



Classic PPO 250/20/10

PPO 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.

In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information 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 and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

PPO Providers—PPO negotiated rates. Members are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-PPO Providers—For non-emergency services, the scheduled amount. For emergency services, same as other health care providers

Other Health Care Providers (*includes those not represented in the PPO provider network*)—The customary & reasonable charge for professional services or the reasonable charge for institutional services.

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 for all providers	\$250/member; maximum of three separate deductibles/family
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	\$500/admission (<i>waived for emergency admission</i>)
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	\$500/admission (<i>waived for emergency admission</i>)
Deductible for emergency room services	\$100/visit (<i>waived if admitted directly from ER</i>)
Annual Out-of-Pocket Maximums	
PPO Providers & Other Health Care Providers	\$2,000/member/year; \$4,000/family/year
Non-PPO Providers	\$6,000/member/year; \$12,000/family/year

The following do not apply to out-of-pocket maximums: deductibles listed above; non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for deductibles listed above; for non-PPO providers & other health care providers, costs in excess of the covered expense; amounts related to a transplant unrelated donor search.

Lifetime Maximum	Unlimited	
Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay¹
Hospital Medical Services (<i>subject to utilization review for inpatient services; waived for emergency admissions</i>)		
➤ Semi-private room, meals & special diets, & ancillary services	10%	30%
➤ Outpatient medical care, surgical services & supplies (<i>hospital care other than emergency room care</i>)	10%	30%
Ambulatory Surgical Centers		
➤ Outpatient surgery, services & supplies	10%	30% <i>(benefit limited to \$350/day)</i>
Hemodialysis		
➤ Outpatient hemodialysis services & supplies	10%	30% <i>(benefit limited to \$350/day)</i>
Skilled Nursing Facility (<i>subject to utilization review</i>)		
➤ Semi-private room, services & supplies (<i>limited to 100 days/calendar year</i>)	10%	30%
Hospice Care		
➤ Inpatient or outpatient services; family bereavement services	20% ²	

¹The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

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

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay ¹
Home Health Care <i>(subject to utilization review)</i>		
➤ Services & supplies from a home health agency <i>(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)</i>	10%	30%
Home Infusion Therapy <i>(subject to utilization review)</i>		
➤ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	30% <i>(benefit limited to \$600/day)</i>
Physician Medical Services		
➤ Office & home visits	\$20/visit ² <i>(deductible waived)</i>	30%
➤ Hospital & skilled nursing facility visits	10%	30%
➤ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	30%
Diagnostic X-ray & Lab		
➤ MRI, CT scan, PET scan & nuclear cardiac scan <i>(subject to utilization review)</i>	10%	30%
➤ Other diagnostic x-ray & lab	10%	30%
Preventive Care Services		
<i>Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits</i>		
➤ Routine physical examinations <i>(birth through age six)</i>	No copay/exam <i>(deductible waived)</i>	30% <i>(benefit limited to \$20/exam)</i>
➤ Immunizations <i>(birth through age six)</i>	No copay <i>(deductible waived)</i>	30% <i>(benefit limited to \$12/immunization)</i>
➤ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam <i>(members 7 years old and older)</i>	No copay/exam <i>(deductible waived)</i>	Not covered
➤ Adult preventive services <i>(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings)</i>	No copay <i>(deductible waived)</i>	30% <i>(deductible waived)</i>
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services <i>(limited to 24 visits/calendar year; additional visits may be authorized)</i>	10%	30% <i>(benefit limited to \$25/visit)</i>
Speech Therapy		
➤ Outpatient speech therapy following injury or organic disease	10%	30%
Acupuncture		
➤ Services for the treatment of disease, illness or injury <i>(limited to \$30/visit & 12 visits/calendar year)</i>	10% ³	30% ³
Temporomandibular Joint Disorders		
➤ Splint therapy & surgical treatment	10%	30%
Pregnancy & Maternity Care		
➤ Physician office visits	\$20/visit ² <i>(deductible waived)</i>	30%
➤ Prescription drug for elective abortion <i>(mifepristone)</i>	10%	30%
Normal delivery, cesarean section, complications of pregnancy & abortion <i>(newborn routine nursery care covered when natural mother is subscriber or spouse/domestic partner)</i>		
➤ Inpatient physician services	10%	30%
➤ Hospital & ancillary services	10%	30%

¹ The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

² The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

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.).

