Anthem Blue Cross - Select HMO

www.anthem.com/ca
Customer service (800) 235-8631

2016

A Health Maintenance Organization

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 3 for details.

Serving: Most of Southern California

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 13 for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2016: Page 14
- Summary of benefits: Page 93

Enrollment codes for this Plan:

B31 Self Only
B33 Self Plus One
B32 Self and Family

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-877

Important Notice from Anthem Blue Cross - Select HMO About

Our Prescription Drug Coverage and Medicare

OPM has determined that the Anthem Blue Cross - Select HMO prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at (800) 772-1213 (TTY: (800) 325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call (800) MEDICARE ((800) 633-4227), (TTY: (877) 486-2048).

Table of Contents

Introduction

This brochure describes the benefits of the Anthem Blue Cross - Select HMO Plan under our contract (CS 2936) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at (800) 235-8631 or through our website: www.anthem.com/ca. The address for Anthem Blue Cross' administrative offices is:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA. 90060-0007

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. If you enroll in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2016, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2016, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Services (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means Anthem Blue Cross.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB Plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at (800) 235-8631 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

(877) 499-7295

Or go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly by your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don’t assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. These conditions and errors are called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events, if you use an Anthem Blue Cross-Select HMO provider. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage Information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment
  - How you can cover your family members
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self and Family or Self Plus One enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of any changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and one eligible family member as described in the chart below.

Children	**Coverage**
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2016 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2015 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

  You will receive an additional 31 days of coverage, for no additional premium, when:

  - Your enrollment ends, unless you cancel your enrollment; or
  - You are a family member no longer eligible for coverage.

  Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

  You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC).

- **Upon divorce**

  If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website at http://www.opm.gov/healthcare-insurance/healthcare/plan-information/.

- **Temporary Continuation of Coverage (TCC)**

  If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

  You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

  Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

  Alernatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHBP coverage.

- **Finding replacement coverage**

  You may convert to a non-FEHB individual policy if:

  - Your coverage under TCC or the spouse equity law ends (if you canceled your coverage or did not pay your premium, you cannot convert);
  - You decided not to receive coverage under TCC or the spouse equity law; or
  - You are not eligible for coverage under TCC or the spouse equity law.

  If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health.

In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance in finding coverage, please contact us at (800) 235-8631or visit our website at www.anthem.com/ca.

- **Health Insurance Marketplace** — If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit **www.HealthCare.gov**. This is a website provided by the U. S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

General features of our HMO

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. Anthem Blue Cross is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the Plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

Your medical group is paid a set amount for each member per month. Your medical group may also get added money for some types of special care or for overall efficiency, and for managing services and referrals. Hospitals and other health care facilities are paid a set amount for the kind of service they provide to you or an amount based on a negotiated discount from their standard rates. If you want more information, please call us at (800) 235-8631, or you may call your medical group.

You do not have to pay any Anthem Blue Cross-Select HMO provider for what we owe them, even if we don't pay them. But you may have to pay a non-Plan provider any amounts not paid to them by us.

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about your health plan, its networks, providers, and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's FEHB website (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Anthem Blue Cross has been serving the health insurance needs of California residents since 1937.

If you want information about us, call1 (800) 235-8631, or write to Anthem Blue Cross, P.O. Box 60007 Los Angeles, CA. 90060-0007. You may also contact us by fax at (818) 234-4147, or visit our website at www.anthem.com/ca.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is:

Southern California Counties

Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Ventura

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency or urgent care services. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2016

Do not rely only on these change description; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- Self Plus One enrollment Option has been added effective January 1, 2016.
- We have removed the exclusion for services, drugs, or supplies related to sex transformations. See page 71.

Changes to this Plan:

- Your share of the non-Postal premium will increase for Self Only and Self and Family enrollment. See page 94.
- Copayments and coinsurance will be waived when you have Medicare Parts A and/or B as your primary insurance. Previously we did not waive any copayments or coinsurance when you had both our Plan and Medicare. See page 82.
- Intensive Behavioral Intervention care will no longer be limited per week, across all setting, depending on the individual's needs and progress. Previously there was a 40 hour per week limit. See page 56.
- The copayment for urgent care services will be $25. Previously the copayment was $40. See pages 26 and 50.
- We will now cover certain services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a *doctor*. Previously the services were not covered. See page 37.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (800) 235-8631 or write to us at Anthem Blue Cross - Select HMO, P.O. Box 60007, Los Angeles, CA. 90060-0007. You may also request replacement cards through our website at www.anthem.com/ca.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care**

Your primary care physician can be a general or family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.

  Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If he or she decides to refer you to a specialist, ask if you can see your current specialist.

  If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
  - reduce our service area and you enroll in another FEHB plan;

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our plan begins, call our customer service department immediately at (800) 235-8631. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval only applies to care shown under *Other services*.

- **Transgender services**

Prior Plan approval must be obtained in advance in order for transgender services to be covered.

Certain providers have been designated to provide transgender services. If a Plan provider is not available you will need to obtain an authorized referral in order for services to be covered. See Section 3. How to request precertification for an admission or get prior authorization for Other services. See page 38 for non-covered services.

Medical necessity criteria for; hysterectomy, salpingo-oophorectomy; ovariectomy , or orchiectomy:

1. The individual is at least 18 years of age; and

2. The individual has capacity to make fully informed decisions and consent for treatment; and

3. The individual has been diagnosed with gender dysphoria and exhibits all of the following:

- The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
- The transsexual identity has been present persistently for at least two years; and
- The disorder is not a symptom of another mental disorder; and
- The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and

4. If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (for example, psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; and

5. Two referrals from qualified mental health professionals who have independently assessed the individual. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (for example, if practicing within the same clinic) are required.

