



Benefits You Can Count On

City of Riverside
Anthem Blue Cross HMO/PPO
Effective January 01, 2014

**Choosing the
right plan is a very
personal thing.**

Use this book to find one that's

- Right for your lifestyle
- Right for your needs
- Right for your peace of mind





**Please share your
feedback with us
in this short survey.**

Your guide to Anthem Blue Cross

Welcome! We're so glad you're taking time to check out all that Anthem Blue Cross has to offer you. Choosing your health care plan (and the benefits that go with it) is an important decision and this booklet is designed to help. Basically, it's a snapshot of the benefits that come with our health plan(s). It shows what's available to you, what you get with each benefit and how the plan(s) work.

Explore the advantages of being an Anthem member.

This booklet goes into all the advantages. But here are the top four:

- 1. Our plans can help you stay healthy.** Health plans aren't just something you need when you're sick. We offer easy-to-use plans that are specially designed for people who already have healthy lifestyles. They include things like free preventive care and discounts on over-the-counter products.
- 2. You get more than just basic coverage.** You get access to tools, resources and guidance that are customized just for you. Plus we offer online programs to help you get and stay healthy. They'll help you reach your personal goals to be as healthy as possible.
- 3. There's so much you can do on our website – after all, it was created just for you.** If you have questions, you'll find the answers you're looking for. Here are some things you can do:
 - Order and print out a temporary member ID card if you lose yours
 - Check the status of a claim
 - Search for a doctor, specialist or hospital
 - Learn about hundreds of health and wellness topics
- 4. Finding an in-network doctor, specialist or hospital is a snap.** It's quick and easy to search online. You can make your search specific by choosing a specialty or entering a doctor's name. And if you're away from home, try searching our National Directory.

Once you get your member ID card, all it takes is three simple steps to discover the world of [anthem.com/ca](https://www.anthem.com/ca).

- Go to [anthem.com/ca](https://www.anthem.com/ca)
- Click on Register
- Create your username and password.

Then you're ready to go!

Your guide to Anthem Blue Cross (continued)

Join our health conversation.

We've brought together a community of health enthusiasts who share information, tips and inspiration on Facebook, Twitter and YouTube. Follow our pages to get exercise tips from people like you. Get advice on reaching your health and wellness goals. And find things like healthy recipes and exercise how-to videos from our health coaches and trainers.

Connect with us today!

- [Facebook.com/HealthJoinIn](https://www.facebook.com/HealthJoinIn)
- [Twitter.com/HealthJoinIn](https://twitter.com/HealthJoinIn)
- [YouTube.com/HealthJoinIn](https://www.youtube.com/HealthJoinIn)

We're teaming up with IBM Watson to help you get the best care.

At times, getting a diagnosis for a complex or rare health issue can be a long, tough process. It's been found that 15-20% of medical errors are caused by a delayed diagnosis.* To help with this issue, we are teaming up with IBM to pioneer a tool using their IBM Watson technology. This tool will help doctors use more complete information about a patient to make a diagnosis. And it will assist them in recommending treatments.

IBM Watson is being developed to access and analyze vast libraries of medical information and millions of health data records. With IBM Watson at their fingertips, we expect that our in-network doctors will be able to make more informed decisions about your health care. And that gets you on the road to your best health quicker.

Visit our website to easily find a doctor or facility.



Scan the code with your mobile capable device for a direct link to anthem.com/ca. Don't have a QR code reader? Download the free ScanLife app to your mobile device or visit scanlife.com.

* Dr. Herb Chase, Columbia University School of Medicine, IBM IBV report, The Future of Connected Healthcare Devices, March 2011.

Understanding your options for health care plans

We think it's important for you to have all the information you need before signing up for a health care plan. Take the time to think about your health care needs and learn how the plans work – so you can make the best decision for you and your family.

Ask these questions before signing up:

Does the plan:

- Have special programs to help you if you have asthma, diabetes or other ongoing conditions?
- Cover physical exams, shots and health screenings to help you stay healthy and avoid health problems?
- Give you information such as brochures, newsletters or online tools about healthy living?
- Offer tools to help you manage your health, as well as your benefits?
- Offer discounts on goods and services to improve your health?

Know the basics of how the plans work

- **Health Maintenance Organization (HMO):** An HMO gives you access to a wide range of services with low copays and low out-of-pocket costs. You get coverage for the doctors, hospitals and other health care providers that are in the plan's network. You have to choose a primary care physician (PCP) who directs your care and gives you referrals to see other doctors, if needed. To see how it works, visit anthem.com/ca/HMObasics.
- **Preferred Provider Organization (PPO):** A PPO plan gives you coverage for doctors and hospitals that are in-network and out-of-network. But you save money by choosing in-network health care providers. To learn more, visit anthem.com/ca/PPObasics.

Here are some definitions:

Deductible: The amount you must pay each year before your plan pays anything. You may have a deductible for health care and a separate one for prescription drugs. Not every plan has a yearly deductible.

Coinsurance: An amount that you pay after you've met your plan's deductible. The plan pays a certain amount and you pay a certain amount.

Copay: A fixed amount (for example, \$15) you pay for a covered health care service, usually when you received the service. The amount can vary by the type of covered health care service.

Know your costs

Health care plans differ in many ways. But with every plan, there's a basic premium, which is how much you and your employer each pay to buy the plan's coverage. The premium may only be a small part of your total cost. There are other payments you may make, which vary by plan. When choosing

Understanding your options for health care plans (continued)

a plan, try to figure out what the total cost is to you and your family, especially if someone in your family has a chronic or serious health condition.

Think about the following:

- Are there deductibles you must pay before the plan begins to help cover your costs?
- Are there copays for office visits, ER visits or inpatient hospital stays?
- What is the coinsurance? What part of the cost of services do you have to pay out of your own pocket? If you use doctors that are out-of-network, how much more will you have to pay to get care?

To see the types of costs that come with our different health care plans, take a look at the Summary of Benefits. Your benefits manager can get you a copy for each type of plan if you don't already have one.

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Helpful links

anthem.com/ca

While you're there check out the Health and Wellness tab

Facebook.com/HealthJoinIn

While you're there check out the Health Personality Quiz

Twitter.com/HealthJoinIn

YouTube.com/HealthJoinIn

[Healthy Footprint](#)

[Glossary](#)

[Member Online Tools](#)



Your Health Benefits

HMO Plan

The big buzz these days is that you have the power to take charge of your health. We would agree that's a good idea. That's why we build our health plans with options, resources and overall support to help you make decisions. This is a quick overview of how your plan works.

One, you have options. As an HMO plan, you choose a medical group or independent practice association (IPA) and primary care physician for each family member from one of the largest networks around. In fact, you have access to more than 35,000 California physicians and specialists and more than 370 hospitals in our HMO network, so you'll find plenty of choices.

Two, as an Anthem Blue Cross member, you have access to a lot of online tools. Helping you make your decisions is important to us, but not nearly as important as helping you make the right decisions — for you, your health and your budget.

Straightforward coverage with a simple copay. Care is guided by your doctor, from primary care to referrals to see a specialist.

HMO at a glance

- **Primary care physicians (PCPs):** Required
Your primary care physician provides preventive care, arranges admissions to hospitals, coordinates care you get from specialists, and helps you make decisions about your health.
- **Referrals:** Required
If your primary care physician determines that you need care from a specialist, your physician will coordinate a referral. Makes getting a referral fast and easy.
- **Claim forms:** No claim forms to submit.
- **Out-of-network benefits:** Not available
Except for emergency or urgent medical care situations, your plan doesn't cover out-of-network care.
- **Out-of-pocket:** We keep your payment simple. You pay a copay — a fixed dollar amount — for care you receive. After that, most covered services are covered at 100%. You generally don't have to worry about paying deductibles or coinsurance when you receive care from your primary care physician.
- **Change medical group or primary care physician:**
Contact Customer Service by the 15th of the month, so that your change becomes effective on the first of the following month.

anthem.com/ca has the answers you need

Simply go to anthem.com/ca for easy access to product, services and health care provider information. And once you get your ID card, register and you can tap into decision-making tools, health information and many resources. It's also the convenient way to order a new ID card, check claims status, find out the cost of services, learn about doctors and hospitals, and so much more.

HMO Plan (continued)

You're covered whenever you travel

If you're traveling in the U.S. or out of the country, your coverage travels with you. If you need emergency care, get the care you need at the closest emergency facility. If you need urgent or approved follow-up care outside of California, you have three ways to find a provider or get the details you need: Go to anthem.com/ca, call BlueCard® Access at 800-810-2583 or call the Customer Service number on your member ID card.

You're getting more than a health plan

You get programs to actually help you manage your health. MyHealth@Anthem®, 360° Health® health management programs, and SpecialOffers@AnthemSM are all available through anthem.com/ca. The programs are explained in detail later in this booklet.

This is a brief overview of your plan's features. Your summary of benefits contains the details. See your benefits manager if you need a copy. **Welcome to Anthem Blue Cross.**

How to find a network doctor

Anthem networks are some of the largest in California. Simply go online and search our provider directory for the type of care you need.

1. Go to anthem.com/ca.
2. Select "Find a Doctor."
3. Select the HMO plan (Look at your benefit summary – it tells you which HMO network you can choose from for your plan. If no network is shown, you choose from our traditional HMO CaliforniaCare network.).
4. Select your provider type.
5. Enter your search criteria.
6. Click "View Results."

Your Summary of Benefits

City of Riverside

Effective 01/01/2014



Custom Preferred Premier HMO 15

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

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

Annual copay maximum:

Individual \$1,500; Family \$3,000

The following copay does not apply to the annual copay maximum: for infertility services

Covered Services	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
Smoking Cessation Program	No copay
Physician Medical Services	
<ul style="list-style-type: none"> • Office & home visits • Specialists • Skilled nursing facility visits • Hospital visits • Injectable medications in physician's office (<i>excluding allergy serum and immunization</i>) • Surgeon & Surgical assistant • Anesthesiologist or anesthesiologist 	<ul style="list-style-type: none"> \$15/visit \$15/visit No copay No copay No copay No copay No copay
Acupuncture	\$15/visit
Outpatient Medical Services (<i>Services received in a hospital, other than emergency room services, or in any facility that is affiliated with a hospital</i>)	
<ul style="list-style-type: none"> • Outpatient surgery & supplies • Advanced Imaging • All other X-ray & laboratory tests (<i>including genetic testing</i>) • Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy • Other Outpatient Medical Services including: Rehabilitation Therapy (Physical, Occupational, or Speech Therapy, limited to a 60-day period of care) 	<ul style="list-style-type: none"> No copay No copay No copay No copay No copay
General Medical Services (<i>when performed in non-hospital-based facility</i>)	
<ul style="list-style-type: none"> • Advanced Imaging • All other X-ray & laboratory tests (<i>including genetic testing</i>) • Allergy testing & treatment (including serums) • Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy • Rehabilitation Therapy (Physical, Occupational, or Speech Therapy or Chiropractic Care, limited to 60-days period of care) 	<ul style="list-style-type: none"> No copay No copay \$15/visit No copay No copay
Emergency Care	
<ul style="list-style-type: none"> • Physician & medical services 	No copay

Covered Services	Per Member Copay
<ul style="list-style-type: none"> Outpatient hospital emergency room services 	\$50/visit (<i>waived if admitted inpatient</i>)
Inpatient Medical Services Semi-private room or private room, medically necessary services & supplies	No copay
Urgent Care (out of service area)	\$15/visit (waived if admitted)
Skilled Nursing Facility (<i>limited to 100 days/calendar year</i>) <ul style="list-style-type: none"> All necessary services & supplies (<i>excluding take-home drugs</i>) 	No copay
Ambulance Services <ul style="list-style-type: none"> Transportation when medically necessary 	No copay
Ambulatory Surgical Center <ul style="list-style-type: none"> Outpatient surgery & supplies 	No copay
Pregnancy and Maternity Care Prenatal & postnatal Professional (physician) services (For your Inpatient copay, see Inpatient Medical Services. For your Outpatient Services copay, see Outpatient Medical Services)	\$15/visit
Elective Abortions (including prescription drug for abortion, mifepristone)	\$150
Prosthetic devices (including Orthotics)	No copay
Durable medical equipment including hearing aids (<i>hearing aids benefit available for one hearing aid per ear every three years; breast pumps and supplies are covered under preventive care at no charge</i>)	No copay
Family Planning and Infertility Services <ul style="list-style-type: none"> Infertility studies & tests Female Sterilization (<i>including tubal ligation and counseling/consultation</i>) Male Sterilization Counseling & consultation 	50% of covered expense [†] No copay \$50 \$15/visit
Mental or Nervous Disorders and Substance Abuse Inpatient Care <ul style="list-style-type: none"> Facility-based care (<i>pre-authorization required</i>) Physician hospital visits 	No copay No copay
Outpatient Care <ul style="list-style-type: none"> Facility-based care (<i>pre-authorization required</i>) Outpatient physician visits (<i>Behavioral Health Treatment for Autism & Pervasive Disorder will be subject to pre-service review</i>) 	No copay \$15/visit
Home Health Care (<i>limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less</i>)	\$15/visit
Hospice Care (<i>Inpatient or outpatient services; family bereavement services</i>)	No copay
Organ and Tissue Transplant <ul style="list-style-type: none"> Inpatient Care Physician office visits Specialist office visits 	No copay \$15/visit \$15/visit

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).

