Anthem Blue Cross

PPO – July 1, 2019
Los Angeles Police Relief Association
Actives & Retirees

This Summary of Benefits is a brief overview of your plan's benefits only. The benefits listed are for both in state and out of state members, there may be differences in benefits depending on where you reside. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Certificate or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information below to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Members are also responsible for all costs over the plan maximums. Plan maximums & other important information appear in italics. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Subject to Utilization Review
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.

Explanation of Maximum Allowed Amount
Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.

PPO Providers - The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.

Non-PPO Providers - For non-emergency care, reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. Members are responsible for the difference between the provider's usual charges & the maximum allowed amount.

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.

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.

Calendar year deductible *(no cross application)*	
PPO Providers & Other Health Care Providers	$350/member; $700/family
Non-PPO Providers	$750/member; $1,500/family
*** If you are a retiree, and you or a covered family member are enrolled in Medicare parts A and/or B, the deductible will be waived***	
Penalty for non-Anthem Blue Cross PPO hospital	25% Penalty *(waived for emergency admission)*
Penalty for non-Anthem Blue Cross PPO hospital or residential treatment center if pre-authorization not obtained	$350/admission *(waived for emergency admission)*
Copay for emergency room services	$150/visit *(waived if admitted directly from ER)*
Annual Out-of-Pocket Maximums *(no cross application)*	
(Each family member must meet the $2,000 OOP max, up to 3 members)	
PPO Providers & Other Health Care Providers	$2,000/member; $6,000 family
Non-PPO Providers	$4,000/member; $12,000 family

The following do not apply to out-of-pocket maximums: non-covered expenses. After an annual out-of-pocket maximum is met for medical during a calendar year, the individual member or family will no longer be required to pay a copay or coinsurance for medical covered expenses for the remainder of that year. The member remains responsible for non-covered expenses.

Lifetime Maximum	Unlimited

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	10%	30%[1]
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	10%	30%[1]
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	10%	30% *(benefit limited to $350/day)*
Hemodialysis		
➢ Outpatient hemodialysis services & supplies	10%	30%
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies	10%	30%
Hospice Care		
➢ Inpatient or outpatient services; family bereavement services	20%[2]	
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to 365 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	20%	
Home Infusion Therapy *(subject to utilization review)*		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	30% *(benefit limited to $600/day)*
Physician Medical Services		
➢ Office & home visits	10%	30%
➢ Hospital & skilled nursing facility visits	10%	30%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	30%
➢ Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	10%	30%
Diagnostic X-ray & Lab		
➢ Other diagnostic x-ray & lab	10%	30%
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 *(deductible waived)*	30%
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(limited to 24 combined visits/calendar year; additional visits may be authorized)*	10%	30%
Speech Therapy	10%	
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 24 combined PPO & Non-PPO visits/calendar year)*	10%[3]	30%[3]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	10%	30%

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Pregnancy & Maternity Care		
➢ Physician office visits (initial visit only)	10%	30%
➢ Prescription drug for abortion *(mifepristone)*	10%	30%
Normal delivery, cesarean section, complications of pregnancy & abortion		
➢ Inpatient physician services	10%	30%
➢ Hospital & ancillary services	10%	30%[4]
Infertility Treatment *(limited to $4,000/calendar year)*		
➢ Diagnosis and treatment of infertility; the member must be under the direct care & treatment of a physician for infertility	50%	50%
Organ & Tissue Transplants *(subject to utilization review; specified transplants covered only when performed at Centers of Medical Excellence [CME] for California; Blue Distinction Centers for Specialty Care [BDCSC] for out of California)*		
➢ Inpatient services provided in connection with	10%	
➢ Physician Office Visits (including specialists/consultants) non-investigative organ or tissue transplants	10%	
➢ Transplant travel expense for an authorized, specified transplant at *CME*	No copay (deductible waived)	
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	10%	30%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts for members with diabetes	10%	30%
Durable Medical Equipment		
➢ Rental or purchase of DME dialysis equipment & supplies	10%	30%
➢ Hearing Aids *(hearing aids benefit is available for one hearing aid per ear every three years; deductible waived)*	20%	
➢ *Breast pump and supplies are covered under preventive care at no charge for in-network*		
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	20%[5]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%[5]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	20%[5]	
Emergency Care		
➢ Emergency room services & supplies *($150 copay waived if admitted)*	10%	10%
➢ Inpatient hospital services & supplies	10%	10%
➢ Physician services	10%	10%

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Mental or Nervous Disorders and Substance Abuse		
➢ Inpatient facility care *(subject to utilization review; waived for emergency admissions)*	10%	30%[6]
➢ Inpatient physician visits	10%	30%
➢ Outpatient facility care	10%	30%[2]
➢ Physician office visits *(Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)*	10%	30%

[1] 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.

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

[3] 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.).

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

[6] 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.

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Premier Plan—Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

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 request an independent medical review, as described in the Evidence of Coverage (EOC).

Services Received Outside of the United States. Services rendered by providers located outside the United States, unless the services are for an emergency, emergency ambulance or urgent care.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt 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) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the Evidence of Coverage (EOC).

Excess Amounts. Any amounts in excess of covered expense or the lifetime maximum.

Work-Related. Any injury, condition or disease arising out of employment for which benefits or payments are covered by any worker's compensation law or similar law. If we provide benefits for such injuries, conditions or diseases we shall be entitled to establish a lien or other recovery under section 4903 of the California Labor Code or any other applicable law, as specified in the EOC/Certificate.

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.

Private Duty Nursing. Private duty nursing services.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state 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 insured person for free.

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

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

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

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.