Medical necessity criteria for; metoidioplasty, phalloplasty, vaginoplasty, penectomy, clitoroplasty, labiaplasty, vaginectomy, scrotoplasty, urethroplasty, or placement of testicular prostheses:

1. The individual is at least 18 years of age; and

2. The individual has capacity to make fully informed decisions and consent for treatment; and

3. The individual has been diagnosed with gender dysphoria and exhibits all of the following:
- The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
- The transsexual identity has been present persistently for at least two years; and
- The disorder is not a symptom of another mental disorder; and
- The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and

4. Individuals without a medical contraindication or otherwise unable or unwilling to take hormones, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician; and

5. Documentation that the individual has completed a minimum of 12 months of successful continuous full time real-life experience in their new gender, across a wide range of life experiences and events that may occur throughout the year (for example, family events, holidays, vacations, season-specific work or school experiences). This includes coming out to partners, family, friends, and community members (for example, at school, work, and other settings).
Note:
- The medical documentation should include the start date of living full time in the new gender.
- Verification via communication with individuals who have related to the individual in an identity-congruent gender role, or requesting documentation of a legal name change, may be reasonable in some cases; and

6. Regular participation in psychotherapy throughout the real-life experience when recommended by a treating medical or behavioral health practitioner; and

7. If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (for example, psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; and

8. Two referrals from qualified mental health professionals who have independently assessed the individual. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (for example, if practicing within the same clinic) are required.

Note: At least one of the professionals submitting a letter must have a doctoral degree (Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D) and be capable of adequately evaluating co-morbid psychiatric conditions. One letter is sufficient if signed by two providers, one of whom has met the doctoral degree specifications, in addition to the specifications set forth above.

Gender reassignment surgery is considered not medically necessary when one or more of the criteria above have not been met.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

- behavioral health treatment for pervasive developmental disorder or autism, and
- authorized referrals to non-Plan providers for the treatment of mental or nervous disorders and substance abuse and for behavioral health treatment for pervasive developmental disorder or autism, and
- transgender services.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call the toll-free telephone number on the back of your member ID card before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee’s name and Plan identification number;
- patient’s name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

  For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

  If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

  If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

  If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

  We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

  You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at (800) 235-8631. You may also call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at (800) 235-8631. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

  A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

  If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

  If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-Plan providers

- When you don't get the required pre-service review before you get facility-based care for the treatment of mental or nervous disorders or substance abuse, or for behavioral health treatment for pervasive developmental disorder or autism, we **will not provide benefits** for those services.
- Facility-based care for the treatment of mental or nervous disorders or substance abuse and behavioral health treatment for pervasive developmental disorder or autism will be provided only when the type and level of care requested is medically necessary and appropriate for your condition. If you go ahead with any services that have been determined to be not medically necessary and appropriate at any stage of the utilization review process, we **will not provide benefits** for those services.
- When services are not reviewed before or during the time you receive the services, we will review those services when we receive the bill for benefit payment. If that review determines that part or all of the services were not medically necessary and appropriate, we **will not provide benefits** for those services.
- If you receive authorized referral services from a non-Plan provider, the Plan provider copay will apply. When you do not get a referral, **no benefits are provided** for services received from a non-Plan provider.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

- Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
- Ask you or your provider for more information.
  - You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.
  - If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
- Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM** — After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care:

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, if any, coinsurance, and copayments) for the covered care you receive.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services. Example: When you see your primary care physician, you pay a copayment of $25 per office visit.
Deductible	This Plan does not have a deductible.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our Plan, you pay 50% of our allowance for infertility services.
Your catastrophic protection out-of-pocket maximum	After your copayments total $3,000 for Self Only or $3,000 per person for Self Plus One, or $6,000 for Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments or coinsurance for these services: • *Infertility services* Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.
Carryover	If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.
When Government facilities bill us	Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits

See page 14 for how our benefits changed this year. Page 93 is a benefits summary of our high option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. Benefits Overview

The benefit package is described in Section 5. Make sure that you carefully review the benefits that are available.

Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at (800) 235-8631 or on our website at www.anthem.com/ca.

When you seek care from within our network, we offer the following unique features:

- No deductibles
- No office visit copay for covered preventive care services
- $25 non-preventive primary care office visit copay
- $25 office visit copay for family planning visits
- $125 emergency room copay
- $250 per day copay up to a maximum of 4 days per covered inpatient hospital admission
- $250 outpatient facility copay for surgery

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage.

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office • Home visits • Office medical consultations • Second surgical opinion	$25 per PCP visit $40 per Specialist visit
• During a hospital stay • In a skilled nursing facility	Nothing
• In an urgent care center	$25 per visit
• Injectable or infused medications given by the doctor in the office This does not include immunizations prescribed by your primary care physician nor allergy serum	30% of Plan allowance up to a maximum of $150
Not covered: • *Consultations given using telephones, facsimile machines, or electronic mail.* • *Services for your personal care, such as: helping in walking, bathing, dressing, feeding, or preparing food. Any supplies for comfort, hygiene or beauty purposes.*	*All charges*
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine Mammograms • Ultrasound • Electrocardiogram and EEG	Nothing
For the following services: • Advanced Imaging Procedures	$100 per test performed in a doctor's office, radiology center, outpatient department of a hospital, or ambulatory surgical center.

