



# Classic HMO 30/500 stay

(for groups of 51 or more)

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 \$500; Two-Party \$1,000; Family \$1,500

The following copay does not apply to the annual copay maximum:

- for infertility services

Covered Services	Per Member Copay
<b>Inpatient Medical Services</b>	
➤ Semi-private room or private room if medically necessary; meals & special diets; services & supplies including: <ul style="list-style-type: none"> <li>— Special care units</li> <li>— Operating room &amp; special treatment rooms</li> <li>— Nursing care</li> <li>— Drugs, medications &amp; oxygen administered in the hospital</li> </ul>	\$500/stay
➤ Blood & blood products	No copay
<b>Outpatient Medical Services</b> <i>(Services received in a hospital, other than emergency room services, or in any facility that is affiliated with a hospital)</i>	
➤ Outpatient surgery & supplies	No copay
➤ Diagnostic X-ray & laboratory procedures <ul style="list-style-type: none"> <li>— CT or CAT scan, MRI or nuclear cardiac scan</li> <li>— PET scan</li> <li>— All other X-ray &amp; laboratory tests <i>(including mammograms and ultrasounds)</i></li> </ul>	\$100/test \$100/test No copay
➤ Radiation therapy, chemotherapy & hemodialysis treatment	No copay
➤ Short-term Physical, Occupational, or Speech Therapy <i>(limited to a 60-day period of care after an illness or injury; additional visits available when approved by the medical group)</i>	\$30/visit
<b>Ambulatory Surgical Center</b>	
➤ Outpatient surgery & supplies	No copay
<b>Skilled Nursing Facility</b> <i>(limited to 100 days/calendar year, including residential treatment centers)</i>	
All necessary services & supplies <i>(excluding take-home drugs)</i>	No copay
<b>Hospice Care</b> <i>(Inpatient or outpatient services for members; family bereavement services)</i>	
No copay	
<b>Home Health Care</b>	
➤ Home visits when ordered by primary care physician <i>(limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less)</i>	\$30/visit
<b>Physician Medical Services</b>	
➤ Office & home visits	\$30/visit
➤ Hospital visits	No copay
➤ Skilled nursing facility visits	No copay
➤ Specialists & consultants	\$30/visit

Covered Services	Per Member Copay
<b>Short-Term Physical, Occupational, or Speech Therapy, or Chiropractic Care when Ordered by the Primary Care Physician</b> <i>(limited to a 60-day period of care after an illness or injury; additional visits available when approved by the medical group)</i>	\$30/visit
<b>Acupuncture</b>	\$30/visit
<b>Surgical Services</b>	
➤ Surgeon & surgical assistant	No copay
➤ Anesthesiologist or anesthesiologist	No copay
<b>General Medical Services</b> <i>(when performed in non-hospital-based facility)</i>	
➤ Diagnostic X-ray & laboratory procedures	
— CT or CAT scan, MRI or nuclear cardiac scan	\$100/test
— PET scan	\$100/test
— All other X-ray & laboratory tests <i>(including mammograms, pap smears, &amp; prostate cancer screening)</i>	No copay
➤ Radiation therapy, chemotherapy & hemodialysis treatment	No copay
<b>Other Medical Services</b>	
➤ Prosthetic devices	No copay
➤ Durable medical equipment including hearing aids <i>(limited to \$5,000/calendar year)</i>	No copay
<b>Health and Wellness Services Preventive Care</b>	
➤ Complete physical exams & periodic routine checkups when ordered by the primary care physician	\$30/exam
➤ Well-baby & well-child care	\$30/exam
➤ Well-woman exams	\$30/exam
➤ Hearing exams	\$30/exam
<b>Vision Exams</b>	
➤ Vision screening from primary care physician <i>(vision screening covers evaluation only; diagnostic &amp; treatment programs, including refractions, from an optometrist or ophthalmologist must be authorized by the primary care physician)</i>	\$30/exam
<b>Health Education and Wellness Programs</b>	
➤ Specified immunizations	No copay
➤ Allergy testing & treatment <i>(including serums)</i>	\$30/exam
➤ Medical social services	No copay
➤ Selected health education programs	No copay
<b>Emergency Care</b>	
<b>In Area</b> <i>(within 20 miles of medical group)</i> <b>and Out of Area</b>	
➤ Physician & medical services	No copay
➤ Outpatient hospital emergency room services	\$125/visit <i>(waived if admitted)</i>
➤ Inpatient hospital services	\$500/stay
<b>Ambulance Services</b>	
➤ Ground or air ambulance transportation when medically necessary, including medical services & supplies	No copay