† Not applicable to the annual copay maximum

Premier HMO - Exclusions and Limitations

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

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

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

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

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

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

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

Services Given by Providers Who Are Not With Anthem Blue Cross HMO. We will not cover these services unless primary care doctor refers the member, except for emergencies or urgent care.

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

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

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

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

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

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

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

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

Clinical Trials. Services and supplies in connection with clinical trials, except as specified as covered in the Evidence of Coverage (EOC).

Consultations given by telephone or fax.

Commercial weight loss programs. Weight loss programs, whether or not they are pursued under medical or doctor supervision, unless specifically listed as covered in this plan. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or for treatment of anorexia nervosa or bulimia nervosa.

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

Custodial Care or Rest Cures. Room and board charges for a hospital stay mostly for a change of scene

or to make the member feel good. Services given by a rest home, a home for the aged, or any place like that.

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

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

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

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

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

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

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

Immunizations. Immunizations needed to travel outside the USA.

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

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

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

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

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

Outpatient Drugs. Outpatient prescription drugs or medications including insulin.

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

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

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

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

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

Sterilization Reversal. Surgery done to reverse a sterilization.

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

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

Coordination of Benefits. The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.



Chiropractic Rider Plan 10/30

The benefits described in this Rider are provided through an agreement between Anthem Blue Cross and American Specialty Health Plans of California (ASH Plans). The services listed below are covered only if provided by an ASH Plans Chiropractor. These benefits are provided in addition to the benefits described in the Anthem Blue Cross HMO Evidence of Coverage (EOC) document. However, when expenses are incurred for treatment received from an ASH Plans Chiropractor, no other benefits other than the benefits described in this Rider will be paid.

Covered Services	Member's Copayment
Office Visit	\$10/visit
Maximum Benefits	
Office Visits to a Chiropractor	30 visits per calendar year
Chiropractic appliances	\$50 per calendar year

Covered Services

Chiropractor Services. Member has up to 30 visits per calendar year for chiropractor care services that are determined by ASH Plans to be medically/clinically necessary. All visits to an ASH Plans chiropractor will be applied towards the maximum number of visits in a calendar year. The ASH Plans chiropractor is responsible for submitting a treatment plan to ASH Plans for prior approval.

Covered services include:

- An initial new patient exam by an ASH Plans chiropractor to determine the appropriateness of chiropractic services.
- Follow-up office visits as set forth in a treatment plan approved by ASH Plans and provided by an ASH Plans chiropractor.
- An established patient exam performed by an ASH Plans chiropractor to assess the need to continue, extend or change a treatment plan approved by ASH Plans.
- Adjunctive physiotherapy modalities and procedures as set forth in a treatment plan approved by ASH Plans and provided by ASH Plans chiropractor.
- Radiological x-rays and laboratory tests when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered services include radiological consultations when determined by ASH Plans to be medically/clinically necessary and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or hospital which has contracted with ASH Plans to provide those services.
- Chiropractic Appliances. Up to \$50 per calendar year when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered chiropractic appliances are limited to:
 - elbow supports, back supports (thoracic), lumbar braces and supports, rib supports, or wrist supports;
 - cervical collars or cervical pillows;
 - ankle braces, knee braces, or wrist braces;
 - heel lifts;
 - hot or cold packs;
 - lumbar cushions;
 - rib belts or orthotics; and
 - home traction units for treatment of the cervical or lumbar regions.

Chiropractic Rider Exclusions & Limitations

Care Not Approved: Any services provided by an ASH Plans chiropractor that are not approved by ASH Plans, except as specified as covered in the Evidence of Coverage (EOC). An ASH Plans chiropractor is responsible for submitting a treatment plan to ASH Plans for prior approval.

Care Not Covered: In addition to any service or supply specifically excluded in the EOC, no benefits will be provided for chiropractic services or supplies in connection with:

- Diagnostic scanning, such as magnetic resonance imaging (MRI) or computerized axial tomography (CAT) scans.
- Thermography.
- Hypnotherapy.
- Behavior training
- Sleep therapy
- Weight programs.
- Any non-medical program or service.
- Pre-employment exams, any chiropractic services required by an employer that are not medically/clinically necessary, or vocational rehabilitation.
- Services and/or treatments which are not documented as medically/clinically necessary.
- Massage therapy.
- Any service or supply for the exam and/or treatment by an ASH Plans chiropractor for conditions other than those related to neuromusculoskeletal disorders.
- Transportation costs including local ambulance charges.
- Education programs, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing.
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services, or other related services.
- All auxiliary aids and services, including, but not limited to, interpreters, transcription services; written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephone compatible with hearing aids;
- Adjunctive therapy not associated with spinal, muscle or joint manipulation.

- Laboratory and diagnostic x-ray studies, except as specified as covered in the EOC.

Non-ASH Plans Chiropractors: Services and supplies provided by a chiropractor who does not have an agreement with ASH Plans to provide covered services under this plan.

Work Related: Care for health problems that are work-related if such health problems are covered by workers' compensation, an employer's liability law or similar law. We will provide care for a work-related health problem, but we have the right to be paid back for that care as described in the EOC.

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

Drugs: Prescription drugs or medicines, including a non-legend or proprietary medicine or medication not requiring a prescription.

Supplements: Vitamins, minerals, dietary and nutritional supplements or other similar products, and any herbal supplements.

Air Conditioners: Air purifiers, air conditioners, humidifiers, supplies or any other similar devices or appliances. All appliances or durable medical equipment, except as specified as covered in the EOC.

Personal Items: Any supplies for comfort, hygiene or beauty purposes, including therapeutic mattresses.

Out-Of-Area and Emergency Care: Out-of-area care is not covered under this Chiropractic Care benefit, except for emergency services. The member should follow the procedures specified by their Anthem Blue Cross HMO plan to obtain emergency or out-of-area care.

Third Party Liability

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

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Modified 10/25/40 20% Self-Injectable \$100 Brand Deductible 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 (deductible waived)
Brand name formulary	\$25.00 ¹ (when no generic equivalent available, deductible waived)
Brand name non-formulary	\$40.00 ¹ (when no generic equivalent available, deductible waived)

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: <i>(assuming deductible has been met)</i>	\$25.00 copay	\$25.00 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.

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 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 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, means some drugs require prior authorization before you can get them (this is similar to prior authorization for medical services). Prior authorization applies to 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
Calendar Year Brand Deductible	\$100/member Maximum of three separate deductibles/family
Retail Pharmacy	
➤ Female oral contraceptives generic and single source brand	No copay (deductible waived)
➤ Preventive Immunizations administered by a retail pharmacy	No copay (deductible waived)
➤ Generic drugs	\$10 (deductible waived)
➤ Brand name formulary drugs ¹	\$25 (when no generic equivalent available; deductible waived)
➤ Brand name non-formulary drugs ¹	\$40 (when no generic equivalent available; deductible waived)
➤ Compound Drugs ¹	\$40
➤ Self-administered injectable drugs, except insulin	20% of prescription drug maximum allowed amount (maximum \$150 copay)
Home Delivery	
➤ Female contraceptives generic and single source brand	No copay (deductible waived)
➤ Generic drugs	\$10 (deductible waived)
➤ Brand name formulary drugs ¹	\$50 (when no generic equivalent available; deductible waived)
➤ Brand name non-formulary drugs ¹	\$80 (when no generic equivalent available; deductible waived)
➤ 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 (deductible waived)
➤ Brand name formulary drugs ¹	\$25 (when no generic equivalent available; deductible waived)
➤ Brand name non-formulary drugs ¹	\$40 (when no generic equivalent available; deductible waived)
➤ 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 deductible (if applicable) & retail pharmacy copay plus: 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug 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)
➤ Home Delivery	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 of the 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
- 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 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 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 is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Your Summary of Benefits

City of Riverside

Effective 1/1/2014



Custom Classic HMO 20/40/250 Admit/125 OP

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

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

Annual copay maximum: Individual \$2,000; Family \$4,000

The following copay does not apply to the annual copay maximum: for infertility services

Covered Services	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
Smoking Cessation Program	No copay
Physician Medical Services	
<ul style="list-style-type: none"> • Office & home visits • Specialists • Skilled nursing facility visits • Hospital visits • Injectable medications in physician's office (<i>excluding allergy serum and immunization</i>) • Surgeon & Surgical assistant • Anesthesiologist or anesthesiologist 	<ul style="list-style-type: none"> \$20/visit \$40/visit No copay No copay 30%/up to \$150 maximum copay No copay No copay
Acupuncture	\$20/visit
Outpatient Medical Services (<i>Services received in a hospital, other than emergency room services, or in any facility that is affiliated with a hospital</i>)	
<ul style="list-style-type: none"> • Outpatient surgery & supplies • Advanced Imaging • All other X-ray & laboratory tests (<i>including genetic testing</i>) • Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy • Other Outpatient Medical Services including: Rehabilitation Therapy (Physical, Occupational, or Speech Therapy, limited to a 60-day period of care) 	<ul style="list-style-type: none"> \$125/admit \$100/test No copay \$40/visit \$40/visit
General Medical Services (<i>when performed in non-hospital-based facility</i>)	
<ul style="list-style-type: none"> • Advanced Imaging • All other X-ray & laboratory tests (<i>including genetic testing</i>) • Allergy testing & treatment (including serums) • Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy • Rehabilitation Therapy (Physical, Occupational, or Speech Therapy or Chiropractic Care, limited to 60-days period of care) 	<ul style="list-style-type: none"> \$100/test No copay \$20/visit \$40/visit \$20/visit
Emergency Care	
<ul style="list-style-type: none"> • Physician & medical services 	No copay

Covered Services	Per Member Copay
<ul style="list-style-type: none"> Outpatient hospital emergency room services 	\$100/visit (waived if admitted inpatient)
Inpatient Medical Services Semi-private room or private room, medically necessary services & supplies	\$250/admit
Urgent Care (out of service area)	\$40/visit (waived if admitted)
Skilled Nursing Facility <i>(limited to 100 days/calendar year)</i> <ul style="list-style-type: none"> All necessary services & supplies (excluding take-home drugs) 	No copay
Ambulance Services <ul style="list-style-type: none"> Transportation when medically necessary 	\$100/trip
Ambulatory Surgical Center <ul style="list-style-type: none"> Outpatient surgery & supplies 	\$125/admit
Pregnancy and Maternity Care Prenatal & postnatal Professional (physician) services (For your Inpatient copay, see Inpatient Medical Services. For your Outpatient Services copay, see Outpatient Medical Services)	\$20/visit
Elective Abortions (including prescription drug for abortion, mifepristone)	\$150
Prosthetic devices (including Orthotics)	No copay
Durable medical equipment including hearing aids <i>(hearing aids benefit available for one hearing aid per ear every three years; breast pumps & supplies are covered under preventive care at no charge)</i>	20%
Family Planning Services <ul style="list-style-type: none"> Infertility studies & tests Female Sterilization (including tubal ligation and counseling/consultation) Male Sterilization Counseling & consultation 	50% of covered expense [†] No copay \$50 \$20/visit
Mental or Nervous Disorders and Substance Abuse Inpatient Care <ul style="list-style-type: none"> Facility-based care (pre-authorization required) Physician hospital visits Outpatient Care <ul style="list-style-type: none"> Facility-based care (pre-authorization required) Outpatient physician visits (Behavioral Health Treatment for Autism & Pervasive Disorder will be subject to pre-service review) 	\$250/admit No copay No copay \$20/visit
Home Health Care <i>(limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less)</i>	\$20/visit
Hospice Care (Inpatient or outpatient services; family bereavement services)	No copay
Organ and Tissue Transplant <ul style="list-style-type: none"> Inpatient Care Physician office visits Specialist office visit 	\$250/admit \$20/visit \$40/visit

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).