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay
Lab, X-ray and other diagnostic tests (cont.)	**High Option**
Advanced Imaging Procedures are imaging procedures, including, but not limited to: Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography, and nuclear cardiac imaging. For a complete list of advanced imaging procedures or if you need more information, please contact your medical group.	$100 per test performed in a doctor's office, radiology center, outpatient department of a hospital, or ambulatory surgical center.
Preventive care, adult	**High Option**
Preventive care services include outpatient services and office visits. Screenings and other services are covered as preventive care services when you have no current symptoms or prior history of a medical condition associated with that screening or service. • Full physical exams and periodic check-ups ordered by your primary care doctor • Vision or hearing screenings* • Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Nothing
• Health education programs given by your primary care physician or the medical group • Health screenings as prescribed by your doctor - Health screenings include: mammograms, Pap tests and any cervical cancer screening tests including human papillomavirus (HPV), prostate cancer screenings, and other medically accepted cancer screening tests, screenings for high blood pressure, type 2 diabetes mellitus, cholesterol, and obesity.** • Intervention services as part of a full physical exam or periodic check-up for the purpose of education or counseling on potential health concerns, including smoking cessation counseling • HIV testing, regardless of whether testing is related to a primary diagnosis • Over the counter items and services (ex. aspirin, vitamin D, etc.) when prescribed by your physician • Screening for obesity and referrals for behavior change interventions for adults with a Body Mass Index (BMI) over 30kg/m2	Nothing
Well woman care; including but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
* Vision screening includes a vision check by your primary care physician to see if it is medically necessary for you to have a complete vision exam by a vision specialist. If approved by your primary care physician, this may include an exam with diagnosis, a treatment program and refractions. Hearing screenings include tests to diagnose and correct hearing. ** This list is not exhaustive. Preventive tests and screenings with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), or those supported by the Health Resources and Services Administration (HRSA) will be covered at No charge. You may call Customer Service using the number on your ID card for additional information about these services. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/	
Not covered: • *Immunizations needed to travel outside the USA.* • *Routine physical or psychological exams or test asked for by a job or other group, such as a school, camp, or sports program.*	*All charges*
Preventive care, children	**High Option**
Preventive care services include outpatient services and office visits. Screenings and other services are covered as preventive care services when you have no current symptoms or prior history of a medical condition associated with that screening or service. • Full physical exams and periodic check-ups ordered by your primary care physician • Vision or hearing screenings* • Immunizations prescribed by your primary care physician • Health education programs given by your primary care physician or the medical group	Nothing
• Health screenings as prescribed by your doctor - Health screenings include: mammograms, Pap tests and any cervical cancer screening tests including human papillomavirus (HPV), prostate cancer screenings, and other medically accepted cancer screening tests, screenings for high blood pressure, type 2 diabetes mellitus, cholesterol, and obesity.** • Intervention services as part of a full physical exam or periodic check-up for the purpose of education or counseling on potential health concerns, including smoking cessation counseling • HIV testing, regardless of whether testing is related to a primary diagnosis	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**High Option**
• Over the counter items and services (ex. aspirin, vitamin D, etc.) when prescribed by your physician	Nothing
*Vision screening includes a vision check by your primary care doctor to see if it is medically necessary for you to have a complete vision exam by a vision specialist. If approved by your primary care doctor, this may include an exam with diagnosis, a treatment program and refractions. Hearing screenings include tests to diagnose and correct hearing. ** This list is not exhaustive. Preventive tests and screenings with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), or those supported by the Health Resources and Services Administration (HRSA) will be covered at No charge. You may call Customer Service using the number on your ID card for additional information about these services. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/	
Not covered: • *Immunizations needed to travel outside the USA.* • *Routine physical or psychological exams or tests asked for by a job or other group, such as a school, camp, or sports program.*	*All charges*
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care and Postnatal care	$25 per office visit
• Screening for gestational diabetes for pregnancy women between 24-28 weeks gestation or first prenatal visit for women at high risk. • Delivery	Nothing Note: You owe a hospital admission copay for inpatient hospital services.
Breastfeeding support, supplies and counseling for each birth	Nothing
Note: Here are some things to keep in mind: • You do not need to preauthorize your normal delivery • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Newborn circumcision is covered under Surgery benefits (see Section 5(b)).	

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**High Option**
• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5(c)) and Surgery benefits (Section 5(b)).	
Not covered: • *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).*	*All charges*
Family planning	**High Option**
Contraceptive counseling	Nothing
A range of voluntary family planning services, such as: • Voluntary sterilization for females (tubal ligation)	$150
• Voluntary sterilization for males (vasectomy)	$50
• Family planning visits	$25
• Doctor's services prescribe, fit and insert an IUD or diaphragm Note: You pay nothing for the IUD or diaphragm dispensed by the doctor.	$25
• Shots and implants for birth control (such as Depo provera) Note: We cover oral contraceptives under the prescription drug benefit. • Genetic testing, when medically necessary	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Over-the-counter contraceptives will not be covered unless a prescription is provided.*	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) Note: We cover injectable fertility drugs under medical benefits. See Section 5(f) Prescription drugs benefits for oral fertility drugs.	50% of Plan allowance for all care
Not covered:	*All charges*

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**High Option**
• *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs*	*All charges*
Allergy care	**High Option**
• Testing and treatment	$40 per office visit
• Allergy injections including serum	Nothing
Treatment therapies	**High Option**
• Chemotherapy	$40
• Radiation therapy	$40
• Hemodialysis including treatment at home if approved by the medical group	$40
• Infusion therapy (home IV and antibiotic therapy)	$40
• Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder	$25
• Medical social services • Respiratory/inhalation therapy • Growth hormone therapy	Nothing
Physical and occupational therapies and cardiac rehabilitation	**High Option**
• Visits for rehabilitative and habilitative physical and occupational therapy • Visits for cardiac rehabilitation You may have **up to a 60 day period of care** after an illness or injury. The 60 day period of care starts with the first visit for rehabilitative and habilitative care. The 60 day limit does not limit the number of visits or treatments you get within the 60 day period. If you need more than the 60 day period of care, your primary care physician must get the approval from your medical group or Anthem. It must be shown that more care is medically necessary. Your medical group or Anthem will approve the extra visits or treatments. Note: We only cover therapy when a provider: • orders the care	$40

Physical and occupational therapies and cardiac rehabilitation - continued on next page

Benefit Description	You pay
Physical and occupational therapies and cardiac rehabilitation (cont.)	**High Option**
Not covered: • *Treatment of frequent recurrences of pain, over a long period of time, that is not related to an active medical condition currently being treated.* • *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.* • *Programs to help you change how you live, like fitness clubs, or dieting programs. This does not apply to cardiac rehabilitation programs approved by your medical group*	*All charges*
Speech therapy	**High Option**
• Visits for rehabilitative and habilitative speech therapy by a licensed speech therapist when prescribed by your physician	Nothing
Vision services (testing, treatment, and supplies)	**High Option**
• Vision screening includes a vision check by your primary care physician to see if it is medically necessary for you to have a complete vision exam by a vision specialist. If approved by your primary care physician, this may include an exam with diagnosis, a treatment program and refractions.	Nothing
Not covered: • *Eyeglasses or contact lenses. Contact lens fitting is not covered.* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	**High Option**
• We cover medically necessary care for the diagnosis and treatment of conditions of the foot, when prescribed by your physician. Note: See durable medical equipment for information on podiatric shoe inserts.	$40 per office visit
Not covered: • *Routine foot care*	*All charges*
Orthopedic and prosthetic devices	**High Option**
You can get devices to take the place of missing parts of your body. • Surgical implants • Artificial limbs and eyes • Breast prostheses following a mastectomy • The first pair of contact lenses or eyeglasses when needed after a covered and medically necessary eye surgery	Nothing

