Your summary of benefits

Anthem BlueCross

Anthem Blue Cross

Your Plan: Modified Premier PPO 250/20/20

Your Network: Prudent Buyer PPO

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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section. In-Network Providers and Non-Network Providers deductibles are combined. Satisfying one helps satisfy the other.*	$250 single / $750 family	$250 single / $750 family
Copay for non-Anthem Blue Cross PPO hospital or residential treatment center *(waived for emergency admission)*	N/A	$500 copay per admission
Copay for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained *(waived for emergency admission)*	N/A	$500 copay per admission
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum. In-Network Providers and Non-Network Providers out of pocket maximums are combined. Satisfying one helps satisfy the other.*	$2,000 single / $4,000 family	$2,000 single / $4,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration.* **This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.*	No charge	40% coinsurance
Doctor Home and Office Services		
Primary care visit to treat an injury or illness *Deductible does not apply to In-Network providers.*	$20 copay per visit[1]	40% coinsurance
Specialist care visit *Deductible does not apply to In-Network providers.*	$20 copay per visit[1]	40% coinsurance

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care *Deductible does not apply to In-Network providers.*	$10 copay per visit[1]	40% coinsurance
Other practitioner visits:		
Retail health clinic *Deductible does not apply to In-Network providers.*	$20 copay per visit[1]	40% coinsurance
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse. Deductible does not apply to In-Network providers.*	$20 copay per visit	40% coinsurance
Chiropractor services *Coverage for In-Network Provider and Non-Network Provider combined is limited to 20 visit limit per benefit period. Deductible does not apply to In-Network providers.*	$5 copay per visit	$5 copay per visit
Acupuncture[1] *Coverage for In-Network Provider and Non-Network Provider combined is limited to 20 visit limit per benefit period.*	20% coinsurance	40% coinsurance
Other services in an office:		
Allergy testing	20% coinsurance	40% coinsurance
Chemo/radiation therapy	20% coinsurance	40% coinsurance
Hemodialysis	20% coinsurance	40% coinsurance
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection (including allergy serum). Maximum of $250 per visit member cost share per drug.*	20% coinsurance	40% coinsurance
Diagnostic Services		
Lab:		
Office	20% coinsurance	40% coinsurance
Freestanding Lab	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
X-ray:		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance

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

Your summary of benefits

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

Your summary of benefits

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

Your summary of benefits

FOOTNOTES:

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

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

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

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

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

Your summary of benefits

Notes:

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

- Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 consecutive days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CA_LG_PPO
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.

Modified Rx 19 Three Tier 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. Reasons for the spiraling costs of prescription drugs are varied: a general increase of prescription medication use, an aging population, research and development of new medications and the expense of direct to consumer advertising. With prescription drug costs increasing at twice the rate of medical care, we developed ways to contain costs so your copays remain affordable, while maintaining your access to safe, effective prescription drugs. Our Prescription Drug Program provides you with choice, flexibility, affordability and access to an extensive network of retail pharmacies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Features That are Part of your Plan

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

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

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

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

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

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

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

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

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

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

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

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

The Prescription Drug Benefit covers the following:

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

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

Prescription Drug Exclusions & Limitations

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

Third Party Liability

Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.
Any service, drug, drug regimen, treatment, or supply furnished, ordered or prescribed by a provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to an emergency medical condition.

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

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