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

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

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

Annual copay maximum: Individual $1,000; Family $3,000

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

Covered Services	Per Member Copay
Inpatient Medical Services	
➢ Semi-private room or private room if medically necessary; meals & special diets; services & supplies including:	No copay
— Special care units	
— Operating room & special treatment rooms	
— Nursing care	
— Drugs, medications & oxygen administered in the hospital	
➢ Blood & blood products	No copay
Outpatient Medical Services *(Services received in a hospital, other than emergency room services, or in any facility that is affiliated with a hospital)*	
➢ Outpatient surgery & supplies	No copay
➢ Diagnostic X-ray & laboratory procedures	
— CT or CAT scan, MRI or nuclear cardiac scan	No copay
— PET scan	No copay
— All other X-ray & laboratory tests *(including mammograms and ultrasounds)*	No copay
➢ Radiation therapy, chemotherapy & hemodialysis treatment	No copay
Ambulatory Surgical Center	
➢ Outpatient surgery & supplies	No copay
Skilled Nursing Facility *(limited to 100 days/calendar year; limit does not apply to mental health and substance abuse)*	
➢ All necessary services & supplies *(excluding take-home drugs)*	No copay
Hospice Care *(Inpatient or outpatient services for members; family bereavement services)*	No copay
Home Health Care	
➢ Home visits when ordered by primary care physician *(one visit by a home health aide equals four hours or less)*	$20/visit
Physician Medical Services	
➢ Office & home visits	$20/visit
➢ Hospital visits	No copay
➢ Skilled nursing facility visits	No copay
➢ Specialists & consultants	$20/visit

Covered Services	Per Member Copay
Short-Term Physical, Occupational, or Speech Therapy, or Chiropractic Care when Ordered by the Primary Care Physician *(limited to a 60-day period of care after an illness or injury; additional visits available when approved by the medical group)*	$20/visit
Acupuncture *(must be approved by your primary care physician)*	$20/visit
Surgical Services	
➢ Surgeon & surgical assistant	No copay
➢ Anesthesiologist or anesthetist	No copay
General Medical Services *(when performed in non-hospital-based facility)*	
➢ Diagnostic X-ray & laboratory procedures	
— CT or CAT scan, MRI or nuclear cardiac scan	No copay
— PET scan	No copay
— All other X-ray & laboratory tests *(including mammograms, pap smears, & prostate cancer screening)*	No copay
➢ Radiation therapy, chemotherapy & hemodialysis treatment	No copay
Other Medical Services	
➢ Prosthetic devices	No copay
➢ Durable medical equipment including hearing aids *(hearing aids benefit available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge)*	No copay
Preventive Care Services	
Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration.	No copay
*This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	
Health Education and Wellness Programs	
➢ Specified immunizations	No copay
➢ Allergy testing & treatment *(including serums)*	$20/exam
➢ Instruction in health maintenance & wellness	No copay
➢ Selected health education programs	No copay
Emergency Care	
In Area *(within 20 miles of medical group)* **and Out of Area**	
➢ Physician & medical services	No copay
➢ Outpatient hospital emergency room services	$150 copay per visit *(waived if admitted)*
➢ Inpatient hospital services	No copay
Ambulance Services	
➢ Ground or air ambulance transportation when medically necessary, including medical services & supplies	No copay

Covered Services	Per Member Copay
Pregnancy and Maternity Care	
Office Visits	
➢ Prenatal & postnatal care (initial visit only)	$20/initial visit
➢ Complications of pregnancy or abortions	$20/visit
Normal Delivery or Cesarean Section, including:	
➢ Inpatient hospital & ancillary services	No copay
➢ Routine nursery care	No copay
➢ Physician services *(inpatient only)*	No copay
Complication of Pregnancy or Abortion, including:	
➢ Inpatient hospital & ancillary services	No copay
➢ Outpatient hospital services	No copay
➢ Physician services *(inpatient only)*	No copay
Abortions *(including prescription drug for abortion [mifepristone])*	No copay
Genetic Testing of Fetus	No copay
Family Planning Services	
➢ Infertility studies & tests	50% of covered expense[1]
➢ Female Sterilization *(including tubal ligation and counseling/consultation)*	No copay
➢ Male Sterilization	$50
➢ Counseling & consultation	$20/visit
Organ and Tissue Transplant	
➢ Inpatient Care	No copay
➢ Physician office visits *(including primary care, specialty care & consultants)*	$20/visit
Mental or Nervous Disorders and Substance Abuse	
➢ Inpatient Facility care *(subject to utilization review; waived for emergency admissions)*	No copay
➢ Inpatient physician visits	No copay
➢ Outpatient facility care	No copay
➢ Physician office visits *(Behavioral Health treatment for Autism* or *Pervasive Development disorders require pre-service review)*	$20/visit

[1] Not applicable to the annual copay maximum

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive the 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 HMO — Exclusions and Limitations

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

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

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

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

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

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

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

Services 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**.**
Services Not Needing Payment. Services the member is not required to pay for or are given to the member at no charge, except services the member got at a charitable research hospital (not with the government). This hospital must:

1. Be known throughout the world as devoted to medical research.
2. Have at least 10% of its yearly budget spent on research not directly related to patient care.
3. Have 1/3 of its income from donations or grants (not gifts or payments for patient care).
4. Accept patients who are not able to pay.
5. Serve patients with conditions directly related to the hospital's research (at least 2/3 of their patients).