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	**High Option**
• Prosthetic devices to restore a method of speaking when required as a result of a laryngectomy • Colostomy supplies • Therapeutic shoes and inserts designed to prevent foot complications due to diabetes • Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient • Supplies needed to take care of these devices	Nothing
Not covered: • *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.*	*All charges*
Durable medical equipment (DME)	**High Option**
You can get equipment and supplies used for the treatment of diabetes: long-lasting medical equipment (called durable medical equipment) and supplies that are rented or bought for you if they are: - Ordered by your primary care physician. - Used only for the health problem. - Used only by the person who needs the equipment or supplies. - Made only for medical use.	50% of Plan allowance
• You can also get nebulizers, including face masks and tubing for treatment of pediatric asthma. Note: These items are not subject to any limits or maximums that apply to coverage for medical equipment.	Nothing
• Special food products and formulas that are part of a diet prescribed by a *doctor* for the treatment of phenylketonuria (PKU). You can get most formulas used in the treatment of PKU from a drugstore. These are covered under your plan's benefits for prescription drugs (see Section 5(f)). Special food products that are not available from a drugstore are covered as medical supplies under your plan's medical benefits.	Nothing
*Equipment and supplies are **not** covered if they are:* • *Only for your comfort or hygiene.* • *For exercise.* • *Only for making the room or home comfortable, such as air conditioning or air filters.* • *Scalp hair prostheses, including wigs or any form of hair replacement.* • *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.*	*All charges*

Benefit Description	You pay
Hearing services (testing, treatment, and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D. or audiologist. Note: For routine hearing screenings performed during a preventive care visit, see Section 5(a) *Preventive care services, adult* and *Preventive care services, children.*	$40 per office visit
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants. Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	50% of Plan allowance up to one per ear every 36 months
Home health services	**High Option**
We will cover home health care furnished by a home health agency (HHA)for **up to 100 visits in a calendar year**. • Care from a registered nurse or licensed vocational nurse who works under a registered nurse or a doctor	$40
• Physical therapy, occupational therapy, speech therapy, or respiratory therapy	$40
• Visits with a medical social service worker	$40
• Care from a health aide who works under a registered nurse with the HHA (one visit equals four hours or less)	$40
• Oxygen therapy, intravenous therapy and medications	$40
• Medically necessary supplies from the HHA	Nothing
Chiropractic	**High Option**
Covered up to 20 visits in a year when you see a chiropractor in the American Specialty Health Plans of California, Inc. (ASH Plans) network. Also up to $50 per calendar year in rental or purchase charges are covered for medical equipment and supplies ordered by an ASH Plans chiropractor, and approved as medically necessary by ASH Plans. Such medical equipment includes: (1) elbow supports, back supports (thoracic), lumbar braces and supports, rib supports, or wrist supports; (2) cervical collars or cervical pillows; (3) ankle braces, knee braces, or wrist braces; (4) heel lifts; (5) hot or cold packs; (6) lumbar cushions; (7) rib belts or orthotics; and (8) home traction units for treatment of the cervical or lumbar regions. **Note:** The *ASH Plans* chiropractor is responsible for obtaining the necessary approval from the Plan.	$15 per office visit
Not covered: • *Any services provided by ASH Plans that are not approved by us, except for the first visit* • *The services of a non-ASH Plans chiropractor*	*All charges*

Benefit Description	You pay
Alternative treatments	**High Option**
Acupuncture – medically necessary acupuncture if referred by your primary care physician.	$40
Not covered: • *Acupressure, or massage to help pain, treat illness or promote health by putting pressure to one or more areas of the body*	*All charges*
Educational classes and programs	**High Option**
Coverage is provided for: • Diabetes education program services supervised by a doctor which include; a) teaching you and your family members about the disease process and how to take care of it; and b) training, education, and nutrition therapy to enable you to use the equipment, supplies, and medicines needed to manage the disease.	$40 per office visit
• Nutritional counseling for the treatment of obesity	Nothing
• Smoking cessation programs for nicotine dependency. We cover medically necessary drugs for nicotine dependency that require a prescription. This does not include those services required under the "Preventive Care Services" benefit. Note: See Section 5(f) Prescription benefits for information on physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence. See Section 5(e) for information on individual and group psychotherapy.	Nothing
• Pediatric asthma education program	$40 per office visit
Cancer clinical trials	**High Option**
Routine patient care costs, as defined below, for phase I, phase II, phase III and phase IV cancer clinical trials. All of the following conditions must be met: • The treatment you get in a clinical trial must either: - Involve a drug that is exempt under federal regulations from a new drug application, or - Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration. • You must have cancer to be able to participate in these clinical trials.	$25 per PCP office visit $40 per Specialist office visit

Cancer clinical trials - continued on next page

Benefit Description	You pay
Cancer clinical trials (cont.)	**High Option**
• Participation in these clinical trials must be recommended by your primary care doctor after deciding it will help you. If the clinical trial is not provided by or through your medical group, your primary care doctor will refer you to the doctor or health care provider who provides the clinical trial. Please see "When You Need a Referral" in the section called "When You Need Care" for information about referrals. You will only have to pay your normal copays for the services you get. • For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.	$25 per PCP office visit $40 per Specialist office visit
Routine patient care cancer clinical trials costs are the costs associated with the services provided, including drugs, items, devices and services which would otherwise be covered under the plan, including health care services which are: • Typically provided absent a clinical trial. • Required solely to provide the investigational drug, item, device or service. • Clinically appropriate monitoring of the investigational item or service. • Prevention of complications arising from the provision of the investigational drug, item, device, or service. • Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or care of the complications.	$25 per PCP office visit $40 per Specialist office visit
Routine patient care cancer clinical trials costs do not include any of the costs associated with any of the following: • Drugs or devices not approved by the Federal Food and Drug Administration that are part of the clinical trial. • Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may need because of the treatment you get for the purposes of the clinical trial. • Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient. • Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the plan. • Health care services usually provided by the research sponsors free of charge to members enrolled in the trial. Note: You will pay for costs of services that are not covered.	$25 per PCP office visit $40 per Specialist office visit
Routine patient care costs for individual participation in phase I, phase II, phase III and phase IV clinical trial conducted to prevent, detect or treat life-threatening diseases or conditions that are federally funded; conducted under investigational new drug application reviewed by FDA; or conducted as a drug trial exempt from the requirement of an investigational new drug application.	$25 per PCP office visit $40 per Specialist office visit