Covered Services	Per Member Copay
<b>Pregnancy and Maternity Care</b>	
<b>Office Visits</b>	
➤ Prenatal & postnatal care	\$30/visit
➤ Complications of pregnancy or therapeutic abortions	\$30/visit
<b>Normal Delivery or Cesarean Section, including:</b>	
➤ Inpatient hospital & ancillary services	\$500/stay
➤ Routine nursery care	No copay
➤ Physician services ( <i>inpatient only</i> )	No copay
<b>Complication of Pregnancy or Therapeutic Abortion, including:</b>	
➤ Inpatient hospital & ancillary services	\$500/stay
➤ Outpatient hospital services	No copay
➤ Physician services ( <i>inpatient only</i> )	No copay
<b>Elective Abortions</b> ( <i>including prescription drug for abortion [mifepristone]</i> )	\$150
<b>Genetic Testing of Fetus</b>	No copay
<b>Family Planning Services</b>	
➤ Infertility studies & tests	50% of covered expense <sup>1</sup>
➤ Tubal ligation	\$150
➤ Vasectomy	\$50
➤ Counseling & consultation	\$30/visit
<b>Organ and Tissue Transplant</b>	
➤ Inpatient Care	\$500/stay
➤ Physician office visits	\$30/visit
➤ Specialist and consultant office visits	\$30/visit
<b>Mental or Nervous Disorders and Substance Abuse</b>	
<b>Inpatient Care</b>	
➤ Facility-based care ( <i>pre-authorization required</i> )	\$500/stay
➤ Physician hospital visits	No copay
<b>Outpatient Care</b>	
➤ Facility-based care ( <i>pre-authorization required</i> )	No copay
➤ Outpatient physician visits ( <i>pre-service review required after the 12th visit</i> )	\$30/visit

<sup>1</sup> Not applicable to the annual copay maximum

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive the Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

# 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).

**Chronic Pain Treatment.** Treatment of frequent recurrences of pain, over a long period of time, that is not related to an active medical condition currently being treated.

**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.

**Growth Hormones.** Growth hormone treatment.

**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.** Orthopedic shoes (except when joined to braces) or shoe inserts (except custom molded orthotics). This does not apply to shoes and inserts designed to prevent or treat foot complications due to diabetes.

**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.

**Sex Change.** Sex change surgery or treatments.

**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.

**Surrogacy.** Any services or supplies given for a surrogate pregnancy (i.e., the bearing of a child by another woman for an infertile couple), unless the member is the surrogate mother.

**Wigs.**

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

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

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# 10/30/50 20% Self-Injectable (for Groups of 51 or more) Prescription Drug Benefits

**PLEASE NOTE:** *The following represents a summary only. Please refer to your Evidence of Coverage (“EOC”) which explains your plan’s Exclusions and Limitations as well as the full range of your covered services in detail.*

*At Anthem Blue Cross, we know that prescription drugs are the fastest-rising item of your total health care benefits cost. Reasons for the spiraling costs of prescription drugs are varied: a general increase of prescription medication use, an aging population, research and development of new medications and the expense of direct to consumer advertising. With prescription drug costs increasing at twice the rate of medical care, we developed ways to contain costs so your copays remain affordable, while maintaining your access to safe, effective prescription drugs. Our Prescription Drug Program provides you with choice, flexibility, affordability and access to an extensive network of retail pharmacies.*

### Getting a Prescription Filled at a Participating Pharmacy

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

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

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

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

Drug Type	Copay Amount
Generic	\$10.00
Brand name formulary	\$30.00 <sup>1</sup>
Brand name non-formulary	\$50.00 <sup>1</sup>

### Finding a Participating Pharmacy

Because our huge pharmacy network includes major drugstore chains plus a wide variety of independent pharmacies, it is easy for you to find a participating pharmacy. You can also find a participating pharmacy by going to our Web site at [anthem.com/ca](http://anthem.com/ca).

### An Extensive Network

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

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

### Using a Participating Pharmacy

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

### Using a Non-Participating Pharmacy

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

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

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

	Out-of-pocket costs using a participating pharmacy	Out-of-pocket costs using a non-participating pharmacy
Pharmacy's normal charge for brand-name formulary drug	\$50.00	\$50.00
You are responsible for:	\$30.00 copay	\$30.00 copay plus 50% of the limited fee schedule plus any amounts exceeding the fee schedule
<b>Total out-of-pocket expenses</b>	<b>\$30.00</b>	<b>Expense varies based on the cost of the medication</b>

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](http://anthem.com/ca).

## Submitting a Claim Form

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

Anthem Blue Cross Prescription Drug Program  
Attn: Anthem Blue Cross  
P.O. Box 4165  
Woodland Hills, CA 91365-4165

## Mail Service Prescription Drug Program

If you take a prescription drug on a regular basis, you may want to take advantage of our mail service program. Ordering your medications by mail is convenient, saves time and depending on your plan design, may even save you money. Besides enjoying the convenience of home delivery, you will also receive a greater supply of medications. To fill a prescription through the mail, simply complete the Mail Service Prescription form. You may obtain the form by calling Customer Service, at the toll-free number listed on your ID card or by going to our Web site at [anthem.com/ca](http://anthem.com/ca).

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

Please note that not all medications are available through the Mail Service Program. Specialty pharmacy drugs are not available through the mail service program, see Specialty Pharmacy Program below.

## Out-Of-State Prescription Benefits

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

## *Additional Features That are Part of your Plan*

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

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

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

## Specialty Pharmacy Program

Specialty medications are usually dispensed as an injectable drug, but may be available in other forms, such as a pill or inhalant. They are used to treat complex conditions. Prescriptions for a specialty pharmacy drug are covered only when ordered through the specialty pharmacy program unless you are given an exception from the specialty drug program (see your EOC for details). The specialty pharmacy program will deliver your medication to you by mail or common carrier (you cannot pick up your medication).

