtener ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357.

Arabic
يتم تقديم خدمات اللغة دون مقابل. يمكنك الاستعانة بمترجم. ويمكنك المطالبة بأن تُقرأ لك بعض المستندات وأن يُرسل بعضها بلغتك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك أو على الرقم 1-888-254-2721للحصول على مزيد من المساعدة، يُرجى الاتصال بإدارة كاليفورنيا للتأمين على الرقم 1-800-927-4357.

Armenian
Թարգմանչական անվճար ծառայություններ: Մենք կարող ենք Ձեզ թարգմանչի ծառայություններ առաջարկել Կարող ենք տրամադրել ինչ-որ մեկին, ով փաստաթղթերը կկարդա Ձեզ համար և կուղարկի դրանք Ձեր լեզվով: Օգնություն ստանալու համար զանգահարեք մեզ Ձեզ ID քարտի վրա նշված հեռախոսահամարով կամ 1-888-254-2721 համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի ապահովագրության նախարարություն հետևյալ հեռախոսահամարով՝ 1-800-927-4357:

Chinese
免費語言服務。您能獲得免費的譯員。您能聽到以您的語言讀出的文件內容，也能獲得以您的語言而寫的部分文件。如需協助，請撥打您的 ID 卡上的號碼或者1-888-254-2721聯絡我們。如需更多協助，請撥打 1-800-927-4357 聯絡CA Dept. of Insurance。

Farsi
خدمات رایگان زبانی. می‌توانید یک مترجم شفاهی بگیرید. می‌توانید بخواهید اسناد را برای شما بخوانند و برخی اسناد نیز به زبان خودتان برایتان ارسال شود. برای دریافت کمک، از طریق شماره فهرست شده در کارت شناسایی‌تان و یا از طریق 1-888-254-2721 با ما تماس بگیرید. برای دریافت کمکهای بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید.

Hindi
बिना लागत की भाषा सेवाएँ। आप दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ पढ़वा सकते हैं और कुछ दस्तावेज़ आपको आपकी भाषा में भेजे जा सकते हैं। मदद के लिए, हमें अपने ID कार्ड पर सूचीबद्ध नंबर पर या 1-888-254-2721 पर कॉल करें। अधिक मदद के लिए 1-800-927-4357 पर CA बीमा विभाग कोकॉल करें।

Hmong
Tsis Xam Tus Nqi Cov Kev Pab Cuam Ntsig Txog Hom Lus. Koj muaj peev xwm tau txais ib tus neeg txhais lus. Koj muaj peev xwm tau txais cov ntaub ntawv nyeem ua koj hom lus rau koj mloog thiab yuav xa ib co ntaub ntawv sau ua koj hom lus tuaj rau koj. Txog rau kev pab, hu rau peb tus nab npawb xov tooj teev tseg cia nyob rau ntawm koj daim ID los sis 1-888-254-2721. Txog rau kev pab ntxiv, hu xov tooj rau Pab Kas Phais Lub Chaw Ua Hauj Lwm CA tus xov tooj 1-800-927-4357.

Japanese
無料言語サービス。通訳サービスを受けられます。希望する言語で文書を読み上げたり、文書を送るサービスも可能です。支援を受けるには、IDカードに記載された番号、または 1-888-254-2721 にお電話ください。支援の詳細は、カリフォルニア州保険局(1-800-927-4357)にお電話ください。

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Khmer
សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែម្នាក់។
អ្នកអាចឲ្យគេអានឯកសារផ្សេងៗជូនអ្នក
និងផ្ញើឯកសារជូនអ្នកជាភាសារបស់អ្នក។
ដើម្បីទទួលជំនួយ សូមហៅ
ទូរស័ព្ទមកយើងតាមលេខដែលបានរាយនៅលើប័ណ្ណ ID
របស់អ្នក ឬក៏លេខ 1-888-254-2721។
ដើម្បីទទួលជំនួយបន្ថែម សូមហៅទូរស័ព្ទទៅ CA Dept.
of Insurance តាមលេខ 1-800-927-4357។

Korean
무료 언어 서비스. 번역사를 이용하실 수 있습니다. 귀하의 언어로 녹음되어 작성된 문서를 받아보실 수 있습니다. 도움을 받으시려면 ID 카드에 기재된 번호 또는 1-888-254-2721로 전화하십시오. 다른 도움이 필요하시면 1-800-927-4357로 보험 CA 부서에 문의 주십시오.