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Any medically necessary eye surgery • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Treatment of burns • Correction of congenital anomalies (see Reconstructive surgery) • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. **Note:** Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing
Medically necessary Transgender reassignment surgical services to treat gender dysphoria will be covered as follows (See Section 3 for medical necessity criteria): • Reassignment surgeries, consisting of any combination of the following; hysterectomy, salpingo-oophorectomy; ovariectomy , or orchiectomy are considered medically necessary when all of the medical necessity criteria are met; or • Reassignment surgeries, consisting of any combination of the following; metoidioplasty, phalloplasty, vaginoplasty, penectomy, clitoroplasty, labiaplasty, vaginectomy, scrotoplasty, urethroplasty, or placement of testicular prostheses are considered medically necessary when all of the medical necessity criteria are met.	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
Surgical treatment of morbid obesity (bariatric surgery) as determined by your medical group, when the treatment is approved in advance. In order for your medical group to consider you for this surgery, you must: • Have a Body Mass Index of 40 or greater, or Body Mass Index of 35 or greater with co-morbid conditions including, but not limited to, life threatening cardio-pulmonary problems (severe sleep apnea, Pickwickian syndrome and obesity related cardiomyopathy), severe diabetes mellitus, cardiovascular disease or hypertension; and • Have actively participated in non-surgical methods of weight reduction; and • Have a psychiatric profile that will allow you to understand, tolerate and comply with all phases of care and are committed to long-term follow-up requirements. Note: Before the bariatric surgery can be approved, your medical group must address post-operative expectations and give you a thorough explanation of the risks and benefits of the procedure.	Nothing
Not covered: • *Any eye surgery just for correcting vision (like nearsightedness and/or astigmatism). Contact lenses and eyeglasses needed after this surgery.* • *Sex change surgery or treatments.* • *Surgery done to reverse sterilization.* • *Surgeries that are considered cosmetic when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo gender reassignment surgery include:* - *Reduction thyroid chondroplasty* - *Liposuction* - *Rhinoplasty* - *Facial bone reconstruction* - *Face lift* - *Blepharoplasty* - *Voice modification surgery* - *Hair removal/hairplasty* - *Breast augmentation* • *Services not stated above as covered*	*All charges*
Reconstructive surgery	**High Option**
• Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function, reducing symptoms or creating a normal appearance, including medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.	Nothing

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**High Option**
• Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema. • Reconstructive surgery of both breasts performed to restore symmetry following a mastectomy.	Nothing
Not covered: • *Cosmetic Surgery. Surgery or other services done only to make you a) look beautiful; b) to improve your appearance; or c) to change or reshape normal parts or tissues of the body.* *This does not apply to reconstructive surgery you might need to a) give you back the use of a body part; b) have for breast reconstruction after a mastectomy; and c) 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.* • *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.*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Splint therapy or surgical treatment for disorders of the joints linking the jawbones and the skull (the temporomandibular joints); including the complex of muscles, nerves and other tissues related to those joints; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*

Benefit Description	You pay
Organ/tissue transplants	**High Option**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Cornea • Heart • Heart-lung • Kidney • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants - isolated small intestine - small intestine with the liver - small intestine with multiple organs such as the liver, stomach, and pancreas • Lung - single/bilateral/lobar • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	Nothing
Blood or Marrow Stem Cell Transplants: Not subject to medical necessity. Plan's denial is limited to the cytogenetics, subtype or staging of the diagnosis (e.g. acute, chronic) as appropriate for the diagnosis Allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) • Hemoglobinopathy • Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic Syndromes • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia Autologous transplant for: • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma recurrence (relapsed)	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• Advanced non-Hodgkin's lymphoma recurrence (relapsed) • Amyloidosis • Neuroblastoma	Nothing
Blood or Marrow Stem Cell Transplants: Not subject to medical necessity: Allogeneic transplant for: • Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) Autologous transplants for: • Multiple myeloma • Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	Nothing
Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. May Be Limited to Clinical Trials. Autologous transplants for: • Advanced Ewing sarcoma • Advanced Childhood kidney cancers • Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) • Childhood rhabdomyosarcoma • Epithelial ovarian cancer • Mantle Cell (Non-Hodgkin lymphoma)	Nothing
Mini-transplants performed in a Clinical Trial Setting (non-myeloablative, reduced intensity conditioning for member over 60 years of age with a diagnosis listed under Section II): Subject to Medical Necessity	Nothing
Tandem transplants for covered transplants: subject to medical necessity review by the Plan. Autologous tandem transplants: • AL Amyloidosis • Multiple myeloma (de novo and treated) • Recurrent germ cell tumors (including testicular cancer)	Nothing
Blood or Marrow Stem Cell Transplants under clinical trials. Allogeneic transplants for: • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Mutiple myeloma (after a previous autologous stem cell transplant or due to primary graft failure, failure to engraft or rejection)	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• Sickle cell • Beta Thalassemia Major Non-myeloablative allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Chronic lymphocytic lymphoma/small lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma (after a previous autologous stem cell transplant or due to primary graft failure, failure to engraft or rejection) • Myeloproliferative Disorders • Myeloproliferative/Myelodysplastic Syndromes • Sickle Cell disease	Nothing
Blood or Marrow Stem Cell Transplants Allogeneic transplants for: • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) • Myeloproliferative disorders • Sickle cell anemia • X-linked lymphoproliferative syndrome Autologous transplants for: • Ependymoblastoma • Ewing's sarcoma • Medulloblastoma • Pineoblastoma • Waldenstrom's macroglobulinemia National Transplant Program (NTP) – We are a member of the Blue Distinction Center for Transplant.	Nothing
Donor testing for up to four bone marrow transplant donors from individuals unrelated to the patient in addition to testing of family members.	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
Not covered: • *Implants of artificial organs* • *Transplants not listed as covered* • *Donor screening tests and donor search expenses, except as shown above*	*All charges*
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Note: We will consider providing benefits for general anesthesia and facility services related to dental care only when the dental care must be provided in a hospital or ambulatory surgery center because the patient is: 1) less than seven years old; 2) developmentally disabled; or 3) the patient's health is compromised and general anesthesia is medically necessary. **We will not cover the dental procedure itself or any of the professional services of a dentist to perform the procedure.**	Nothing