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

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

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

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

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

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

Consultations given by telephone or fax.

Commercial weight loss programs. Weight loss programs, whether or not they are pursued under medical or *doctor* 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 for treatment of anorexia nervosa or bulimia nervosa.

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

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

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

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

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

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

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as 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 require either a written prescription or dispensing by a licensed pharmacist.

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

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

Immunizations. Immunizations needed to travel outside the USA.

Infertility Treatment. Any infertility treatment including artificial insemination or in vitro fertilization, sperm bank, and any related laboratory tests.

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.

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

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

Non-Prescription Drugs. Non-prescription, over-the-counter drugs or medicines.

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

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.

Outpatient Drugs. Outpatient prescription drugs or medications including insulin.

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

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

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

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

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

Sterilization Reversal. Surgery done to reverse a sterilization.

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

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

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.

HMO 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	$100	$100
You are responsible for:	$25 copay	50% of the limited fee schedule plus any amounts exceeding the fee schedule
Total out-of-pocket expenses	**$25.00**	**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 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.	
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[2]	$25
➢ Brand name non-formulary drugs[2]	$40
➢ Specialty pharmacy drugs (including self-administered injectable drugs, except insulin)	20% of prescription drug covered expense to a maximum $150 copay
Insulin Drugs	
➢ Generic drugs	$15
➢ Brand name drugs[2]	$25
➢ Brand name non-formulary drugs[2]	$40
Home Delivery Program	
➢ Female oral generic contraceptives and single source brand	No copay
➢ Generic drugs	$30
➢ Brand name drugs[2]	$50
➢ Brand name non-formulary drugs[2]	$80
➢ Specialty pharmacy drugs (including self-administered injectable drugs, except insulin)	20% of prescription drug covered expense to a maximum of $300 copay for 30-day supply
Insulin Drugs	
➢ Generic drugs	$30
➢ Brand name drugs[2]	$50
➢ Brand name non-formulary drugs[2]	$80
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, but double copay is required (*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 cost shares are included in the medical out-of-pocket maximum. See medical plan summary of benefits for details.

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.

Supplemental benefits for HMO enrollees up to $1,000 per calendar year for covered services received from Prudent Buyer PPO and non-PPO providers and providers who are not represented in the Prudent Buyer PPO network.

Anthem Blue Cross

Preferred HMO (CaliforniaCare Plus) Plan A Los Angeles Police Relief Association Active & Retirees

The outpatient benefits outlined below supplement the Anthem Blue Cross HMO core plan.

Calendar Year Deductible	$100/individual; a maximum of three separate deductibles for each family
Calendar Year Maximum *(excludes calendar year deductible amount)*	$1,000 in plan payments for covered expense
Covered Services	**Per Member Copay**
Hospital Outpatient Services *(excluding emergency room services/supplies)*	20%
Ambulatory Surgical Centers	20%
Physician Medical Services ➢ Office and home visits, including specialists and consultants ➢ Surgeon, surgical assistant and anesthesiologist or anesthetist ➢ Vision and hearing examinations ➢ Allergy testing and treatment	20%
Diagnostic X-ray & Lab *(including mammograms, Pap smears, & prostate cancer screenings)*	20%
Advanced Imaging	20%
Acupuncture	20%
Physical Therapy, Physical Medicine and Occupational Therapy *(including chiropractic services)* *(limited to 12 visits/calendar year)*	No copay

Benefit payment is available for covered services received from:

1. PPO (Prudent Buyer) Plan network providers;
2. Non-PPO providers when there is an authorized referral from a PPO provider (without a referral from a PPO provider, copay is 40%).
3. Providers whose specialties are not represented in the PPO network.

Reimbursement for services received from PPO providers is based on negotiated rates; reimbursement for services received from non-PPO providers and from providers not represented in the PPO network is based on customary and reasonable allowances.

Preferred HMO (CaliforniaCare Plus) Plan Exclusions & Limitations

In addition to the Anthem Blue Cross HMO exclusions & limitations listed in the Anthem Blue Cross HMO core plan, Preferred HMO supplemental benefits are not provided for expenses incurred for or in connection with the following items:

Not Specifically Listed. Services or supplies not specifically listed in the Preferred HMO
supplement rider.

Not Covered. Services received before the member's Anthem Blue Cross HMO coverage becomes effective. Services received after the member's coverage ends, as specified as covered in the EOC. Services or supplies listed under the Anthem Blue Cross HMO exclusions & limitations, except that "Acupuncture" is covered under Preferred HMO supplemental benefits. A referral is not required from the primary care physician or medical group when the member uses the PLUS benefits.

Inpatient services. Services or supplies received during an inpatient stay.[1]

Inpatient Surgery. Surgery which is not performed on an outpatient basis.[1]

Emergency Services. Services or supplies in the treatment of an emergency.[1]

Routine Examinations or Tests. Routine physical examinations, tests or immunizations.[1]
Education or Counseling. Educational services, or nutritional counseling. Food supplements.[1]

Maternity Care. Services or supplies in connection with pregnancy.[1]

Family Planning & Infertility Treatment. Counseling for family planning or problems of fertility & infertility.[1]

Mental or Nervous Disorders & Alcohol or Drug Dependence. Services & supplies for the treatment of mental or nervous disorders & alcohol or drug dependence.[1]

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**.**

Third Party Liability – Blue Cross of California 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.
[1]Covered under the Anthem Blue Cross HMO benefits.