[†] Not applicable to the annual copay maximum

Classic HMO - Exclusions and Limitations

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

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

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

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

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

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

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

Services Given by Providers Who Are Not With Anthem Blue Cross HMO. We will not cover these services unless primary care doctor refers the member, except for emergencies or urgent care.

Services Not Needing Payment. Services the member is not required to pay for or are given to the member at no charge, except services the member got at a charitable research hospital (not with the government). This hospital must: 1. Be known throughout the world as devoted to medical research. 2. Have at least 10% of its yearly budget spent on research not directly related to patient care. 3. Have 1/3 of its income from donations or grants (not gifts or payments for patient care). 4. Accept patients who are not able to pay. 5. Serve patients with conditions directly related to the hospital's research (at least 2/3 of their patients).

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

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

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

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

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

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

Clinical Trials. Services and supplies in connection with clinical trials, except as specified as covered in the Evidence of Coverage (EOC).

Consultations given by telephone or fax.

Commercial weight loss programs. Weight loss programs, whether or not they are pursued under medical or *doctor* supervision, unless specifically listed as covered in this *plan*. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to *medically necessary* treatments for morbid obesity or for treatment of anorexia nervosa or bulimia nervosa.

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

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

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

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

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

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

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

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

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

Immunizations. Immunizations needed to travel outside the USA.

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

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

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

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

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

Outpatient Drugs. Outpatient prescription drugs or medications including insulin.

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

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

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

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

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

Sterilization Reversal. Surgery done to reverse a sterilization.

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

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

Coordination of Benefits - The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

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The benefits described in this Rider are provided through an agreement between Anthem Blue Cross and American Specialty Health Plans of California (ASH Plans). The services listed below are covered only if provided by an ASH Plans Chiropractor. These benefits are provided in addition to the benefits described in the Anthem Blue Cross HMO Evidence of Coverage (EOC) document. However, when expenses are incurred for treatment received from an ASH Plans Chiropractor, no other benefits other than the benefits described in this Rider will be paid.

Covered Services	Member's Copayment
Office Visit	\$10/visit
Maximum Benefits	
Office Visits to a Chiropractor	30 visits per calendar year
Chiropractic appliances	\$50 per calendar year

Covered Services

Chiropractor Services. Member has up to 30 visits per calendar year for chiropractor care services that are determined by ASH Plans to be medically/clinically necessary. All visits to an ASH Plans chiropractor will be applied towards the maximum number of visits in a calendar year. The ASH Plans chiropractor is responsible for submitting a treatment plan to ASH Plans for prior approval.

Covered services include:

- An initial new patient exam by an ASH Plans chiropractor to determine the appropriateness of chiropractic services.
- Follow-up office visits as set forth in a treatment plan approved by ASH Plans and provided by an ASH Plans chiropractor.
- An established patient exam performed by an ASH Plans chiropractor to assess the need to continue, extend or change a treatment plan approved by ASH Plans.
- Adjunctive physiotherapy modalities and procedures as set forth in a treatment plan approved by ASH Plans and provided by ASH Plans chiropractor.
- Radiological x-rays and laboratory tests when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered services include radiological consultations when determined by ASH Plans to be medically/clinically necessary and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or hospital which has contracted with ASH Plans to provide those services.
- Chiropractic Appliances. Up to \$50 per calendar year when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered chiropractic appliances are limited to:
 - elbow supports, back supports (thoracic), lumbar braces and supports, rib supports, or wrist supports;
 - cervical collars or cervical pillows;
 - ankle braces, knee braces, or wrist braces;
 - heel lifts;
 - hot or cold packs;
 - lumbar cushions;
 - rib belts or orthotics; and
 - home traction units for treatment of the cervical or lumbar regions.

Chiropractic Rider Exclusions & Limitations

Care Not Approved: Any services provided by an ASH Plans chiropractor that are not approved by ASH Plans, except as specified as covered in the Evidence of Coverage (EOC). An ASH Plans chiropractor is responsible for submitting a treatment plan to ASH Plans for prior approval.

Care Not Covered: In addition to any service or supply specifically excluded in the EOC, no benefits will be provided for chiropractic services or supplies in connection with:

- Diagnostic scanning, such as magnetic resonance imaging (MRI) or computerized axial tomography (CAT) scans.
- Thermography.
- Hypnotherapy.
- Behavior training
- Sleep therapy
- Weight programs.
- Any non-medical program or service.
- Pre-employment exams, any chiropractic services required by an employer that are not medically/clinically necessary, or vocational rehabilitation.
- Services and/or treatments which are not documented as medically/clinically necessary.
- Massage therapy.
- Any service or supply for the exam and/or treatment by an ASH Plans chiropractor for conditions other than those related to neuromusculoskeletal disorders.
- Transportation costs including local ambulance charges.
- Education programs, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing.
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services, or other related services.
- All auxiliary aids and services, including, but not limited to, interpreters, transcription services; written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephone compatible with hearing aids;
- Adjunctive therapy not associated with spinal, muscle or joint manipulation.

- Laboratory and diagnostic x-ray studies, except as specified as covered in the EOC.

Non-ASH Plans Chiropractors: Services and supplies provided by a chiropractor who does not have an agreement with ASH Plans to provide covered services under this plan.

Work Related: Care for health problems that are work-related if such health problems are covered by workers' compensation, an employer's liability law or similar law. We will provide care for a work-related health problem, but we have the right to be paid back for that care as described in the EOC.

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

Drugs: Prescription drugs or medicines, including a non-legend or proprietary medicine or medication not requiring a prescription.

Supplements: Vitamins, minerals, dietary and nutritional supplements or other similar products, and any herbal supplements.

Air Conditioners: Air purifiers, air conditioners, humidifiers, supplies or any other similar devices or appliances. All appliances or durable medical equipment, except as specified as covered in the EOC.

Personal Items: Any supplies for comfort, hygiene or beauty purposes, including therapeutic mattresses.

Out-Of-Area and Emergency Care: Out-of-area care is not covered under this Chiropractic Care benefit, except for emergency services. The member should follow the procedures specified by their Anthem Blue Cross HMO plan to obtain emergency or out-of-area care.

Third Party Liability

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

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Modified 10/25/40 20% Self-Injectable \$100 Brand Deductible 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 (deductible waived)
Brand name formulary	\$25.00 ¹ (when no generic equivalent available, deductible waived)
Brand name non-formulary	\$40.00 ¹ (when no generic equivalent available, deductible waived)

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: <i>(assuming deductible has been met)</i>	\$25.00 copay	\$25.00 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.

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 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 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, means some drugs require prior authorization before you can get them (this is similar to prior authorization for medical services). Prior authorization applies to 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
Calendar Year Brand Deductible	\$100/member Maximum of three separate deductibles/family
Retail Pharmacy	
➤ Female oral contraceptives generic and single source brand	No copay (deductible waived)
➤ Preventive Immunizations administered by a retail pharmacy	No copay (deductible waived)
➤ Generic drugs	\$10 (deductible waived)
➤ Brand name formulary drugs ¹	\$25 (when no generic equivalent available; deductible waived)
➤ Brand name non-formulary drugs ¹	\$40 (when no generic equivalent available; deductible waived)
➤ Compound Drugs ¹	\$40
➤ Self-administered injectable drugs, except insulin	20% of prescription drug maximum allowed amount (maximum \$150 copay)
Home Delivery	
➤ Female contraceptives generic and single source brand	No copay (deductible waived)
➤ Generic drugs	\$10 (deductible waived)
➤ Brand name formulary drugs ¹	\$50 (when no generic equivalent available; deductible waived)
➤ Brand name non-formulary drugs ¹	\$80 (when no generic equivalent available; deductible waived)
➤ 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 (deductible waived)
➤ Brand name formulary drugs ¹	\$25 (when no generic equivalent available; deductible waived)
➤ Brand name non-formulary drugs ¹	\$40 (when no generic equivalent available; deductible waived)
➤ 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 deductible (if applicable) & retail pharmacy copay plus: 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug 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)
➤ Home Delivery	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 of the 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
- 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 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 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 is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

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Your Summary of Benefits

City of Riverside

Effective 1/1/2014



Custom Value HMO 20/40/250/3 day

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

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

Annual copay maximum:

Individual \$3,000; Family \$6,000

The following copay does not apply to the annual copay maximum: for infertility services

Covered Services	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
Smoking Cessation Program	No copay
Physician Medical Services	
<ul style="list-style-type: none"> • Office & home visits • Specialists • Skilled nursing facility visits • Hospital visits • Injectable medications in physician's office (<i>excluding allergy serum and immunization</i>) • Surgeon & Surgical assistant • Anesthesiologist or anesthesiologist 	<ul style="list-style-type: none"> \$20/visit \$40/visit No copay No copay 30%/up to \$150 maximum copay No copay No copay
Acupuncture	\$20/visit
Outpatient Medical Services (<i>Services received in a hospital, other than emergency room services, or in any facility that is affiliated with a hospital</i>)	
<ul style="list-style-type: none"> • Outpatient surgery & supplies • Advanced Imaging • All other X-ray & laboratory tests (<i>including genetic testing</i>) • Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy • Other Outpatient Medical Services including: Rehabilitation Therapy (Physical, Occupational, or Speech Therapy, limited to a 60-day period of care) 	<ul style="list-style-type: none"> \$125/admit \$100/test No copay \$40/visit \$40/visit
General Medical Services (<i>when performed in non-hospital-based facility</i>)	
<ul style="list-style-type: none"> • Advanced Imaging • All other X-ray & laboratory tests (<i>including genetic testing</i>) • Allergy testing & treatment (including serums) • Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy • Rehabilitation Therapy (Physical, Occupational, or Speech Therapy or Chiropractic Care, limited to 60-days period of care) 	<ul style="list-style-type: none"> \$100/test No copay \$20/visit \$40/visit \$20/visit
Emergency Care	
<ul style="list-style-type: none"> • Physician & medical services 	No copay

Covered Services	Per Member Copay
<ul style="list-style-type: none"> Outpatient hospital emergency room services 	\$150/visit (waived if admitted inpatient)
Inpatient Medical Services Semi-private room or private room, medically necessary services & supplies	\$250/day, up to 3 day max
Urgent Care (out of service area)	\$40/visit (waived if admitted)
Skilled Nursing Facility <i>(limited to 100 days/calendar year)</i> <ul style="list-style-type: none"> All necessary services & supplies (excluding take-home drugs) 	No copay
Ambulance Services <ul style="list-style-type: none"> Transportation when medically necessary 	\$100/trip
Ambulatory Surgical Center <ul style="list-style-type: none"> Outpatient surgery & supplies 	\$125/admit
Pregnancy and Maternity Care Prenatal & postnatal Professional (physician) services (For your Inpatient copay, see Inpatient Medical Services. For your Outpatient Services copay, see Outpatient Medical Services)	\$20/visit
Elective Abortions (including prescription drug for abortion, mifepristone)	\$150
Prosthetic devices (including Orthotics)	No copay
Durable medical equipment including hearing aids <i>(hearing aids benefit available for one hearing aid per ear every three years; breast pumps & supplies are covered under preventive care at no charge)</i>	50%
Family Planning Services <ul style="list-style-type: none"> Infertility studies & tests Female Sterilization (including tubal ligation and counseling/consultation) Male Sterilization Counseling & consultation 	50% of covered expense [†] No copay \$50 \$20/visit
Mental or Nervous Disorders and Substance Abuse Inpatient Care <ul style="list-style-type: none"> Facility-based care (pre-authorization required) Physician hospital visits Outpatient Care <ul style="list-style-type: none"> Facility-based care (pre-authorization required) Outpatient physician visits (Behavioral Health Treatment for Autism & Pervasive Disorder will be subject to pre-service review) 	\$250/day, up to 3 day max No copay No copay \$20/visit
Home Health Care <i>(limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less)</i>	\$20/visit
Hospice Care (Inpatient or outpatient services; family bereavement services)	No copay
Organ and Tissue Transplant <ul style="list-style-type: none"> Inpatient Care Physician office visits Specialist office visits 	\$250/day, up to 3 day max \$20/visit \$40/visit

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).