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$250 per day for a maximum of 4 days
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood transfusions. This includes the cost of blood, blood products or blood processing • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services **Note**: Inpatient hospital services are covered for dental care only when the stay is: - Needed for dental care because of other medical problems you may have; - Ordered by a doctor (M.D.) or a dentist (D.D.S.); and - Approved by the medical group.	Nothing

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We will consider providing benefits for facility services related to dental care only when the dental care must be provided in a hospital or ambulatory surgery center because the patient is: • Less than seven years old; • Developmentally disabled; or the • Patient's health is compromised and general anesthesia is medically necessary. Services are limited to a 3 day hospital stay. We will not cover the dental procedure itself or any of the professional services of a dentist to perform the procedure	Nothing unless surgery is performed. $250 per outpatient surgery admission
Other outpatient hospital services supplies, including physical therapy, occupational therapy, or speech therapy.*	$40
However, for each of the following outpatient services, your copay will be: • Chemotherapy • Radiation therapy • Hemodialysis treatment • Infusion therapy *These rehabilitative services are limited to a 60 day period of care after an illness or injury. If you need more than the 60 day period of care, your primary care doctor must get the approval from your medical group or Anthem. (See Section 5(a) - Rehabilitative Care.)	$40

Benefit Description	You pay
Skilled nursing care facility benefits	**High Option**
We cover the following care in a skilled nursing facility for up to **100 days in a calendar year**. • A room with two or more beds • Special treatment rooms • Regular nursing services • Laboratory tests • Physical therapy, occupational therapy, speech therapy, or respiratory therapy • Drugs and medicines given during your stay. This includes oxygen. • Blood transfusions • Needed medical supplies and appliances	Nothing
Hospice care	**High Option**
We cover the following hospice care if you have an illness that may lead to death. Your primary care physician will work with the hospice and help develop your care plan. The hospice must send a written care plan to your medical group every 30 days. • Interdisciplinary team care to develop and maintain a plan of care • Short-term inpatient hospital care in periods of crisis or as respite care. Respite care is provided on an occasional basis for up to five consecutive days per admission • Physical therapy, occupational therapy, speech therapy and respiratory therapy • Social services and counseling services • Skilled nursing services given by or under the supervision of a registered nurse • Certified home health aide services and homemaker services given under the supervision of a registered nurse • Diet and nutrition advice; nutrition help such as intravenous feeding or hyperalimentation • Volunteer services given by trained hospice volunteers directed by a hospice staff member • Drugs and medicines prescribed by a doctor • Medical supplies, oxygen and respiratory therapy supplies • Care which controls pain and relieves symptoms • Bereavement services, including assessing the needs of the bereaved family and developing a care plan to meet those needs, both before and after death. Bereavement services are available to covered members of the immediate family (spouse, children, step-children, parents, brothers and sisters) for up to one year after the employee's or covered family member's death	Nothing

Benefit Description	You pay
Ambulance	**High Option**
You can get these services from a licensed ambulance in an emergency or when ordered by your primary care physician. (We will provide benefits for these services if you receive them as a result of a 9-1-1 emergency response system call for help if you think you have an emergency.) Air ambulance is also covered, but, only if ground ambulance service can't provide the service needed. Air ambulance service, if medically necessary, is provided only to the nearest hospital that can give you the care you need. • Base charge and mileage • Disposable supplies • Monitoring, EKG's or ECG's, cardiac defibrillation, CPR, oxygen, and IV Solutions	$100 per trip Nothing for all other services and supplies

Section 5(d). Emergency services/accidents

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan doctors must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage.
- The amounts listed below are for the charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e. physicians, etc.) are in Section 5(a) or (b).

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What is urgent care?

We provide coverage for medically necessary care by non-Plan providers to prevent serious deterioration of your health resulting from an unforeseen illness or injury when you are more than 20 miles from your medical group (or your medical group's enrollment area hospital if you are enrolled in an independent practice association), and seeking health services cannot wait until you return.

If you need urgent care you should seek medical attention immediately. If you are admitted to a hospital for urgently needed care, you should contact your primary care physician or Medical Group within 48 hours, unless extraordinary circumstances prevent such notification. Follow-up care will be covered when the care required continues to meet our definition of "Urgent Care". Urgent care is defined as services received for a sudden, serious, or unexpected illness, injury or condition, which is not an emergency, but which requires immediate care for the relief of pain or diagnosis and treatment of such condition.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What is urgent care?

We provide coverage for medically necessary care by non-Plan providers to prevent serious deterioration of your health resulting from an unforeseen illness or injury when you are more than 15 miles (or 30 minutes) from your medical group (or your medical group's enrollment area hospital if you are enrolled in an independent practice association), and seeking health services cannot wait until you return.

If you need urgent care you should seek medical attention immediately. If you are admitted to a hospital for urgently needed care, you should contact your primary care physician or Medical Group within 48 hours, unless extraordinary circumstances prevent such notification. Follow-up care will be covered when the care required continues to meet our definition of "Urgent Care". Urgent care is defined as services received for a sudden, serious, or unexpected illness, injury or condition, which is not an emergency, but which requires immediate care for the relief of pain or diagnosis and treatment of such condition.

What to do in case of emergency.

If you need emergency services, get the medical care you need right away. In some areas, there is a 9-1-1 emergency response system that you may call for emergency services (this system is to be used only when there is an emergency that requires an emergency response).

Once you are stabilized, your primary care physician must approve any care you need after that.