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay ¹
Organ & Tissue Transplants (subject to utilization review; specified organ transplants covered only when performed at Centers of Medical Excellence [CME])		
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants	10%	
➤ Transplant travel expense for an authorized, specified transplant at a CME (recipient & companion transportation limited to \$10,000 per transplant)	No copay (deductible waived)	
➤ Unrelated donor search, limited to \$30,000 per transplant		
Bariatric Surgery (subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at Centers of Medical Excellence [CME])		
➤ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	10%	
➤ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric CME (member's transportation to & from CME limited to \$130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from CME limited to \$130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & \$100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & \$100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to \$25/day/person for 4 days/trip)	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	\$20/visit (deductible waived)	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 including hearing aids, dialysis equipment & supplies (hearing aids benefit available for one hearing aid per ear every three years)	10%	30%
Related Outpatient Medical Services & Supplies		
➤ Ground or air ambulance transportation, services & disposable supplies	20% ²	
➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20% ²	
➤ Autologous blood (self-donated blood collection, testing, processing & storage for planned surgery)	20% ²	

¹ The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

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

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay ¹
Specialty Pharmacy Drugs (<i>utilization review may be required</i>)		
➤ Specialty pharmacy drugs filled through the specialty pharmacy program (<i>limited to 30-day supply; not covered if benefits are provided through prescription drug benefits, if applicable</i>)	10%	Not covered ²
If member does not get specialty pharmacy drugs from the specialty pharmacy program, member will not receive any specialty pharmacy drug benefits under this plan, unless the member qualifies for an exception as specified in the EOC.		
Emergency Care		
➤ Emergency room services & supplies (<i>\$100 deductible waived if admitted</i>)	10%	10%
➤ Inpatient hospital services & supplies	10%	10%
➤ Physician services	10%	10%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➤ Facility-based care (<i>subject to utilization review; waived for emergency admissions</i>)	10%	30%
➤ Inpatient physician visits	10%	30%
Outpatient Care		
➤ Facility-based care (<i>subject to utilization review; waived for emergency admissions</i>)	10%	30%
➤ Outpatient physician visits (<i>pre-service review required after the 12th visit</i>)	\$20/visit ³ (<i>deductible waived</i>)	30%

¹ The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

² 10% copay if member or non-PPO physician obtains drug from Specialty Pharmacy Program; otherwise, not covered.

³ The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

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.

Classic PPO 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).

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

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 EOC.

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

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.

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 member 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.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

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.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

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

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

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

Sterilization Reversal.

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.

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 supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specified as covered in the EOC.

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.

Chronic Pain. Treatment of chronic pain, 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 or 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.

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

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.

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Pre-Existing Condition Exclusion — No payment will be made for services or supplies for the treatment of a pre-existing condition during a period of six months following either: (a) the member's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. However, this limitation does not apply to a child born to or newly adopted by an enrolled subscriber or spouse/domestic partner, or to conditions of pregnancy. Also if a member was covered under creditable coverage, as outlined in the member's EOC, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six-month period.

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.

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10/25/40 20% Self-Injectable Prescription Drug Benefits

Rx 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. The reasons for the spiraling costs of prescription drugs are varied and include: 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 the drug's type (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 summarizes the relation between drug type and your copay amount at a participating pharmacy:

Drug Type	Copay Amount
Generic	\$10.00
Brand name formulary	\$25.00 ¹
Brand name non-formulary	\$40.00 ¹

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 800-700-2541 or by going to our Web site 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 you not more than the prescription drug maximum allowed amount.

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. If you do not have the original pharmacy receipt(s) showing the date filled, name and address of the pharmacy, doctor's name, NDC number, name of drug and strength, quantity and days supply, prescription number, and the amount paid, 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 **prescription drug maximum allowed amount**. The prescription drug maximum allowed amount may be considerably less than you paid for your medication. You are responsible for any difference in cost between the prescription drug maximum allowed amount and what you paid for your medication.