† Not applicable to the annual copay maximum

Value HMO - Exclusions and Limitations

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

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

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

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

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

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

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

Services Given by Providers Who Are Not With Anthem Blue Cross HMO. We will not cover these services unless primary care doctor refers the member, except for emergencies or urgent care.

Services Not Needing Payment. Services the member is not required to pay for or are given to the member at no charge, except services the member got at a charitable research hospital (not with the government). This hospital must: 1. Be known throughout the world as devoted to medical research. 2. Have at least 10% of its yearly budget spent on research not directly related to patient care. 3. Have 1/3 of its income from donations or grants (not gifts or payments for patient care). 4. Accept patients who are not able to pay. 5. Serve patients with conditions directly related to the hospital's research (at least 2/3 of their patients).

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

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

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

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

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

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

Clinical Trials. Services and supplies in connection with clinical trials, except as specified as covered in the Evidence of Coverage (EOC).

Consultations given by telephone or fax.

Commercial weight loss programs. Weight loss programs, whether or not they are pursued under medical or *doctor* supervision, unless specifically listed as covered in this *plan*. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to *medically necessary* treatments for morbid obesity or for treatment of anorexia nervosa or bulimia nervosa.

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

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

Dental Services or Supplies. Dentures, bridges, crowns, caps, or dental prostheses, dental implants,

dental services, tooth extraction, or treatment to the teeth or gums. Cosmetic dental surgery or other dental services for beauty purposes.

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

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

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

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

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

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

Immunizations. Immunizations needed to travel outside the USA.

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

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

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

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

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

Outpatient Drugs. Outpatient prescription drugs or medications including insulin.

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

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

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

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

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

Sterilization Reversal. Surgery done to reverse a sterilization.

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

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

Coordination of Benefits - The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

Anthem Blue Cross is the trade name of Blue Cross of California. Independent Licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.



Modified 10/25/40 20% Self-Injectable \$100 Brand Deductible 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 (deductible waived)
Brand name formulary	\$25.00 ¹ (when no generic equivalent available, deductible waived)
Brand name non-formulary	\$40.00 ¹ (when no generic equivalent available, deductible waived)

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: <i>(assuming deductible has been met)</i>	\$25.00 copay	\$25.00 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.

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 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 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, means some drugs require prior authorization before you can get them (this is similar to prior authorization for medical services). Prior authorization applies to 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
Calendar Year Brand Deductible	\$100/member Maximum of three separate deductibles/family
Retail Pharmacy	
➤ Female oral contraceptives generic and single source brand	No copay (deductible waived)
➤ Preventive Immunizations administered by a retail pharmacy	No copay (deductible waived)
➤ Generic drugs	\$10 (deductible waived)
➤ Brand name formulary drugs ¹	\$25 (when no generic equivalent available; deductible waived)
➤ Brand name non-formulary drugs ¹	\$40 (when no generic equivalent available; deductible waived)
➤ Compound Drugs ¹	\$40
➤ Self-administered injectable drugs, except insulin	20% of prescription drug maximum allowed amount (maximum \$150 copay)
Home Delivery	
➤ Female contraceptives generic and single source brand	No copay (deductible waived)
➤ Generic drugs	\$10 (deductible waived)
➤ Brand name formulary drugs ¹	\$50 (when no generic equivalent available; deductible waived)
➤ Brand name non-formulary drugs ¹	\$80 (when no generic equivalent available; deductible waived)
➤ 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 (deductible waived)
➤ Brand name formulary drugs ¹	\$25 (when no generic equivalent available; deductible waived)
➤ Brand name non-formulary drugs ¹	\$40 (when no generic equivalent available; deductible waived)
➤ 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 deductible (if applicable) & retail pharmacy copay plus: 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug 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)
➤ Home Delivery	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 of the 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
- 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 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 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 is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

PPO Plan

The big buzz these days is that you have the power to take charge of your health. We would agree that's a good idea. That's why we build our health plans with options, resources and overall support to help you make decisions. This is a quick overview of how your plan works.

One, you have options. With a PPO plan, you're free to choose your doctor without referrals. Of course, in-network care will usually cost less than out-of-network care. Through the BlueCard® program you have access to nearly 80% of doctors and 90% of hospitals across the nation, so you'll find plenty of choices. The point is, the choice is yours.

Two, as an Anthem member, you have access to a lot of online tools. Helping you make your decisions is important to us, but not nearly as important as helping you make the right decisions — for you, your health and your budget.

With no primary doctor requirement and no referrals, you're free to make your own decisions about your health care.

PPO at a glance

- **PRIMARY CARE PHYSICIANS (PCPs):** Not required
You can make your own decisions about your doctors, your care and your costs.
- **REFERRALS:** Not needed
You have the freedom to choose any licensed provider. However you can receive significant cost savings when you visit a network provider for covered services. You pick who you want to see. Makes getting second opinions very easy.
- **CLAIM FORMS:** No claim forms to submit when using network providers. Network providers will submit claims for you.
- **OUT-OF-NETWORK BENEFITS:** Available, but at lower coverage levels than in-network
We've negotiated special rates with our network doctors and hospitals on behalf of our members. By staying in-network, you can take advantage of these rates and receive higher levels of coverage.
- **OUT-OF-POCKET:** Common services like office visits, prescriptions and preventive care only require a copay — a fixed dollar amount — and your plan pays the rest. Other than that, most covered services involve deductibles or coinsurance.

You can see what services cost before your visit

Through anthem.com/ca, you can estimate the costs for inpatient and outpatient services and doctor visits. What better way to help you determine what to do?

PPO Plan (continued)

anthem.com/ca has the answers you need

Simply go to anthem.com/ca for easy access to product, services and health care provider information. And once you get your ID card, register and you can tap into decision-making tools, health information and many resources. It's also the convenient way to order a new ID card, check claims status, find out the cost of services, learn about doctors and hospitals, and so much more.

You're covered whenever you travel

If you're traveling in the U.S. or out of the country, your coverage travels with you. If you need emergency care, get the care you need at the closest emergency facility. If you need urgent or approved follow-up care outside of California you have three ways to find a provider or get the details you need: Go to anthem.com/ca, call BlueCard® Access at 800-810-2583 or call the customer service number on your member ID card.

You're getting more than a health plan

You get programs to actually help you manage your health. MyHealth@Anthem®, 360° Health® health management programs, and SpecialOffers@AnthemSM are all available through anthem.com/ca. The programs are explained in detail later in this booklet.

This is a brief overview of your plan's features. Your summary of benefits contains the details. See your benefits manager if you need a copy. **Welcome to Anthem.**

HOW TO FIND A NETWORK DOCTOR

Anthem networks are some of the largest in California. Simply go online and search our provider directory for the type of care you need.

- 1. Go to anthem.com/ca.**
- 2. Select "Find a Doctor."**
- 3. Select the PPO plan.**
- 4. Select your provider type.**
- 5. Select a specialist, if needed.**
- 6. Enter your search criteria.**
- 7. Click "View Results."**

Your Summary of Benefits

City of Riverside

Effective 01/01/2014



Custom PPO and BC PPO Premier PPO 0/15/10

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

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

Subject to Utilization Review

Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.

Explanation of Maximum Allowed Amount

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

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

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

For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar Year Deductible

PPO Providers & Other Health Care Providers	None
Non PPO Providers	\$250/member; \$750/family
Additional 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	\$25/visit (<i>waived if admitted directly from ER</i>)
Annual Out-of-Pocket Maximums (<i>no cross accumulation</i>)	
• PPO Providers & Other Health Care Providers	\$1,000/member
• Non-PPO Providers	\$3,000/member

The following does not apply to out of pocket maximum; non-covered expense. After a member reaches the out-of pocket maximum, the member remains responsible for costs in excess of the covered expense.

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 (<i>including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing</i>), 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 (<i>deductible waived</i>)	30%
Physician Medical Services		
• Office & home visits (<i>includes retail health clinic & online visit</i>)	\$15/visit (<i>deductible waived</i>)*	30%
• Hospital & skilled nursing facility visits	10%	30%
• Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	30%
• Drugs administered by a medical provider (<i>certain drugs are subject to utilization review</i>)	10%	30%

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Diabetes Education Programs <i>(requires physician supervision)[†]</i> <ul style="list-style-type: none"> Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training 	\$15/visit <i>(deductible waived)</i>	30%
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services <i>(limited to 24 visits/calendar year; additional visits may be authorized)</i>	10%	30%
Speech Therapy <ul style="list-style-type: none"> Outpatient speech therapy 	10%	30%
Acupuncture <ul style="list-style-type: none"> Services for the treatment of disease, illness or injury <i>(limited to 12 visits/calendar year)</i> 	10% [‡]	30% [‡]
Diagnostic X-ray & Lab <ul style="list-style-type: none"> Other diagnostic x-ray & lab 	10%	30%
Advanced Imaging <i>(subject to utilization review)</i>	10%	30% <i>(benefit limited to \$800/procedure)</i>
Urgent Care <i>(physician services)[†]</i>	\$15/visit <i>(deductible waived)</i>	30%
Emergency Care <ul style="list-style-type: none"> Emergency room services & supplies <i>(\$25 deductible waived if admitted inpatient)</i> Physician services 	10% 10%	10% 10%
Hospital Medical Services <i>(subject to utilization review for inpatient and certain outpatient services; waived for emergency admissions)</i> <ul style="list-style-type: none"> Semi-private or private room, medically necessary services & supplies Outpatient medical care, surgical services & supplies <i>(hospital care other than emergency room care)</i> 	10% 10%	30% 30%
Skilled Nursing Facility <i>(subject to utilization review)</i> <ul style="list-style-type: none"> Semi-private room, services & supplies <i>(limited to 100 days/calendar year)</i> 	10%	30%
Related Outpatient Medical Services & Supplies <ul style="list-style-type: none"> Ground or air ambulance transportation, services & disposable supplies <i>(air ambulance in a non-medical emergency is subject to pre-service review and benefit limited to \$50,000 for non-PPO)</i> Blood transfusions, blood processing & the cost of unreplaced blood & blood products[§] Autologous blood <i>(self-donated blood collection, testing, processing & storage for planned surgery)[§]</i> 	10% 20% 20%	In an emergency or with an authorized referral: 10%; Non-emergency: 30% 20% 20%
Ambulatory Surgical Centers <i>(certain surgeries are subject to utilization review)</i> <ul style="list-style-type: none"> Outpatient surgery, services & supplies 	10%	30% <i>(benefit limited to \$350/admit)</i>
Pregnancy & Maternity Care <ul style="list-style-type: none"> Physician office visits Prescription drug for elective abortion <i>(mifepristone)</i> Normal delivery, cesarean section, complications of pregnancy & abortion. Refer to the Physician & Hospital Medical Services benefits for both inpatient and outpatient hospital coverage.	\$15/visit <i>(deductible waived)[†]</i> 10%	30% 30%
Mental or Nervous Disorders and Substance Abuse <p>Inpatient Care</p> <ul style="list-style-type: none"> Facility-based care <i>(subject to utilization review; waived for emergency admissions)</i> Inpatient physician visits <p>Outpatient Care</p> <ul style="list-style-type: none"> Facility-based care <i>(subject to utilization review; waived for emergency admissions)</i> Outpatient physician visits <i>(Behavioral Health treatment for Autism & Pervasive Disorder will be subject to pre-service review)</i> 	10% 10% 10% \$15/visit <i>(deductible waived)[†]</i>	30% 30% 30% 30%
Durable Medical Equipment <i>(may be subject to utilization review)</i>		

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
<ul style="list-style-type: none"> Rental or purchase of DME including hearing aids (<i>hearing aids benefit is available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network</i>) 	10%	30%
Home Health Care (<i>subject to utilization review</i>) <ul style="list-style-type: none"> 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</i>) 	10%	30%
Home Infusion Therapy (<i>subject to utilization review</i>) <ul style="list-style-type: none"> 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>)
Hemodialysis <ul style="list-style-type: none"> Outpatient hemodialysis services & supplies 	10%	30% (<i>benefit limited to \$350/visit for free standing hemodialysis center</i>)
Hospice Care <ul style="list-style-type: none"> Inpatient or outpatient services; family bereavement services 	No copay (<i>deductible waived</i>)	30%
Bariatric Surgery (<i>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</i>) <ul style="list-style-type: none"> Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity Travel expenses for an authorized, specified surgery (<i>recipient & companion transportation limited to \$3,000 per surgery</i>) 	10%	Not covered ^f
Organ & Tissue Transplants (<i>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] and CME for out of California</i>) <ul style="list-style-type: none"> Inpatient services provided in connection with non-investigative organ or tissue transplants Transplant travel expense for an authorized, specified transplant (<i>recipient & companion transportation limited to \$10,000 per transplant</i>) Unrelated donor search, limited to \$30,000 per transplant 	10%	Not covered ^f
Prosthetic Devices <ul style="list-style-type: none"> 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%

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 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.