- Ask the hospital or emergency room doctor to call your primary care physician.
- Your primary care physician will approve any other medically necessary care or will take over your care

If You Are In-Area

You are in-area if you are 15-miles or 30-minutes or less from your medical group (or 15-miles or 30-minutes or less from your medical group's hospital, if your medical group is an independent practice association).

If you need emergency services, get the medical care you need right away. If you want, you may also call your primary care physician and follow his or her instructions.

Your primary care physician or medical group may:

- ask you to come into their office;
- give you the name of a hospital or emergency room and tell you to go there;
- order an ambulance for you;
- give you the name of another doctor or medical group and tell you to go there; or
- tell you to call the 9-1-1 emergency response system.

If You're Out of Area

You can still get emergency services if you are more than 15-miles or 30-minutes away from your primary care physician or medical group.

If you need emergency services, get the medical care you need right away (follow the instructions above for When There is an Emergency). In some areas, there is a 9-1-1 emergency response system that you may call for emergency services (this system is to be used only when there is an emergency that requires an emergency response). You must call us within 48 hours if you are admitted to a hospital.

Remember:

- We won't cover services that don't fit what we mean by emergency services.
- Your primary care physician must approve care you get once you are stabilized, unless Anthem Blue Cross Select HMO approves it.
- Once your medical group or Anthem Blue Cross-Select HMO give an approval for emergency services, they cannot withdraw it.

Benefit Description	You pay
Emergency inside or outside of our service area	**High Option**
• Emergency care at a doctor's office	$25 per office visit
• Emergency care at an urgent care center	$25 per visit
• Emergency care on an outpatient basis at a hospital (if care results in admission to a hospital, the copayment will not apply)	$125 per visit
• Emergency care at a hospital on an inpatient basis	$250 per day for a maximum of 4 days
Ambulance	**High Option**
You can get these services from a licensed ambulance in an emergency. (We will provide benefits for these services if you receive them as a result of a 9-1-1 emergency response system call for help if you think you have an emergency.) Air ambulance is also covered, but, only if ground ambulance service can't provide the service needed. Air ambulance service, if medically necessary, is provided only to the nearest hospital that can give you the care you need. • Base charge and mileage • Disposable supplies • Monitoring, EKG's or ECG's, cardiac defibrillation, CPR, oxygen, and IV Solutions	$100 per trip Nothing for all other services and supplies

Section 5(e). Mental health and substance abuse benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage.
- You can get care for outpatient professional treatment of mental health and substance abuse conditions by a Plan provider without getting prior approval from your medical group. In order for care to be covered, you must go to a Plan provider. You can get a directory of Plan providers from us by calling (800) 235-8631. You must get prior approval for all inpatient and outpatient facility based care and any visits to a non-Plan provider. Please see Medical Management Programs on page 52 for more information.

Benefit Description	You pay
Professional services	**High Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy • Behavioral health treatment for pervasive developmental disorder or autism See the section "Benefits for Pervasive Developmental Disorder or Autism" for a description of the services that are covered. You must get our approval first for all behavioral health treatment services for the treatment of pervasive developmental disorder or autism in order for these services to be covered by this plan. Read "Medical Management Programs" to find out how to get approvals. No benefits are payable for these services if our approval is not obtained.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions. $25 per office visit
Inpatient hospital physician visit	Nothing

Professional services - continued on next page

Benefit Description	You pay
Professional services (cont.)	**High Option**
Individual and group psychotherapy for the treatment of smoking cessation	Nothing
Nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa	Nothing
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility. • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Residential treatment center Before you get services for facility-based care for the treatment of mental or nervous disorders or substance abuse, you must get our approval first. Read "Medical Management Programs" to find out how to get approvals.	$250 per day for a maximum of 4 days
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility. • Services in approved treatment programs, such as partial hospitalization, half-way house, full-day hospitalization, or facility-based intensive outpatient treatment	Nothing
Not covered: • *Academic or educational testing or counseling. Remedying an academic or education problem. Any educational treatment or any services that are educational, vocational, or training in nature except as specifically provided or arranged by us.* • *Treatment of any sexual problems unless due to a medical problem, physical defect, or disease.*	*All charges*

Medical Management Programs

Medical Management Programs apply to the following services:

- Facility-based care for the treatment of mental or nervous disorders and substance abuse and,

- Behavioral health treatment for pervasive developmental disorder or autism, as specified in the section "Benefits for Pervasive Developmental Disorder or Autism", and
- Authorized referrals to non-Plan providers for the treatment of mental or nervous disorders and substance abuse and for behavioral health treatment for pervasive developmental disorder or autism.

The medical management programs are set up to work together with you and your doctor to be sure that you get appropriate medical care and avoid costs you weren't expecting.

You don't have to get a referral from your primary care doctor when you go to a Plan provider for professional services, such as counseling, for the treatment of mental or nervous disorders or substance abuse or for behavioral health treatment for pervasive developmental disorder or autism. You can get a directory of Plan providers who specialize in the treatment of mental or nervous disorders or substance abuse by calling the customer service number on your Member ID card.

Your primary care doctor must provide or coordinate all other care and your medical group must approve it.

The Medical Management Programs consist of the Utilization Review Program and the Authorization Program. These apply as follows:

- The Utilization Review Program applies to facility-based care for the treatment of mental or nervous disorders or substance abuse, and to behavioral health treatment for pervasive developmental disorder or autism.
- The Authorization Program applies to referrals to non-Plan providers for the treatment of mental or nervous disorders or substance abuse and for behavioral health treatment for pervasive developmental disorder or autism and for transgender services.
- All transgender services.

We will pay benefits only if you are covered at the time you get services, and our payment will follow the terms and requirements of this Plan.

Utilization Review Program

The utilization review program looks at whether care is medically necessary and appropriate, and the setting in which care is provided. We will let you and your doctor know if we have determined that services can be safely provided in an outpatient setting, or if we recommend an inpatient stay. We certify and monitor services so that you know when it is no longer medically necessary and appropriate to continue those services.

This plan includes the processes of pre-service, care coordination, and retrospective reviews to determine when services should be covered. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service where care is provided. This plan requires that covered services be medically necessary for benefits to be provided.

