Your Summary of Benefits
Classic PPO

Classic PPO 500/30/20

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 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 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.

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	$500/member; $1,500/family
○ Non-PPO Providers	$750/member; $2,250/family
Additional deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	$500/admission *(waived for emergency admission)*
Deductible for emergency room services	$150/visit *(waived if admitted directly from ER)*
Annual Out-of-Pocket Maximums *(no cross application)*	
○ PPO Providers & Other Health Care Providers	$3,500/member; $7,000/family
○ Non-PPO Providers	$7,000/member; $14,000/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 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.

Lifetime Maximum Unlimited

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member 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. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay *(deductible waived)*	40%
Physician Medical Services		
○ Office & home visits *(includes retail health clinic & online visit)*	$30/visit ‡ *(deductible waived)*	40%
○ Hospital & skilled nursing facility visits	20%	40%
○ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	40%

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Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay†
• Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	20%	40%
Diabetes Education Programs *(requires physician supervision)*‡ • Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$30/visit *(deductible waived)*	40%
• **Physical Therapy, Physical Medicine & Occupational Therapy** • **Chiropractic Services** *(limited to 30 visits /calendar year)* ††	20% $30/visit *(deductible waived)*	40% 40%
Speech Therapy	20%	40%
Acupuncture • Services for the treatment of disease, illness or injury *(limited 20 visits/calendar year)*	$30/visit *(deductible waived)*	40%
Diagnostic X-ray & Lab • Other diagnostic x-ray & lab	20%	40%
Advanced Imaging *(subject to utilization review)*	20%	40% *(benefit limited to $800/procedure)*
Urgent Care *(physician services)*‡	$30/visit *(deductible waived)*	40%
Emergency Care • Emergency room services & supplies *($150 deductible waived if admitted inpatient)* • Physician services	20% 20%	20% 20%
Hospital Medical Services *(subject to utilization review for inpatient and certain outpatient services; waived for emergency admissions)* • Semi-private or private room, medically necessary services & supplies • Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20% 20%	40% *(benefit limited to $1,000/day for non-emergency admission)* 40% *(benefit limited to $350/admit)*
Skilled Nursing Facility *(subject to utilization review)* • Semi-private room, services & supplies *(limited to 100 days/calendar year)*	20%	40%
Related Outpatient Medical Services & Supplies • Ground or air ambulance transportation, services & disposable supplies *(air ambulance in a non-medical emergency is subject to pre-service review and benefit limited to $50,000 for non-PPO)* • Blood transfusions, blood processing & the cost of unreplaced blood & blood products § • Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*§	20% 20% 20%	*In an emergency or with an authorized referral: 20%; Non-emergency: 40%* 20% 20%
Ambulatory Surgical Centers *(certain surgeries are subject to utilization review)* • Outpatient surgery, services & supplies	20%	40% *(benefit limited to $350/admit)*
Pregnancy & Maternity Care • Physician office visits • Prescription drug for abortion (*mifepristone*) Normal delivery, cesarean section, complications of pregnancy & abortion. Refer to the Physician & Hospital Medical Services benefits for both inpatient and outpatient hospital coverage.	$30/visit ‡ *(deductible waived)* 20%	40% 40%
Mental or Nervous Disorders and Substance Abuse • Inpatient facility care (*subject to utilization review; waived for emergency admissions*) • Inpatient physician visits • Outpatient facility care	20% 20% 20%	40% *(benefit limited to $1,000/day for non-emergency admission)* 40% 40% *(benefit limited to $350/admit)*