‡ 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.).

§ 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.

Premier Plan-Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.
Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Evidence of Coverage (EOC).

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 Evidence of Coverage (EOC).

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 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 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, except as specified as covered in the EOC. Routine hearing tests.

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

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

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

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

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan. This exclusion includes,

but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).

Sterilization Reversal. Reversal of sterilization.

Infertility Treatment. Services or supplies furnished in connection with the diagnosis and treatment of infertility, except as specifically stated in the EOC.

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+F6 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.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

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

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

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

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

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

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

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

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

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

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

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

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.

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

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

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.

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.



Modified 10/25/40 20% Self-Injectable \$100 Brand Deductible Prescription Drug 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 (deductible waived)
Brand name formulary	\$25.00 ¹ (when no generic equivalent available, deductible waived)
Brand name non-formulary	\$40.00 ¹ (when no generic equivalent available, deductible waived)

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: <i>(assuming deductible has been met)</i>	\$25.00 copay	\$25.00 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.

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 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 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, means some drugs require prior authorization before you can get them (this is similar to prior authorization for medical services). Prior authorization applies to 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
Calendar Year Brand Deductible	\$100/member Maximum of three separate deductibles/family
Retail Pharmacy	
➤ Female oral contraceptives generic and single source brand	No copay (deductible waived)
➤ Preventive Immunizations administered by a retail pharmacy	No copay (deductible waived)
➤ Generic drugs	\$10 (deductible waived)
➤ Brand name formulary drugs ¹	\$25 (when no generic equivalent available; deductible waived)
➤ Brand name non-formulary drugs ¹	\$40 (when no generic equivalent available; deductible waived)
➤ Compound Drugs ¹	\$40
➤ Self-administered injectable drugs, except insulin	20% of prescription drug maximum allowed amount (maximum \$150 copay)
Home Delivery	
➤ Female contraceptives generic and single source brand	No copay (deductible waived)
➤ Generic drugs	\$10 (deductible waived)
➤ Brand name formulary drugs ¹	\$50 (when no generic equivalent available; deductible waived)
➤ Brand name non-formulary drugs ¹	\$80 (when no generic equivalent available; deductible waived)
➤ 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 (deductible waived)
➤ Brand name formulary drugs ¹	\$25 (when no generic equivalent available; deductible waived)
➤ Brand name non-formulary drugs ¹	\$40 (when no generic equivalent available; deductible waived)
➤ 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 deductible (if applicable) & retail pharmacy copay plus: 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug 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)
➤ Home Delivery	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 of the 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
- 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 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 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 is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Take care of yourself

Remember to get preventive care

Getting regular checkups and exams can help you stay well and catch problems early. It may even save your life.

Our health plans cover 100% of the services listed in this preventive care flier.¹ When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket. You may have to pay part of the costs if you use a doctor outside the network.

Preventive versus diagnostic care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses.

For example, say your doctor suggests you have a colonoscopy because of your age when you have no symptoms. That's preventive care. On the other hand, say you have symptoms and your doctor suggests a colonoscopy to see what's causing your symptoms. That's diagnostic care.

Here's a listing of the types of preventive services we cover. See your benefit plan to learn more.

Child preventive care (birth through 18 years)

Preventive care physical exams are covered. So are the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Ask your doctor what's right for you.

Preventive physical exams

Screening tests (depending on your age) may include

- Behavioral screening and counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- Lead testing
- Newborn screening
- Oral (dental health) assessment
- Screening and counseling for obesity
- Screening and counseling for sexually transmitted infections
- Type 2 diabetes screening
- Vision² screening

Take care of yourself (continued)

Immunizations

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b (Hib)
- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chicken pox)

Adult preventive care (19 years and older)

Preventive care physical exams are covered. So are the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Ask your doctor what's right for you.

Preventive physical exams

Screening tests and services (depending on your age) may include

- Aortic aneurysm screening (men who have smoked)
- Blood pressure
- Bone density test to screen for osteoporosis
- Breast cancer, including exam and mammogram
- Breastfeeding support, supplies and counseling (female)^{3,4}
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and CT colonography (as appropriate)
- Contraceptive (birth control) counseling and FDA-approved contraceptive medical services provided by a doctor, including sterilization (female)^{4,5}
- Depression screening
- Eye chart test for vision²
- Height, weight and BMI
- HIV screening and counseling
- HPV screening (female)⁴
- Intervention services (includes counseling and education):
 - Behavioral counseling to promote a healthy diet
 - Counseling related to aspirin use for the prevention of cardiovascular disease (does not include coverage for aspirin)
 - Counseling related to genetic testing for women with a family history of breast or ovarian cancer
 - Counseling related to chemoprevention for women with a high risk of breast cancer
 - Primary care intervention to promote breastfeeding

Take care of yourself (continued)

- Screening and behavioral counseling related to alcohol misuse
- Screening and behavioral counseling related to tobacco use
- Screening and counseling for interpersonal and domestic violence
- Screening and counseling for obesity
- Pelvic exam and Pap test, including screening for cervical cancer
- Prostate cancer, including digital rectal exam and PSA test
- Screenings during pregnancy (including, but not limited to, gestational diabetes⁴, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV)
- Sexually transmitted infections
- Immunizations
- Type 2 diabetes screening

Immunizations

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A
- Hepatitis B
- HPV
- Influenza (flu)
- Meningococcal (meningitis)
- MMR
- Pneumococcal (pneumonia)
- Varicella (chicken pox)
- Zoster (shingles)

This sheet is not a contract or policy. If there is any difference between this sheet and the group policy, the provisions of the group policy will govern. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for Exclusions & Limitations.

- 1 The range of preventive care services covered at no cost share when provided in-network are designed to meet the requirements of federal and state law. The Department of Health and Human Services has defined the preventive services to be covered under federal law with no cost-share as those services described in the U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your Ohio insurance policy. To learn more about what your plan covers, see your certificate of coverage or call the customer care number on your ID card.
- 2 Some plans cover additional vision services. Please see your contract or Certificate of Coverage for details.
- 3 Breast pumps and supplies must be purchased from an in-network medical provider for 100% coverage; we recommend using an in-network durable medical equipment (DME) supplier.
- 4 This benefit is covered under health care reform's women's preventive services. For group plan members, these services are covered with policy years beginning after August 1, 2012. For members with individual coverage, these benefits are effective for new members on or after August 1, 2012 and for current members on January 1, 2013. This benefit also applies to those younger than 19.
- 5 To get 100% coverage for a covered prescription for birth control, it must be a generic drug or a brand-name drug that doesn't have a generic equivalent. Also, you'll need to fill the prescription at an in-network pharmacy. A cost-share may apply for other prescription contraceptives, based on your drug benefits.

Got ID cards?

We know the peace of mind your member identification (ID) card brings you and your loved ones. That's why Anthem Blue Cross (Anthem) and Anthem Blue Cross Life and Health Insurance Company have made sure you never have to leave home without it.

If you have not yet received your permanent ID card and want to access health care services, you can print a temporary ID card online through our website, anthem.com/ca.

Tell me how

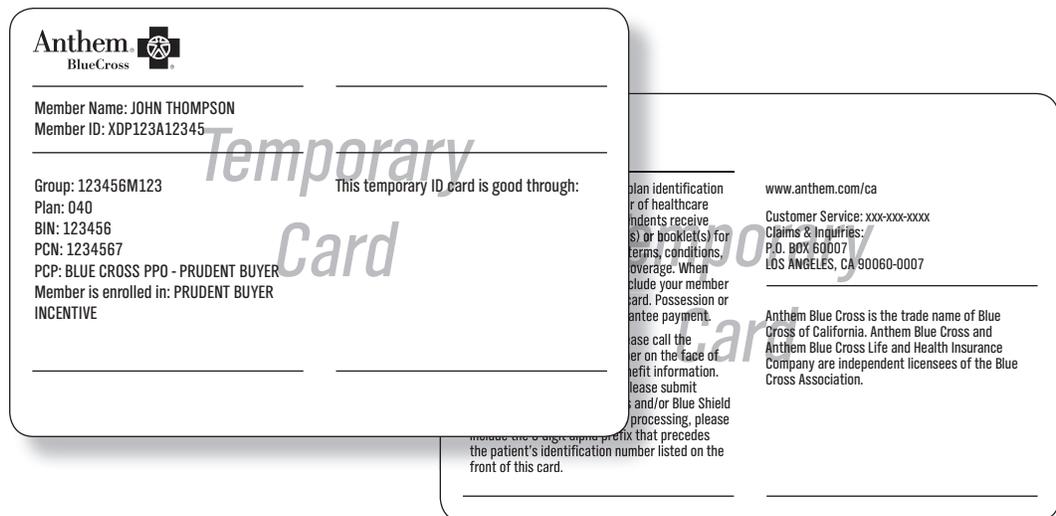
It's a simple four-step process:

1. Before starting, check with your employer to confirm your information has been added into Anthem's system. Your name, date of birth and ZIP code must match exactly what is on file with Anthem. You cannot register before your plan effective date.
2. Go to anthem.com/ca, in the top-right corner log in to the secure Member site. If you have not visited this site before, you will need to establish an account by clicking on "Register." When you are asked for a member ID number during online registration, enter it as it appears on your member ID card. If you do not have your member ID number, call Anthem Customer Service or get it from Human Resources.
3. Click the "Customer Support" tab in the top right corner. Select the "Print Temporary ID Card" option and follow the instructions on how to create and print the temporary ID card.
4. You can print the ID card using your own printer and use the card at your next doctor's appointment.

Take a look at a sample below.

Note: The temporary ID card may not include all of your benefit information.

If you have any questions, a Customer Service number is on the temporary ID card. We hope this option gives you the peace of mind you and your family deserve.



Coverage While Traveling or Temporarily Residing Outside California (HMO/POS)

You are always covered by your Anthem Blue Cross plan. Whether you're traveling on business, away for fun or temporarily out-of-state, your coverage travels with you. The BlueCard® program gives you access to the various Blue Cross provider networks across the U.S. You'll have access to medical care most anywhere you're staying.

Emergency Care

If you need emergency care, you should call 911 or go to the nearest hospital without contacting Anthem first. Just give us a call within 24 hours or as soon as reasonably possible.

For urgent or follow-up care — it's as easy as accessing your local network

When you may need urgent care or follow-up medical care that can be performed on an outpatient basis (for example, removal of stitches, allergy shots or care following emergency services) — getting medical care away from home is as convenient as accessing the local network with just one added step.

1. Find a provider from the BlueCard listing. Like when at home, you can search online at anthem.com/ca or call the member services number on your member ID card. You can also call BlueCard Access at 800-810-BLUE (2583).
2. (This is the additional step.) Call Anthem Member Services to verify your coverage.
3. Show your ID card at the time of service.

Enjoy your travels. We're happy to go with you.

Coverage While Traveling (PPO)

You are always covered by your Anthem Blue Cross plan (Anthem). Whether you're traveling on business, away for fun or temporarily living in another state, your coverage travels with you. The BlueCard® program gives you access to the various Anthem Blue Cross provider networks across the U.S. You'll have access to medical care most anywhere you're staying.

It's as easy as accessing your local network.

Getting medical care away from home is as convenient as accessing the local network — with just one added step.

1. Find a provider from the BlueCard listing. Like when at home, you can search online at anthem.com/ca or call the member services number on your member ID card. You can also call BlueCard Access at 800-810-BLUE (2583).
2. (This is the additional step.) Call Anthem member services to verify your coverage.
3. Show your ID card at the time of service.

One additional step. No additional hassles. BlueCard providers, just like Anthem network providers, will file your claims for you. Anthem will still send your explanation of benefits so you can double check how the service was covered.

As always, if you need emergency care, you should go to the nearest hospital without contacting Anthem first. Just give us a call within 24 hours or as soon as reasonably possible.

Enjoy your travels. We're happy to go with you.



Kids leaving home? Let Anthem go, too.