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 ²	\$50.00
You are responsible for:	\$25.00 copay	\$25 copay plus 50% of the prescription drug maximum allowed amount plus any amounts exceeding the prescription drug maximum allowed amount.
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 Web site at anthem.com/ca.

Submitting a Claim Form

Check to see that all sections of the claim form are completed and mail to:

Anthem Blue Cross Prescription Drug Program
 Attn: Anthem Blue Cross
 P.O. Box 145433
 Cincinnati, OH 45250-5433

Mail Service Prescription Drug Program

If you take a prescription drug on a regular basis, you may want to take advantage of our mail service 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 Mail Service 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 Web site at anthem.com/ca.

Once you complete the form, simply mail it with your copay and prescription in the envelope attached to the Mail Service brochure.

Please note that not all medications are available through the Mail Service Program. Specialty pharmacy drugs are not available through the mail service 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, means some drugs require prior authorization before you can get them (this is similar to prior authorization for medical services). Prior authorization applies to a certain medications that are often a second line of therapy. To receive prior authorization, you must meet specific criteria. The criteria will be based on medical policy and the pharmacy and

therapeutics established guidelines. You may need to try a drug other than the one originally prescribed if we determine that it should be clinically effective for you. Drugs which require prior authorization are not covered unless you receive a prior approval from Anthem Blue Cross.

In order for you to get a drug which requires prior authorization, your physician needs to make a written request to us for you. 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/Certificate 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.

Covered Services (outpatient prescriptions only)	Per Member Copay for Each Prescription or Refill
Retail Pharmacy	
➤ Generic drugs	\$10
➤ Brand name formulary drugs ¹	\$25
➤ Brand name non-formulary drugs ¹	\$40
➤ Compound Drugs ¹	\$40
➤ Self-administered injectable drugs, except insulin	20% of prescription drug maximum allowed amount (maximum \$150 copay)
Mail Service	
➤ Generic drugs	\$10
➤ Brand name formulary drugs ¹	\$50
➤ Brand name non-formulary drugs ¹	\$80
➤ Self-administered injectable drugs, except insulin	20% of prescription drug maximum allowed amount (maximum \$300 copay)
Specialty Pharmacy Drugs (may only be obtained through the specialty pharmacy program)	
➤ Generic drugs	\$10
➤ Brand name formulary drugs ¹	\$25
➤ Brand name non-formulary drugs ¹	\$40
➤ Self-administered injectable drugs, except insulin	20% of prescription drug maximum allowed amount (maximum \$150 copay)
Non-participating Pharmacies (compound drugs & specialty pharmacy drugs not covered at a retail pharmacy)	Member pays the above retail pharmacy copay plus: 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount
Supply Limits³	
➤ 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)
➤ Mail Service	90-day supply
➤ Specialty Pharmacy	30-day supply

¹ **Preferred Generic Program.** If a member requests a formulary or non-formulary 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 charge for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost for 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 (formulary or non-formulary) is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.

² Prescription drug maximum allowed amount.

³ Supply limits for certain drugs may be different. Please refer to the EOC/Certificate for complete information.

The Prescription Drug Benefit covers the following:

- 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.
- Insulin
- Syringes when dispensed for use with insulin and other self-injectable drugs or medications
- Prescription oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per year and are subject to the brand name copay.
- 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.
- 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 copays are separate from the medical copays of the medical plan and are not applied toward the 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/Certificate

Services or supplies for which the member is not charged

Oxygen

Cosmetics & health or beauty aids. However, health aids that are medically necessary and meet the requirements as specified as covered in the EOC/Certificate.

Drugs labeled "Caution, Limited by Federal Law to Investigational Use," or experimental drugs.

Drugs or medications prescribed for experimental indications

Any expense for a drug or medication incurred in excess of the prescription drug maximum allowed amount.

Drugs which have not been approved for general use by the State of California Department of Health or the Food and Drug Administration. This does not apply to drugs that are medically necessary for a covered condition.

Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products.

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 condition.

Anorexiant 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 ineffective.

Compound medications unless:

- a. There is at least one component in it that is a prescription drug; and
- b. It is obtained from a participating pharmacy. **Member will have to pay the full cost of the compound medications 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 Life and Health Insurance Company is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

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