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Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[†]
• Physician office visits *(Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)*	$30/visit (*deductible waived*) [‡]	40%
Durable Medical Equipment *(may be subject to utilization review)* • Rental or purchase of DME *(breast pump and supplies are covered under preventive care at no charge for in-network)*	20%	40%
Home Health Care *(subject to utilization review)* • Services & supplies from a home health agency *(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less)*	20%	40%
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	20%	40% (*benefit limited to $600/day*)
Hemodialysis • Outpatient hemodialysis services & supplies	20%	40% *(benefit limited to $350/visit for free standing hemodialysis center)*
Hospice Care • Inpatient or outpatient services; family bereavement services	No copay *(deductible waived)*	40%
Bariatric Surgery *(subject to utilization review; covered only when performed at a Centers of Medical Excellence [CME] for California; Blue Distinction Centers for Specialty Care [BDCSC] for out of California)* • Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity • Travel expenses for an authorized, specified surgery *(recipient & companion transportation limited to $3,000 per surgery)*	20% No copay (*deductible waived*)	Not covered[f] Not covered[f]
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 non-investigative organ or tissue transplants • Transplant travel expense for an authorized, specified transplant *(recipient & companion transportation limited to $10,000 per transplant)* • Unrelated donor search, limited to $30,000 per transplant	20% No copay (*deductible waived*)	Not covered[f] Not covered[f]
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	20%	40%

Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
In addition to the benefits described above, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.

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.

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

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

§ These providers may not be represented in the PPO network in the state where the member receives services.

f Exception: If service is performed at a Centers of Medical Excellence [CME] for California or Blue Distinction Centers for Speciality Care [BDCSC] for out of California, the services will be covered same as the PPO (in-network) benefit.

†† Additional visits as authorized if medically necessary; pre-service review must be obtained prior to receiving the services.

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 Certificate.

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 Certificate.

Excess Amounts. Any amounts in excess of covered expense or any medical benefit 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 Certificate.

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 Certificate.

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; and5. 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 Certificate.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use if the program is not affiliated with Anthem. Smoking cessation drugs except as specified as covered in the EOC or Certificate.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. For dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:
1. Extraction, restoration, and replacement of teeth; 2. Services to improve dental clinical outcomes.
This exclusion does not apply to the following:
1. Services which we are required by law to cover; 2. Services specified as covered in this booklet;
3. Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.

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

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

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

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

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 Certificate.

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 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/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 Certificate.

Clinical Trials - Services and supplies in connection with clinical trials, except as specified as covered in the Certificate or 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 Certificate. 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 Certificate.

Acupuncture. Acupuncture treatment, except as specified as covered in the Certificate. 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 Certificate.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the Certificate. 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 Certificate.

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

Private Duty Nursing. Private duty nursing services.

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.

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.

Wigs.

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.

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.

Your Summary of Benefits
Prescription Drug Plan

Anthem Blue Cross

$10/$30/$50/30%

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.*

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 ID card. The amount you pay for a covered prescription - your copay - will be determined by which formulary tier the drug falls into *(a description of the drug tiers is listed below).*
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. You may have to pay an additional charge that represents the cost difference between the brand-name medication and the generic equivalent.
The formulary is a list of recommended brand and generic medications. Drugs on the formulary are grouped by 'tiers.' A number of factors are considered when classifying drugs into tiers, including, but not limited to: the absolute cost of the drug; the cost of the drug relative to other drugs in the same therapeutic class; the availability of over-the-counter alternatives; and other clinical and cost-effectiveness factors.

Tier 1 - Lowest copayment - Drugs offering the greatest value within a therapeutic class. Some of these are generic equivalents of brand name drugs.
Tier 2 - Medium copayment - Drugs on this tier are generally the more affordable brand-name drugs. Other drugs are on this tier because they are "preferred" within their therapeutic classes, based on clinical effectiveness and value.
Tier 3 - Highest copayment - These are higher cost brand-name drugs. Some Tier 3 drugs may have generics or equivalents in Tier 1. In addition, some drugs on this tier may have been evaluated to be less cost-effective than equivalent drugs on lower tiers.
Tier 4 - Tier 4 drugs are those that have the higher cost share than tier 3 drugs. This tier includes non-preferred drugs that may be generic, single source brand name drugs, multi-source brand, or specialty drugs.

Copies of our tiered drug formulary list are furnished to your providers. They are updated quarterly and are available online at www.anthem.com/ca, click on Customer Care, Download Forms and then choose Anthem Blue Cross Drug List (tiered). You or your provider may also contact our Pharmacy Customer Service at 800-700-2541.
You may also sign up online to get important updates by email. To get updates from us by email, follow these steps: - Log in to anthem.com/ca - Choose the Profile Link in your Welcome section on the right side of the page - Enter your email address in your profile information - Check the box below your email address to receive information from us.