Have dependents living outside California? They may be eligible for coverage under your HMO or Point-of-Service (POS) plan.

Find out how!

Call the Anthem Blue Cross Guest Membership Program at 800-827-6422. They have everything you need to get started:

- Verify provider availability in the area where your dependent lives.
- Request a Guest Membership application.
- Get help in submitting your Guest Membership application and answers to any questions you have along the way.

Across the country

You and your dependents living outside California may be able to enroll in HMO coverage with a partner Blue Cross and Blue Shield plan under our Guest Membership Program. The Guest Membership Program is for members who will be temporarily residing outside their home state for a minimum of 90 days. The following states participate in the Anthem Blue Cross Guest Membership Program.*

Arizona	Illinois	Minnesota	Ohio
Arkansas	Indiana	Missouri	Oklahoma
Colorado	Kentucky	Nevada	Pennsylvania
Connecticut	Louisiana	New Hampshire	Rhode Island
Delaware	Maine	New Jersey	South Carolina
Florida	Maryland	New Mexico	Texas
Georgia	Massachusetts	New York	Virginia
Hawaii	Michigan	North Carolina	Wisconsin

*These states may have regions that are not covered. Therefore, applicants can still be denied coverage if the region within the guest state does not have Away From Home Care (AFHC) providers.

Thank you for choosing Anthem Blue Cross as your health plan.

Your pharmacy benefits

We're glad you're part of our prescription drug plan. We think it's important for you to have access to a wide range of affordable medicines. And we work hard to provide you with the best service. If you have any questions about your plan, call us at the phone number on your member ID card.

Save money on your prescriptions

Here are some easy ways to get the most from your plan – and save on your medicine.

Choose the drugs you need from our drug list

Our drug list (sometimes called a formulary) is a list of prescription drugs covered by your plan. It's made up of hundreds of brand-name and generic drugs. We research drugs and choose ones that are safe, work well and offer the best value. Sometimes we update the drug list when new drugs come to market, or if new research becomes available. If your plan uses a tiered drug list, view the drugs we cover at www.anthem.com/ca/national4tier.

You'll save money by taking medicines that are on the drug list. Drugs that aren't on the list may have a higher copay or may not be covered, depending on your plan.

Also, some drugs need our review and need to get an OK from us before the prescription is filled to make sure they're covered. This is called **prior authorization**. This review focuses mainly on drugs that may have:

- A risk of serious side effects or drug interactions
- High potential for incorrect use or abuse
- Better alternatives that may cost less
- Rules for use with very specific conditions

Your pharmacist will tell you if your drug needs prior authorization.

Try generic drugs

Generic drugs cost much less than most brand-name drugs. So ask your doctor if there's a generic choice for your medicine – and if it might work for you. Generic drugs are approved by the Food and Drug Administration (FDA) and work as well as the brand-name choices.

Use over-the-counter (OTC) drugs when you can

You don't need a prescription for OTC drugs. They often have the same active ingredients as the prescription versions but usually cost a lot less. OTC allergy and heartburn medicines are good examples. Just ask your doctor if it's okay to swap your prescription drug for an OTC medicine.

Your pharmacy benefits (continued)

Visit in-network pharmacies

Our retail pharmacy network includes more than 64,000 pharmacies across the country, including major chains, grocery stores and independent pharmacies. That means you have easy access to your medicine wherever you are – at work, at home or even on vacation. Using pharmacies in the network will help save money. And when picking up your prescription at the pharmacy, don't forget to show your member ID card.

To make sure your pharmacy is in our network, visit [anthem.com/ca](https://www.anthem.com/ca). Click on **Prescription Benefits** and sign in. On the pharmacy page, click on **Find a Pharmacy**.

Sign up for our convenient Home Delivery Pharmacy

Home delivery is a safe, easy way to get medicine you need on a regular basis. Prescriptions are sent to your home within two weeks from the time the pharmacy gets your order. Pharmacists can answer your drug questions by phone any time. Plus, you may be able to save money on your medicine.

Our Home Delivery Pharmacy is managed by Express Scripts. See the next page to learn how to get started.

Get support from our specialty pharmacy

Accredo, the Express Scripts specialty pharmacy, provides medicine and support and for people with complex and long-term conditions. Specialty drugs come in different forms like pills or liquids. And some need to be injected, infused or inhaled. These drugs often need special storage and handling and may be given to you by a doctor or nurse.

Accredo's programs help people with some complex conditions. These programs teach you about treatment for your condition and help you understand and cope with drug side effects. Nurses and pharmacists will even set up time with you to find out how you are doing.

Call 888-773-7376, Monday through Friday, 8 a.m. to 9 p.m., Eastern time, to learn how Accredo's condition support programs can help you better manage your health condition.

Information at your fingertips

Wherever you are, you can easily access your pharmacy information online.

Check out [anthem.com/ca](https://www.anthem.com/ca)

Simply click on Prescription Benefits and sign in. Once you're signed in, you'll have access to lots of tools and drug information, all in one spot. You can check order status, order refills, price a drug, renew a prescription and much more. And when you're on the go, just type [anthem.com/ca](https://www.anthem.com/ca) into any mobile web browser to find in-network pharmacies near you. You can also find in-network doctors, hospitals and ERs.

Getting started with Home Delivery Pharmacy

If you take prescribed medicine on a regular basis, you can get up to a 90-day supply mailed right to your door.* Here's how to start:

Step one

Create a profile with your contact information and billing information

There are two ways to do this:

- **By phone:** Call 866-297-1013, or
- **Online:** Log into [anthem.com/ca](https://www.anthem.com/ca).
 - Click on "Prescription Benefits," (if you haven't done so, register on [anthem.com/ca](https://www.anthem.com/ca)).
 - Click on "Switch to Home Delivery." You'll be sent to the Express Scripts website.
 - Click on "My Profile & Settings" and complete the following sections:
 - + Your personal information
 - + Payment method

Remember, we cannot process your order without having your contact and billing information on file.

Step two

See your doctor for a prescription for a 90-day supply of your medicine

You'll need a 90-day supply of your prescription for your first Home Delivery Pharmacy order. But you should also ask your doctor to write you another prescription for an additional 30-day supply. This is so you can get the 30-day supply filled at your local pharmacy while your first Home Delivery order is being processed.

Step three

Send us your prescription

There are two ways you can put your first order in:

- **By Fax:** Ask your doctor to fax us your prescription and member ID card to 866-272-8856
- **By mail:** Go to [anthem.com/ca](https://www.anthem.com/ca) and download a form and mail it to us
 - Log in then click on "Refill a Prescription." You'll be sent to the Express Scripts website.
 - Click on "Fill a New Prescription," then "Print an Order Form."
 - You can choose to print a blank form or one that has your information already on it.
 - Click on "Print Your Form."
 - Fill out the form and mail it with your prescription to:

Home Delivery Pharmacy
PO Box 66558
St. Louis, MO
63166-6558

Important: All prescriptions and refills, including those submitted by your physician, are processed as soon as they are received. Please do not submit your prescription unless you are ready to have it filled.

Step four

Pay for your prescription

The Home Delivery Pharmacy accepts many payment methods. Use the option that's best for you. You can pay with a check, money order, major credit card or debit card. You can also keep a major credit card on file for easy payments. With this option, you can increase or decrease the maximum limit charged to the card to help you manage your out-of-pocket costs more effectively. For more information or questions about credit card payments, please call the number on your ID card.

Important to know

Your medicine will be sent to your home within two weeks from the time the Home Delivery Pharmacy gets your order. If you need your medicine sooner, call 866-297-1013 to ask for your order to be sent overnight. You will be charged an additional fee. Your order will be sent through the post office, UPS or FedEx. Please note, with some medicines, you may have to sign to accept delivery.

Need to order refills? It's even easier!

You can order refills by phone, mail or at anthem.com/ca. Refills take about three to five days to process and ship. Here's how to order a refill:

By phone

- Have your prescription label and credit card ready.
- Call 866-297-1013 and select "Automated Refill Order Line" from the menu. Or press zero any time to speak with a representative. If you are speech or hearing impaired, call 800-899-2114.
- Follow the prompts to place your order.

By mail

Fill out the order form that you got with a previous order. Attach your label from the medicine or write your refill number in the space provided. Mail the form and your payment to the Home Delivery Pharmacy address.

Online

- Log in (username/password required) and click "Pharmacy."
- Under Pharmacy Self Service, click "Order a Refill."
- You will be redirected to the Express Scripts site.
- Choose the drugs you want to refill, and click "Add Refills to Cart."
- Review the order, shipping method, payment method, medical information and contact information.
- Click "Place My Order."

Auto Refill

Follow the first three steps above for ordering refills online, then:

- Click the "Setup Auto Refills" tab
- Follow the easy steps to Select prescriptions, choose refill dates and review your order.

We're here to help

If you have questions about how to get started with the Home Delivery Pharmacy, just give us a call at 866-297-1013, 24 hours a day, 7 days a week.



HOME DELIVERY PHARMACY ORDER FORM

To MAIL your prescription:

1. "Patient" box must be filled out.
2. Have your Doctor write a prescription.
3. Send your new prescription along with this completed form to:
Express Scripts Home Delivery Service
PO Box 66558
St. Louis MO 63166-6558

To FAX your prescription:

1. Both "Dr/Prescriber" and "Rx Form" boxes must be filled out.
2. Doctor can fax to: 1-866-272-8856
 - **Class II prescriptions cannot be faxed.**
 - Faxes will only be accepted from a doctor's office.

PATIENT

Member ID: _____

First Name: _____ Last Name: _____

Date of Birth: _____ Phone: _____

Address: _____

E-mail: _____

Allergies: _____

Health Conditions: _____

Over-the-Counter Medications: _____

DOCTOR/PRESCRIBER

DEA: _____

Name: _____

Address: _____

Phone: _____

Fax: _____

PATIENT OPTIONS

- I want non-child resistant caps, when available.
- I want a copy of my bottle label in large print on a separate sheet of paper.
- Check here for rush delivery. Once your order is received and filled, it will be shipped overnight for \$21.

If you want to make a payment or update your health conditions, please visit your health plan provider's website.



2161



Rx			
_____	_____	Date: ___ / ___ / ___	
First Name	Last Name		
Drug Name/Form/Strength	Qty	Directions for Use	Refills
X _____ Doctor/Prescriber Signature – Substitution Permissible		X _____ Doctor/Prescriber Signature – Dispense as Written	
Stamped signatures cannot be accepted.			

Important Confidentiality Notice: This and any documents accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.



Health, Wellness & Anthem Advantages

Your Anthem plan has so much to offer, you won't want to miss a thing.

Register at anthem.com/ca today!

Understanding your health plan just got a whole lot easier.

Your health; what's more important? So shouldn't understanding your health plan be just as important? We think so. So we made it easier, with anthem.com/ca.

Once you register, you'll see how anthem.com/ca makes complex information easy to understand and easy to use. You'll be able to know what's covered and what's not, what your costs will be for procedures, prescription drugs, doctor visits and so much more. Not only that, you can also save money and live better with our online tools that keep you informed, in control and at your healthy best. Take a look at all you can do:

Get an idea of what your costs will be before you go

Did you know that different hospitals and facilities charge different amounts for the same services? Now you can know your cost before you set foot in the hospital by going to anthem.com/ca. By getting an estimate of your costs based on the benefits of your health plan, you can choose a facility that fits your budget.

To learn more visit anthem.com/ca/costvideo.

Find a Doctor (dentist, pharmacy or hospital)

You can search for doctors, hospitals and other health care facilities quickly online. You can also make your search more specific by choosing a specialty or entering the name of a doctor or facility. And, if you're away from home, you can also search our National Directory.

To search our online Provider Finder:

- Log in at anthem.com/ca
- Select "Find a Doctor" and follow the steps on the screen.

Print a temporary ID card

If you haven't received your permanent ID card yet and want to access health care services now, you can print your temporary ID card online.* Your temporary ID card expires 30 days after its issue date and isn't meant to replace your permanent ID card, which you'll still get in the mail.

*Not all members may be able to request a temporary ID card.

To learn about all the great tools on anthem.com/ca go to anthem.com/ca/guidedtour

Your Anthem plan has so much to offer, you won't want to miss a thing. (continued)

Get members' only discounts on health-related products and services through SpecialOffers

Enjoy discounts such as 20% savings on vitamins and supplements. Save \$20 with a minimum purchase of \$100, plus free shipping and free returns at 1-800 CONTACTS and Glasses.com. Get more from your membership by exploring over 50 discounts available to you.