Punjabi
ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਕੋਈ ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾ ਸਕਦਾ ਹੈ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ ਜਾਂ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। ਜ਼ਿਆਦਾ ਮਦਦ ਲਈ, ਸੀਏ ਡਿਪਾਰਟਮੈਂਟ ਔਫ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 ਤੇ ਕਾਲ ਕਰੋ।

Russian
Бесплатные языковые услуги. Вы можете получить услуги устного переводчика. Вам могут прочитать документы или направить некоторые из них на вашем языке. Для получения помощи звоните нам по телефону, указанному на вашей идентификационной карте, или по номеру 1-888-254-2721. Для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по номеру 1-800-927-4357.

Tagalog
Mga Libreng Serbisyo para sa Wika. Maaari kayong kumuha ng interpreter. Maaari ninyong ipabasa ang mga dokumento at ipadala ang ilan sa mga ito sa inyo sa wikang ginagamit ninyo. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa 1-888-254-2721. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357.

Thai
ไม่มีค่าบริการเกี่ยวกับภาษาท่านสามารถขอใช้บริการล่ามได้ ท่านสามารถขอให้เจ้าหน้าที่อ่านเอกสารได้ท่านฟังและเอกสารบางอย่างจะส่งถึงท่านโดยใช้ภาษาของท่านหากต้องการความช่วยเหลือโปรดโทรหาเราตามหมายเลขที่ระบุอยู่บนบัตรประจำตัวของท่านหรือที่หมายเลข 1-888-254-2721 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดตามแผนก CA Dept. of Insurance ที่หมายเลข 1-800-927-4357

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có thông dịch viên. Quý vị có thể yêu cầu đọc tài liệu cho quý vị nghe và yêu cầu gửi một số tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, hãy gọi cho số được ghi trên thẻ ID của quý vị hoặc số 1-888-254-2721. Để được giúp đỡ thêm, hãy gọi cho Sở Bảo Hiểm California (California Department of Insurance) theo số 1-800-927-4357.

TTY/TTD:711

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The legal stuff we're required to tell you

How we keep your information safe and secure

As a member, you have the right to expect us to protect your personal health information. We take this responsibility very seriously, following all state and federal laws, as well as our own policies.

You also have certain rights and responsibilities when receiving your health care. To learn more about how we protect your privacy, your rights and responsibilities when receiving health care, and your rights under the Women's Health and Cancer Rights Act, go to **anthem.com/ca/privacy**. For a printed copy, please contact your Benefits Administrator or Human Resources representative.

How we help manage your care

To see if your health benefits will cover a treatment, procedure, hospital stay or medicine, we use a process called utilization management (UM). Our UM team is made up of doctors and pharmacists who want to be sure you get the best treatments for certain health conditions. They review the information your doctor sends us before, during or after your treatment. We also use case managers. They're licensed health care professionals who work with you and your doctor to help you manage your health conditions. They also help you better understand your health benefits.

To learn more about how we help manage your care, go to **anthem.com/ca/memberrights**. To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

Special enrollment rights

Open enrollment usually happens once a year. That's the time you can choose a plan, enroll in it or make changes to it. If you choose not to enroll, there are special cases when you're allowed to enroll during other times of the year.

- **If you had another health plan that was canceled**. If you, your dependents or your spouse are no longer eligible for benefits with another health plan (or if the employer stops contributing to that health plan), you may be able to enroll with us. You must enroll within 31 days after the other health plan ends (or after the employer stops paying for the plan). For example: You and your family are enrolled through your spouse's health plan at work. Your spouse's employer stops paying for health coverage. In this case, you and your spouse, as well as other dependents, may be able to enroll in one of our plans.
- **If you have a new dependent**. You gain new dependents from a life event like marriage, birth, adoption or if you have custody of a minor and an adoption is pending. You must enroll within 31 days after the event. For example: If you got married, your new spouse and any new children may be able to enroll in a plan.
- **If your eligibility for Medicaid or SCHIP changes**. You have a special period of 60 days to enroll after:
  - You (or your eligible dependents) lose Medicaid or the State Children's Health Insurance Program (SCHIP) benefits because you're no longer eligible.
  - You (or eligible dependents) become eligible to get help from Medicaid or SCHIP for paying part of the cost of a health plan with us.

Get the full details

Read your ***Certificate of Coverage***, which spells out all the details about your plan. You can it find on **anthem.com/ca**.