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.

Using a Participating Pharmacy

You can control the cost of your prescription drugs by using our 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 may increase. You will likely need to pay for the entire amount of the prescription and then submit a prescription drug claim form for reimbursement to us.
Members that submit claims from non-participating pharmacies are reimbursed based on on the lesser of the billed charge or 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 paying any difference in cost between the prescription drug maximum allowed amount and what you paid for your 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.

Home Delivery Program

If you take a prescription drug on a regular basis, you may want to take advantage of our mail service program. To fill a prescription through the mail, simply complete the Home Delivery 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.
Please note that not all medications are available through the Home Delivery Program. Certain specialty pharmacy drugs are not available through the home delivery program, see Specialty Pharmacy Program below.

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 specified specialty pharmacy drugs are covered only when ordered through the specialty pharmacy program unless you are given an exception from the specialty drug program *(see 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 that must be obtained through the specialty pharmacy program are limited to a 30-day supply for each fill.

Covered Services (outpatient prescriptions only)	Per Member Cost Share for each Prescription or Refill
Retail Participating Pharmacy	
• Preventive immunizations administered by a retail pharmacy	No copay
• Female oral contraceptives generic and single source brand	No copay
• Tier 1 drugs *(includes diabetic supplies)*	$10
• Tier 2 drugs ‡	$30
• Tier 3 drugs *(includes compound drugs)* ‡	$50
• Tier 4 drugs †	30% of prescription drug maximum allowed amount *(maximum $150 copay per fill)*
Home Delivery Program	
• Female oral contraceptives generic and single source brand	No copay
• Tier 1 drugs *(includes diabetic supplies)*	$10
• Tier 2 drugs ‡	$60
• Tier 3 drugs ‡ f	$100
• Tier 4 drugs †	30% of prescription drug maximum allowed amount *(maximum $300 copay per fill)*
Specialty Pharmacy Program Certain specialty pharmacy drugs must be obtained through the specialty pharmacy program and are limited to a 30 day supply. Please contact customer service number on the back of your ID card to see if your drug is on the specialty pharmacy program or you can get a list of drugs required to be dispensed by our specialty pharmacy program at anthem.com/ca. From our home page: Click on **Customer Care; Then select "I need to: Choose: Download Forms"; In the pharmacy library section, click on "Specialty Drug List."**	Applicable copay applies
Non-participating Pharmacies (*compound drugs & certain specialty pharmacy drugs not covered*)	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 Limits§	
• 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)
• Home Delivery	90-day supply
• Specialty Pharmacy	30-day supply

The Prescription Drug Benefit covers the following:

- Preventive flu, shingles and pneumonia vaccines administered by a participating retail pharmacy.
- Outpatient prescription drugs and medications which the law restricts to sale by prescription.
- Formulas prescribed by a physician for the treatment of phenylketonuria.
- 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.
- Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copay for tier 2 or tier 3 copay.
- Certain over-the-counter drugs approved by the Pharmacy and Therapeutics Process to be included in the prescription drug formulary.
  Prescription drug cost shares are included in the medical out-of-pocket maximum. See medical plan summary of benefits for details.

† Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program.

‡ 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.

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

ƒ Compound drugs are not covered through home delivery; only covered through certain retail participating pharmacies.

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 Process 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 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.

Drugs used primarily to treat infertility (including, but not limited to, Clomid, Pergonal and Metrodin), unless medically necessary for another condition.

Anorexiants and drugs used for weight loss, except when used to treat morbid obesity (e.g., diet pills & appetite suppressants).

Drugs obtained outside the U.S, unless they are furnished in connection with urgent care or an emergency.

Allergy desensitization products or allergy serum.

Infusion drugs, except drugs that are self-administered subcutaneously.

Herbal supplements, nutritional and dietary supplements.

Formulas and special foods for the treatment of phenylketonuria (PKU).

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.

Off label prescription drugs

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