Health and wellness information with lots of personal support

Keeping you healthy is our main goal. Helping you do it makes us happy. So let's get you going.

Take the online MyHealth Assessment. It's your first step toward a healthier lifestyle.

Health Assessment is a private questionnaire that you fill out online. This is the place where we can get a good picture of your current health situation, future health goals and possible health risks. Once you fill out the questionnaire you'll get a health assessment score and a risk profile based on your answers. You'll also get tips and action plans to help you improve your health.

For a look at how MyHealth Assessment works go to anthem.com/ca/guidedtour/assessment.

Keep your health history organized in one safe place with MyHealth Record

Enter your personal medical information to keep on file for easy access for everyday use or if there's an emergency. You can enter dates of immunizations, tests and screenings, prescription and over-the-counter drugs you take, medical conditions and more. You can also print your information so you can easily share it with your doctors. This can help avoid potential drug interactions and taking the same tests and procedures more than once.

To learn more about MyHealth Record go to anthem.com/ca/guidedtour/record.

Achieve your health goals with the help of Healthy Lifestyles

Whether you'd like to lose weight, stop smoking, stress less and exercise more, you'll get the support you need with Healthy Lifestyles online tools and resources. Take advantage of online fitness tracking and customized workout plans, discounts on spa services and massage therapists, healthy recipes, quit smoking programs and more. Plus, you can get added support from our online community forums.

Isn't it time your life got a little easier. If you're not already registered at anthem.com/ca, why not do it now? It's fast, secure and oh so easy!

360° Health® programs

Options. Extras. Support. Helping you improve your health and wellness.

Your health goals and needs are as unique as you are. What's right for one person is not always right for another. Maybe you're managing a health condition. Or maybe you want to stay healthy, eat better or get in shape. Whatever your needs, Anthem gives you a choice of programs to help you meet your personal goals in a way that fits you and helps you live your life to the fullest. From tips and tools to help you learn about preventive care to nurses who can answer your health questions anytime, 360° Health can help you take better control over your health. And it can give you the power to make the decisions that are right for you.

To learn more about 360° Health, go to anthem.com/ca. Look under Health and Wellness. Here are programs we offer:

24/7 NurseLine

Round-the-clock access to health information can really help your peace of mind and your physical well-being. That's why we have registered nurses ready to speak with you about your general health issues any time of the day or night. Just call the 24/7 NurseLine toll-free number to get answers to questions like these:

- Can the problem be treated at home?
- Do you need to see your doctor?
- Should you go to the emergency room or urgent care for this? Where is the nearest one?

Making the right call can help you avoid unnecessary worry and costs. And, most importantly, it can help safeguard your health and the health of your family. To learn more visit anthem.com/ca/nurseline_video.

To reach 24/7 NurseLine, just call the customer service number on your ID card and ask to speak to a 24/7 NurseLine representative.

Future Moms

If you are pregnant, we know your goal is to have a safe delivery and a healthy baby. Our Future Moms program helps you make healthy choices while you're pregnant and when you deliver your baby. Register for Future Moms and you'll get:

- 24/7 toll-free access to a registered nurse who'll answer your questions and talk to you about pregnancy-related issues. Our nurses will also call to see how you're doing.
- A helpful book: ***Your Pregnancy Week by Week*** and a maternity care diary.
- Tips and facts to help you handle any unexpected events.
- A questionnaire to see if you're at risk for preterm delivery.
- Useful tools to help you, your doctor and your Future Moms nurse track your pregnancy and spot possible risks.

Enroll in Future Moms by calling the customer service number on your ID card. Ask to speak to a Future Moms representative. To learn more visit anthem.com/ca/futuremoms_video.

360° Health[®] programs (continued)

ConditionCare

If you or a covered family member has an ongoing illness or health problem, let us help you get more out of life. Our ConditionCare nurses help people of all ages take care of the symptoms of asthma and diabetes. And they work closely with adults who have chronic obstructive pulmonary disease (COPD), heart failure and coronary artery disease. With ConditionCare you'll get the tools you need to help you feel your very best. Our ConditionCare nurses gather information from you and your doctor. Then they create a personalized plan for you.

Information and support are as close as your phone. Call the customer service number on your ID card and ask to speak to a ConditionCare Nurse. To learn more visit anthem.com/ca/conditioncare_video.

MyHealth Advantage

MyHealth Advantage can keep you and your bank account healthier.

Here's how it works: We review your health status daily and check to see what medications you're taking. If we see that any of your medicines could interact with each other, we contact your doctor right away. We also keep track of when you need routine tests and checkups. If we notice anything that needs attention, we send you a reminder called a "MyHealth Note". MyHealth Note has a summary of all your recent claims. And from time to time, we give you tips on how to save you money on your medications. To learn more visit anthem.com/ca/myhealthadvantage_video.

Behavioral Health Resource

Dealing with complex mental health and medical conditions can be confusing and frustrating. But you don't have to face them alone. Our program can help guide you through your mental and physical health care challenges. The program's care managers are licensed mental health professionals. They'll work closely with you to make a plan that can help you meet your mental health goals and tackle any barriers that might get in the way. The care managers will also make sure that all of your doctors and anyone else giving you care all work together so that you get the best care. They'll also help you get the most value from your plan benefits.

To learn more, call the customer service number on your ID card and ask to speak to a Behavioral Health Resource representative.

Get the most from your Anthem Blue Cross benefits

We want to help you get maximum value from your health care benefits — and from your health care dollars. Here are some tips that can help you do both.

Use network providers

With more than 53,500 health care professionals and nearly 400 hospitals in our California network, you have many excellent, affordable choices.

Your out-of-pocket costs are lower in network

- Network providers accept negotiated reimbursement fees as payment in full for covered services.
- You are generally only responsible for your copay and/or coinsurance for covered services.

Other advantages of staying in network

- Network providers file claims for you.
- They obtain preauthorizations for you.
- When needed, they refer you to other network doctors, hospitals or facilities, where your costs are also lower.
- As your health care advocate, they help ensure you receive appropriate, cost-effective care.

Understand non-network costs and responsibilities

- Your PPO benefits give you the flexibility to seek out-of-network health care, but you will share more of the costs — which can add up quickly.

Why non-network care costs more

- Many non-network provider fees exceed customary and reasonable rates, which can mean higher out-of-pocket costs for you.
- In addition to your copay and/or coinsurance for covered services, you will owe any difference between our reimbursement and the provider's total bill.

Your non-network responsibilities are greater

When you go out of network, **you** are responsible for:

- Filing claims
- managing paperwork
- obtaining any necessary preauthorizations
- paying provider bills
- determining whether any referrals are in network or out of network

Be an informed consumer

At Anthem Blue Cross, we're committed to sharing information that can help you make health care decisions that work for you and your family. Because a little knowledge can help keep your health care costs down, it pays to be informed. When you or a family member need non-emergency care:

- Log on to anthem.com/ca
- Select *Find a Doctor*.
- Follow the prompts for a list of network doctors and hospitals in your area.

With our strong California PPO network, you're likely to find quality, affordable health care close to home or work. If you don't see a provider listed on our website, they are not in the network. But, if medically necessary, your network doctor can request a non-network authorization. Call Customer Service for details.

Remember, you enjoy more savings — and more convenience — with network providers.

Anthem Blue Cross is the trade name of Blue Cross of California, Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark. © The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Get the most from your Anthem Blue Cross benefits (continued)

Thank you for choosing Anthem Blue Cross; we appreciate the opportunity to serve you. Anytime you have questions, please call Customer Service.

In an emergency*

Your health always comes first. In an emergency, go to the closest emergency room immediately. You, a family member or your treating physician should call your primary care physician or medical group as soon as possible so that your network doctor — who knows your health history — can direct your care. This is especially important if you are at a non-network hospital. Involving your network doctor right away may mean quicker transfer to a network hospital, where your out-of-pocket costs will be much lower. As soon as possible, you or a representative should call us at the toll-free Customer Service number on your member ID card. The earlier we're aware of your situation, the better we can help you get the most from your benefits.

Always keep this information handy

To help ensure you get the right health care for you — in any situation — you should always carry:

- Your Anthem Blue Cross ID card
- Your primary care physician's name and phone number
- The names and numbers of any specialty doctors you're seeing
- A list of all prescription and non-prescription medications you're taking, including dosage and frequency

* Anthem Blue Cross defines an emergency as: A sudden, serious and unexpected illness, injury or health problem (including sudden and unexpected severe pain) that requires immediate care.

Visit [anthem.com/ca](https://www.anthem.com/ca) today

As an Anthem Blue Cross member, you get 24/7 access to online tips and tools that:

- Support your healthy lifestyle
- Encourage essential preventive care
- Connect you with important health improvement programs
- Help you be a savvy health care consumer



Information You Should Know

Managing your care if you need to go to a hospital or get certain medical treatment

If you or a family member needs certain types of medical care (for example: surgery, treatment in a doctor's office, physical therapy, etc.), you may want to know more about these programs and terms. They may help you better understand your benefits and how your health plan manages these types of care.

Utilization management

Utilization management (UM) is a program that is part of your health plan. It lets us make sure you're getting the right care at the right time. Our UM review team, made up of licensed health care professionals such as nurses and doctors, do medical reviews. The team goes over the information your doctor has sent us to see if the requested surgery, treatment or other type of care is medically needed. The UM review team checks to make sure the treatment meets certain rules set by your health plan. After reviewing the records and information, the team will approve (cover) or deny (not cover) the treatment. The UM review team will let you and your doctor know as soon as possible.

We can do medical reviews like this before, during and after a member's treatment. Here's an explanation of each type of review:

The prospective or pre-service review (done before you get medical care)

We may do a prospective review before a member goes to the hospital or has other types of service or treatment. Here are some types of medical needs that might call for a prospective review:

- A hospital visit
- An outpatient procedure
- Tests to find the cause of an illness, like magnetic resonance imaging (MRI) and computed tomography (CT) scans
- Certain types of outpatient therapy, like physical therapy or emotional health counseling
- "Durable medical equipment" (DME), like wheelchairs, walkers, crutches, hospital beds and more

The concurrent review (done during medical care and recovery)

We do a concurrent review when you are in the hospital or are released and need more care related to the hospital stay. This could mean services or treatment in a doctor's office, regular office visits, physical or emotional therapy, home health care, durable medical equipment, a stay in a nursing home, emotional health care visits and more. The UM review team looks at the member's medical information at the time of the review to see if the treatment is medically needed.

Managing your care if you need to go to a hospital or get certain medical treatment (continued)

The retrospective or post-service review (done after you get medical care)

We do a retrospective review when you have already had surgery or another type of medical care. When the UM review team learns about the treatment, they look at the medical information the doctor or provider had about you at the time the medical care was given. The team then can see if the treatment was medically needed.

Case management

Case managers are licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

Preauthorization

Preauthorization is the process of getting approval from your health plan before you get services. This process lets you know if we will cover a service, supply, therapy or drug. We approve services that meet our standards for needed and appropriate treatment. The guidelines we use to approve treatment are **based on standards of care in medical policies, clinical guidelines and the terms of your plan**. As these may change, **we review our preauthorization guidelines regularly**. Preauthorization is also called “precertification,” “prior authorization,” or “pre-approval.”

Here’s how getting preauthorization can help you out:

Saving time. Preauthorizing services can save a step since you will know if you are eligible and what your benefits are before you get the service. The doctors in our network ask for preauthorization for our members.

Saving money. Paying only for medically necessary services helps everyone save. Choosing a doctor who’s in our network can help you get the most for your health care dollar.

What can you do? Choose an in-network doctor. Talk to your doctor about your conditions and treatment options. Ask your doctor which covered services need preauthorization or call us to ask. The doctor’s office will ask for preauthorization for you. Plus, costs are usually lower with in-network doctors.

If you choose an out-of-network provider, be sure to call us to see if you need preauthorization. Non-network providers may not do that for you. If you ever have a question about whether you need preauthorization, just call the preauthorization or precertification phone number on your ID card.

There are times when we may need to do a benefit review for a health care service you plan to receive or have already received. We do this to find out what your plan will cover for that service. During the review, we take a look at the terms, benefits, limitations and exclusions of your particular plan. This means we may check to see if your plan covers the service, if you’ve already reached a benefit limit for the service, and if you can see a provider outside of the network. We may also review other aspects of your plan.