Hearing Aids or Tests. Hearing aids, except as specified as covered in the EOC. Routine hearing tests.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions. Eyeglasses or contact lenses, except as specified as covered in the EOC.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the EOC.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*. 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 dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).

Sterilization Reversal. Reversal of sterilization.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Gene Therapy. Gene therapy as well as any drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

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).

Orthopedic Supplies. 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 Certificate

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

Health Club Memberships. 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 *physician*. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the EOC. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *plan* 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 requirement either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority,
except as specified as covered in the EOC.

Acupuncture. Acupuncture treatment, except as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or, as specified as covered in the EOC.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs, medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. 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 should have been obtained from the specialty pharmacy program.**

Contraceptive Devices. Contraceptive devices prescribed for birth control, except as specified as covered in the EOC.

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

Medical Equipment, Devices and Supplies. This plan does not cover the following: • Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
• Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
• Enhancements to standard equipment and devices that is not medically necessary.
• Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is medically necessary in your situation.
This exclusion does not apply to the medically necessary treatment as specifically stated as covered in the EOC/Certificate.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Residential accommodations.
Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility or residential treatment center. This exclusion includes procedures, equipment, services, supplies or charges for the following:
• Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
• Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
• Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
• Wilderness camps.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Wigs.

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

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.

Medicare. For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed or as required by federal law, as described in the EOC. If you do not enroll in Medicare Part B, we will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.

Services Received from Providers on a Federal or State Exclusion List. 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.

Drugs Given to you by a Doctor. The following exclusions apply to drugs you receive from a doctor:
• Delivery Charges. Charges for the delivery of prescription drugs.
• Clinically-Equivalent Alternatives. Certain prescription drugs may not be covered if you could use a clinically equivalent drug, unless required by law. "Clinically equivalent" means drugs that for most members, will give you similar results for a disease or condition. If you have questions about whether a certain drug is covered and which drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.
If you or your doctor believes you need to use a different prescription drug, please have your doctor or pharmacist get in touch with us. We will cover the other prescription drug only if we agree that it is medically necessary and appropriate over the clinically equivalent drug. We will review benefits for the prescription drug from time to time to make sure the drug is still medically necessary.
• Compound Drugs. Compound drugs unless all of the ingredients are FDA-approved in the form in which they are used in the compound drug and as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a prescription to dispense, and the compound drug is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
• Drugs Contrary to Approved Medical and Professional Standards. Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
• Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the plan or us.
• Drugs Over the Quantity Prescribed or Refills After One Year. Drugs in amounts over the quantity prescribed or for any refill given more than one year after the date of the original prescription.
• Drugs Prescribed by Providers Lacking Qualifications, Registrations and/or Certifications. Prescription drugs prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications as determined by us.
• Drugs That Do Not Need a Prescription. Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter drugs that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a doctor.
• Lost or Stolen Drugs. Refills of lost or stolen drugs.
• Non-Approved Drugs. Drugs not approved by the FDA.

PPO Prescription Drug Benefits
Los Angeles Police Relief Association

Rx Benefits

PLEASE NOTE*: The following represents a summary only. Please refer to your Evidence of Coverage ("EOC") 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.

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 brand-name or generic 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 following chart summarizes the relation between drug type and your copay amount at a participating pharmacy:

Drug Type	Copay Amount
Generic	$15
Brand name formulary	$25
Brand name non-formulary	$40

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 calling Pharmacy Customer Service at 855-250-8954 or by going to our website at www.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.

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 drug	$50	$50
You are responsible for:	$25 copay	50% of the limited fee schedule plus any amounts exceeding the fee schedule
Total out-of-pocket expenses	**$25**	**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 www.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 www.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.

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 receive prior authorization, a drug must meet specific criteria. The criteria are 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 a prior 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.

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.

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.	
Annual Out-of-Pocket Maximum for Prescription Drugs	$4,850/member; $7,700/family
Participating Retail Pharmacy	
➢ Preventive immunizations administered by a retail pharmacy	No copay
➢ Female oral generic contraceptives and single source brand	No copay
➢ Generic drugs	$15
➢ Brand name formulary drugs	$25
➢ Brand name non-formulary drugs	$40
➢ Specialty pharmacy drugs (including self-administered injectable drug, except insulin)	20% of prescription drug covered expense to a maximum of $150 copay
Home Delivery	
➢ Female oral generic contraceptives and single source brand	No copay
➢ Generic drugs	$30
➢ Brand name formulary drugs	$50
➢ Brand name non-formulary drugs	$80
➢ Specialty pharmacy drugs (including self-administered injectable drug, except insulin)	20% of prescription drug covered expense to a maximum of $300 copay for 60 or 90 day supply
Non-participating Pharmacies	*Member pays:* 50% of the maximum amount allowed & costs in excess of the maximum amount up to $250 per prescription
Supply Limits[1]	
➢ Retail Pharmacy *(participating and non-participating)*	30-day supply; (90 days for maintenance drugs) 60-day supply for federally 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 maintenance drugs requires double copay (retail pharmacies)
➢ Home Delivery	90-day supply

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

[2] **Preferred Generic Program**. If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost of that type of prescription drug. The Preferred Generic Program does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.

The Prescription Drug Benefit covers the following:

- All eligible immunizations administered by a participating retail pharmacy.
- Outpatient prescription drugs and medications.
- 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 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) by the patient or family member.
- 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.

Prescription drug copays are separate from the medical copays of the medical plan and are not applied toward the medical Annual Out-of-Pocket Maximums under the Medical Plan.

Prescription Drug Exclusions & Limitations

Immunizing agents, biological sera, blood, blood products or blood plasma.

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.

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.

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.

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.

Compound medications unless there is at least one component in it that is a covered prescription drug.

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.

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