You may have to pay the full cost of a specialty pharmacy drug if it is not obtained from the specialty pharmacy program.

Specialty drugs are limited to a 30-day supply for each fill.

## Programs for Member's Special Health Needs

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

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

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

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

**Members who take multiple prescription medications** can take advantage of our pharmacy utilization management programs that encourage the safe, effective distribution of prescription medications. We have a program that protects the welfare of members with multiple prescription medications by carefully monitoring their prescription therapy to help reduce the danger of toxic drug interaction.

For additional information regarding your prescription drug benefits, please call Pharmacy Customer Service at the toll-free number printed on your member ID card.

Covered Services (outpatient prescriptions only)	Per Member Copay for Each Prescription or Refill
<b>Retail Pharmacy</b>	
➤ Generic drugs	\$10
➤ Brand name formulary drugs <sup>1</sup>	\$30
➤ Brand name non-formulary drugs <sup>1</sup>	\$50
➤ Compound Drugs <sup>1</sup>	\$50
➤ Self-administered injectable drugs, except insulin	20% of prescription drug covered expense (maximum \$150 copay)
<b>Mail Service</b>	
➤ Generic drugs	\$20
➤ Brand name formulary drugs <sup>1</sup>	\$60
➤ Brand name non-formulary drugs <sup>1</sup>	\$100
➤ Self-administered injectable drugs, except insulin	20% of prescription drug covered expense (maximum \$300 copay)
<b>Specialty Pharmacy Drugs</b> (may only be obtained through the specialty pharmacy program)	
➤ Generic drugs	\$10
➤ Brand name formulary drugs <sup>1</sup>	\$30
➤ Brand name non-formulary drugs <sup>1</sup>	\$50
➤ Self-administered injectable drugs, except insulin	20% of prescription drug covered expense (maximum \$150 copay)
<b>Non-participating Pharmacies</b> (compound drugs & specialty pharmacy drugs not covered at a retail pharmacy)	Member pays the above retail pharmacy copay plus: 50% of the remaining prescription drug covered expense & costs in excess of the maximum amount allowed
<b>Supply Limits<sup>2</sup></b>	
➤ Retail Pharmacy (participating and non-participating)	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)
➤ Mail Service	90-day supply
➤ Specialty Pharmacy	30-day supply

<sup>1</sup> **Mandatory Generic Substitution** If a member requests a formulary or non-formulary brand name drug when a generic drug substitution exists, the member pays the generic drug copay plus the difference in cost between the negotiated rate for the generic drug and the brand name drug dispensed, but not more than 50% of our cost of the prescription drug. Mandatory generic substitution 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.

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

#### The Prescription Drug Benefit covers the following:

- Outpatient prescription drugs and medications which the law restricts to sale by prescription. Formulas prescribed by a physician for the treatment of phenylketonuria. These formulas are subject to the copay for brand name drugs.
- Insulin
- Syringes when dispensed for use with insulin and other self-injectable drugs or medications
- Prescription oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per year and are subject to the brand name copay.
- Injectable drugs which are self-administered by the subcutaneous route (under the skin) by the patient or family member. Drugs that have Food and Drug Administration (FDA) labeling for self-administration
- All compound prescription drugs that contain at least one covered prescription ingredient
- Diabetic supplies (i.e., test strips and lancets)
- Prescription drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
- Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copay for brand name drugs.
- Certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

Prescription drug copays are separate from the medical copays of the medical plan and are not applied toward the Annual Out-of-Pocket Maximums under the Medical Plan

# Prescription Drug Exclusions & Limitations

Immunizing agents, biological sera, blood, blood products or blood plasma

Hypodermic syringes &/or needles, except when dispensed for use with insulin & other self-injectable drugs or medications

Drugs & medications used to induce spontaneous & non-spontaneous abortions

Drugs & medications dispensed or administered in an outpatient setting, including outpatient hospital facilities and physicians' offices

Professional charges in connection with administering, injecting or dispensing drugs

Drugs & medications that may be obtained without a physician's written prescription, except insulin or niacin for cholesterol lowering and certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

Drugs & medications dispensed by or while confined in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility

Durable medical equipment, devices, appliances & supplies, even if prescribed by a physician, except contraceptive diaphragms, as specified as covered in the EOC

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.

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 (a) the Drug Limited Fee Schedule for drugs dispensed by non-participating pharmacies; or (b) the prescription drug negotiated rate for drugs dispensed by participating pharmacies or through the mail service program

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

Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products. This does not apply to medically necessary drugs that the member can only get with a prescription under state and federal law.

Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of drug for medically necessary treatment of a medical condition other than one that is cosmetic.

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

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

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

Allergy desensitization products or allergy serum

Infusion drugs, except drugs that are self-administered subcutaneously

Herbal supplements, nutritional and dietary supplements except for formulas for the treatment of phenylketonuria.

Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was ineffective.

Compound medications unless:

- There is at least one component in it that is a prescription drug; and
- 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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