Your rights and responsibilities as a member

As a member you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights". And helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and federal laws, and our privacy rules.
- Get information about our company and services, and our network of doctors and other health care providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your health care plan and in the way your plan works.
- Make a complaint or file an appeal about:
 - Your health care plan
 - Any care you get
 - Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future
- Participate in matters that deal with the company policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.

Your rights and responsibilities as a member (continued)

You have the responsibility to:

- Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan says that you to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all health care plan rules and policies.
- Let our Customer Service department know if you have any changes to your name, address or family members covered under your plan.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.

For details about your coverage and benefits, please read your "Subscriber Agreement".

Important legal information you should take time to read

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act explains your rights for treatment under the health plans if you need a mastectomy. Plain and simple... we're here for you.

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.
- All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance.

HIPAA NOTICE OF PRIVACY PRACTICES

The HIPAA Notice of Privacy Practices explains the rules around how we handle your private information under HIPAA laws. Plain and simple... we don't share your information unless it's needed to manage your benefits or you give us the OK to do it.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

Important legal information you should take time to read (continued)

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.

Important legal information you should take time to read (continued)

- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people, who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. They can help you apply your rights, file a complaint, or talk with you about privacy issues.

Important legal information you should take time to read

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This Notice is provided by the following companies: **Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company**

STATE NOTICE OF PRIVACY PRACTICES

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice.

We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

Because PI is defined as any information that can be used to make judgements about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.



Language Assistance Notice

Effective January 1, 2009

IMPORTANT: An interpreter can be provided for you to communicate with your doctor or health plan at no cost. To get an interpreter or to ask about written information in your language, please contact your group administrator.

IMPORTANTE: Se le puede brindar sin costo los servicios de un intérprete para que pueda comunicarse con su médico o plan de salud. Para obtener un intérprete o para solicitar información escrita en su idioma, comuníquese con el administrador de su grupo. (Spanish)

重要提示: 您與您的醫生或保健計畫交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請聯絡您的團體行政人員。(Cantonese or Mandarin)

중요: 의사 또는 건강보험사와의 의사소통을 위하여 통역사를 무료로 이용하실 수 있습니다. 통역이나 한국어로 번역된 정보를 원하시면 그룹 담당자에게 요청하시기 바랍니다. (Korean)

MAHALAGA: Mai-alok ang tagapagsalin sa iyo nang libre upang makipag-usap ka sa iyong doktor o planong pangkalusugan. Upang kumuha ng tagapagsalin o magtanong tungkol sa nakasulat na impormasyon sa iyong lengguahe, paki-usap ang tagapangasiwa ng iyong pangkat. (Tagalog)

CHÚ Ý QUAN TRỌNG: Quý vị có thể được thông dịch viên giúp đỡ miễn phí khi quý vị cần tiếp xúc với bác sĩ hoặc nhân viên trong chương trình bảo hiểm sức khỏe của quý vị. Để được thông dịch viên giúp đỡ hoặc được cấp thông tin, văn bản chuyển ngữ sang ngôn ngữ của quý vị, xin quý vị vui lòng liên lạc ban quản trị chương trình bảo hiểm. (Vietnamese)



Anthem Blue Cross Life and Health Insurance Company
Notice of Language Assistance

IMPORTANT: An interpreter can be provided for you to communicate with your doctor or health plan at no cost. To get an interpreter or ask about written information in your language, please call the phone number listed on the back of your ID card or contact your group administrator.

IMPORTANTE: Se le puede brindar sin costo los servicios de un intérprete para que pueda comunicarse con su médico o plan de salud. Para obtener un intérprete o para solicitar información en su idioma, llame al número que figura en el reverso de su tarjeta de identificación o póngase en contacto con el administrador de su grupo. (Spanish)

重要提示: 您與您的醫生或保健計畫交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請撥打您識別證背面的電話號碼，或聯絡您的團體行政人員。(Chinese)

CHÚ Ý QUAN TRỌNG: Quý vị có thể được thông dịch viên giúp đỡ miễn phí khi quý vị cần tiếp xúc với bác sĩ hoặc nhân viên trong chương trình bảo hiểm sức khỏe của quý vị. Để được thông dịch viên giúp đỡ hoặc được cấp thông tin, văn bản chuyên ngữ sang ngôn ngữ của quý vị, xin quý vị vui lòng gọi số điện thoại ghi phía sau thẻ hội viên của quý vị hoặc liên lạc ban quản trị chương trình bảo hiểm. (Vietnamese)

MAHALAGA: Mai-alok ang tagapagsalin sa iyo nang libre upang makipag-usap ka sa iyong doktor o planong pangkalusugan. Upang kumuha ng tagapagsalin o magtanong tungkol sa nakasulat na impormasyon sa iyong lengguahe, paki-tawagan ang numero ng telepono na nakalista sa likod ng iyong ID card o paki-usap ang tagapangasiwa ng iyong pangkat. (Tagalog)

중요: 의사 또는 건강보험사와의 의사소통을 위하여 통역사를 무료로 이용하실 수 있습니다. 통역이나 한국어로 번역된 정보를 원하시면 가입자님의 ID 카드 뒷면에 있는 전화번호로 연락하시거나 그룹 담당자에게 요청하시기 바랍니다. (Korean)

ԿԱՐԵՎՈՐ: Ձեր բժշկի կամ առողջապահական ծրագրի հետ հաղորդակցվելու համար՝ Ձեզ անվճար քարզմանիչ կարող է մատակարարվել: Թարգմանիչ ստանալու կամ Ձեր լեզվով գրավոր տեղեկությունների մասին հարցնելու համար՝ խնդրվում է զանգահարել Ձեր ինքնուրույն քարտի ետևի մասում գրված հեռախոսի համարով կամ կապվել Ձեր խմբային կառավարչի հետ: (Armenian)

ПОМНИТЕ: Для общения с вашим врачом или представителем плана медицинского страхования вам могут предоставить бесплатные услуги переводчика. Для того, чтобы получить услуги переводчика или попросить о предоставлении информации в письменном виде на вашем языке, пожалуйста, позвоните по номеру, который указан на оборотной стороне вашей идентификационной карты (ID card), или свяжитесь с администратором вашей медицинской группы. (Russian)

重要事項: 医師、および、ヘルスプラン担当者との意思疎通には、通訳者による通訳サービスを無料で受けることができます。通訳者サービス、または、あなたが話す言語で書かれた文書による情報を要請するには、あなたのIDカードの裏側に記載された電話番号に電話をするか、または、あなたの属するグループのアドバイザーに連絡をとってください。(Japanese)

توجه: مترجم شفاهی بصورت رایگان برای تسهیل ارتباط شما با پزشک و یا برنامه بهداشتیتان در دسترس می باشد. جهت درخواست مترجم شفاهی و یا اطلاعات کتبی به زبان مادری خود، لطفاً یا به شماره تلفن موجود در پشت کارت شناسایی (ID) زنگ بزنید و یا با مسئول گروهتان تماس بگیرید. (Persian)

ਜ਼ਰੂਰੀ ਸੂਚਨਾ: ਤੁਹਾਡੇ ਡਾਕਟਰ ਨਾਲ ਜਾਂ ਹੈਲਥ ਪਲਾਨ ਬਾਰੇ ਗੱਲਬਾਤ ਕਰਨ ਲਈ ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਏ (ਅਨੁਵਾਦਕ) ਦੀ ਸੇਵਾ ਮੁਫਤ ਦਿੱਤੀ ਜਾ ਸਕਦੀ ਹੈ। ਦੁਭਾਸ਼ੀਆਂ ਲੈਣ ਲਈ ਜਾਂ ਲਿਖਤ ਜਾਣਕਾਰੀ ਪੰਜਾਬੀ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਆਈ.ਡੀ. ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ ਜਾਂ ਆਪਣੇ ਗਰੁੱਪ ਪ੍ਰਬੰਧਕ ਨੂੰ ਸੰਪਰਕ ਕਰੋ। (Punjabi)

សារៈសំខាន់ : យើងអាចផ្តល់អ្នកបកប្រែជូនអ្នកដោយឥតគិតថ្លៃ សំរាប់ប្រាស្រ័យទាក់ទងជាមួយនឹងគ្រូពេទ្យ ឬគំរោងសុខភាពរបស់អ្នក ។ ដើម្បីទទួលបានអ្នកបកប្រែ ឬសាកសួរអំពីព័ត៌មានដែលសំរាប់ការសាខ្មែរ សូមទូរស័ព្ទទៅលេខដែលមានកត់នៅលើខ្នងអត្តសញ្ញាណប័ណ្ណរបស់អ្នក ឬទាក់ទងអ្នកគ្រប់គ្រងក្រុមរបស់អ្នក ។ (Khmer)

TSEEM CEEB: Yeej nrhiav tau ib tug neeg pab txhais lus uas yuav pab koj nrog koj tus kws kho mob los sis pawg kho mob tham pub dawb rau koj. Yog xav tau ib tug neeg txhais lus los sis xav tau cov ntawv hauv koj yam lus, thov hu mus rau tus naj npawb xov tooj nram qab koj daim ID los sis hu mus rau tus neeg saib xyuas koj pawg hauj lwm. (Hmong)

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Description of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contributing toward your or your dependents' other coverage); if a court has ordered coverage be provided for your dependents; if you meet or exceed a lifetime limit on all benefits under another health plan; or if you become eligible for assistance under a state Medicaid or SCHIP health plan with respect to cost of care under the employer's plan. However, you must request enrollment within 31 days after your or your dependents' other coverage is exceeded or ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage or domestic partnership, birth, adoption or placement for adoption or court order, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, please contact your employer's group health insurance representative.

If your health plan is subject to California state law, any special enrollment rights that apply to an eligible spouse also apply to an eligible domestic partner, as defined by your health plan.

If you have a medical condition before joining our plan, you may have to wait for coverage.

This plan has a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will pay for health care services related to that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins.

This exclusion may last up to six months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period.* However, you can cut down the length of this exclusion period by the number of days you had coverage. Most prior health coverage is considered creditable coverage and can be used to cut down the pre-existing condition exclusion if you have not had a break in coverage. The maximum allowable break in coverage is 180 days if your prior coverage was provided through an employer and ended because either:

- Your employment (or the person's employment through which you had this coverage) ended;
- The availability of coverage through employment or sponsored by an employer has terminated; or
- An employer's contribution toward health coverage has terminated.

For prior coverage that was not provided through an employer, such as individual coverage or coverage through a government program like Medicaid, the maximum allowable break in coverage is 63 days.

To reduce the six-month exclusion period by your creditable coverage, Anthem Blue Cross would need a copy of your "certificate of creditable coverage" from your prior Health Insurance Carrier. If you do not have a "certificate of creditable coverage," but you do have prior health coverage, please follow the steps below to get this information.

Other exceptions to the exclusion period include:

- Being pregnant (You will not have to wait if you are pregnant.)
- If you are under age 19
- Children who are signed up for coverage within 31 days after birth, adoption or placement for adoption

If you had recent health coverage, follow these steps to show proof of that coverage:

1. Check your last ID card from the company you had health coverage with to get the phone number or address.
2. If your coverage was through your last job and you don't know how to reach the insurance company that covered you before, call the Human Resources phone number where you used to work.
3. Check if you have a health plan booklet or other information about your coverage from that company. You may be able to find a phone number there. You can always call Anthem Blue Cross for help on how to do this.

(continued)

4. Once you have the contact information for the company that you had health coverage with, contact that company.
 - Ask how to get a “certificate of creditable coverage” or other proof that you had health coverage there.
 - Once you get your “certificate of creditable coverage” from the company, send it to the address listed on the back of your new ID card.

Need help?

We're here for you. Call us at the phone number on the back of your ID card if you have questions about coverage for pre-existing conditions. If you don't have your ID card yet, contact your Human Resources department for the phone number.

*If your health plan is not subject to California state law, the length of the pre-existing condition exclusion may be up to 12 months (or up to 18 months if you are a late enrollee). Also, the maximum allowable break in coverage may be no more than 63 days in all situations.



Don't forget to click here to give us your feedback if you have not already done so.

Once you're a member, it's easy to get answers to any questions about your plan.

Just call the number on the back of your member identification (ID) card after you get it.



Life products underwritten by Anthem Blue Cross Life and Health Insurance Company. Disability products underwritten by Anthem Life Insurance Company.

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The Healthy Lifestyles programs are administered by Healthways, Inc., an independent company.