Certain services require pre-service review of benefits in order for benefits to be provided.

- **Plan providers will initiate the review on your behalf.**
- **You may ask a non-Plan provider to call the toll free number on your Member ID card to initiate the review for you. Remember that services provided by a non-Plan provider are covered only if they are emergency services, urgent care, or services for which you received an authorized referral.**

In both cases, it is your responsibility to initiate the process and ask your doctor to request pre-service review. You may also call us directly. Pre-service review criteria are based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. We may determine that a service that was initially prescribed or requested is not medically necessary if you have not previously tried alternative treatments that are more cost effective.

You need to make sure that your doctor contacts us before scheduling you for any service that requires utilization review. If you get any such service without following the directions under "How to Get Utilization Reviews," no benefits will be provided for that service.

Utilization review has three parts:

- **Pre-service review.** We look at non-emergency facility-based care for the treatment of mental or nervous disorders and substance abuse and decide if the proposed facility-based care is medically necessary and appropriate. We also review all behavioral health treatment for pervasive developmental disorder or autism as specified in the section "Benefits for Pervasive Developmental Disorder or Autism".
- **Care Coordination review.** We look at and decide whether scheduled, non-emergency inpatient hospital stays and residential treatment center admissions are medically necessary and appropriate when pre-service review is not required or we are notified while service is being provided, such as with an emergency admission to a hospital.
- **Retrospective review.** We look at services that have already been provided:
  - When a pre-authorization, pre-service or care coordination review was not completed; or
  - To examine and audit medical information after services were provided.

Note: Retrospective review may also be done for services that continued longer than originally certified.

Effect on Benefits

- When you don't get the required pre-service review before you get facility-based care for the treatment of mental or nervous disorders or substance abuse, or for behavioral health treatment for pervasive developmental disorder or autism, we **will not provide benefits** for those services.
- Facility-based care for the treatment of mental or nervous disorders or substance abuse and behavioral health treatment for pervasive developmental disorder or autism will be provided only when the type and level of care requested is medically necessary and appropriate for your condition. If you go ahead with any services that have been determined to be not medically necessary and appropriate at any stage of the utilization review process, we **will not provide benefits** for those services.
- When services are not reviewed before or during the time you receive the services, we will review those services when we receive the bill for benefit payment. If that review determines that part or all of the services were not medically necessary and appropriate, we **will not provide benefits** for those services.

How to Get Utilization Reviews

Remember, you must make sure that the review has been done.

Pre-Service Reviews

No benefits will be provided if you do not get pre-service review before receiving scheduled services, as follows:

- You must tell your doctor that this plan requires pre-service review. Doctors who are Plan providers will ask for the review for you. The toll-free number for pre-service review is on your Member ID card.
- For all scheduled services that require utilization review, you or your doctor must ask for the pre-service review at least three working days before you are to get services.
- We will certify services that are medically necessary and appropriate. For facility-based care for the treatment of mental or nervous disorders or substance abuse we will, if appropriate, certify the type and level of services, as well as a specific length of stay. You, your doctor and the provider of the service will get a written notice showing this information.
- If you do not get the certified service within 90 days of the certification, or if the type of the service changes, you must get a new pre-service review.

Care Coordination Reviews

- If pre-service review was not done, you, your doctor or the provider of the service must contact us for care coordination review. If you have an emergency admission or procedure, you need to let us know within one working day of the admission or procedure, unless your condition prevented you from telling us or a member of your family was not available to tell us for you within that time period.
- When you tell Plan providers that you must have utilization review, they will call us for you. You may ask a non-Plan provider to call the toll free number on your Member ID card or you may call directly.

- When we decide that the service is medically necessary and appropriate, we will, depending upon the type of treatment or procedure, certify the service for a period of time that is medically appropriate. We will also decide on the medically appropriate setting.
- If we decide that the service is not medically necessary and appropriate, we will tell your doctor by telephone no later than 24 hours after the decision. We will send written notice to you and your doctor within two business days after our decision. But care will not be stopped until your doctor has been notified and a plan of care that meets your needs has been agreed upon.

Retrospective Reviews

- We will do a retrospective review:
  - If we were not told of the service you received, and were not able to do the appropriate review before your discharge from the hospital or residential treatment center.
  - If pre-service or care coordination review was done, but services continued longer than originally certified.
  - For the evaluation and audit of medical documentation after you got the services, whether or not pre-service or care coordination review was performed.
- If such services are determined to not have been medically necessary and appropriate, we will deny certification.

Authorization Program

The authorization program provides prior approval for medical care or service by a non-Plan provider. The service you receive must be a covered benefit of this plan.

You must get approval before you get any non-emergency or non-urgent service from a non-Plan provider for the following services:

- **Treatment of mental or nervous disorders or substance abuse, and**
- **Behavioral health treatment for pervasive developmental disorder or autism, and**
- **Transgender services.**

The toll-free number to call for prior approval is on your Member ID card.

If you get any such service, and do not follow the procedures set forth in this section, no benefits will be provided for that service.

Authorized Referrals. In order for the benefits of this plan to be provided, you must get approval **before** you get services from non-Plan providers. When you get proper approvals, these services are called authorized referral services.

Effect on Benefits. If you receive authorized referral services from a non-Plan provider, the Plan provider copay will apply. When you do not get a referral, **no benefits are provided** for services received from a non-Plan provider.

How to Get an Authorized Referral. You or your doctor must call the toll-free telephone number on your Member ID card **before** scheduling an admission to, or before you get the services of, a non-Plan provider.

When an Authorized Referral Will be Provided. Referrals to non-Plan providers will be approved only when all of the following conditions are met:

- There is no Plan provider who practices the specialty you need, provides the required services or has the necessary facilities within 50-miles of your home; AND
- You are referred to the non-Plan provider by a doctor who is a Plan provider; AND
- The services are authorized as medically necessary before you get the services.

Disagreements with Medical Management Program Decisions

- If you or your doctor don't agree with a Medical Management Program decision, or question how it was reached, either of you may ask for a review of the decision. To request a review, call the number or write to the address included on your written notice of determination. If you send a written request it must include medical information to support that services are medically necessary.
- If you, your representative, or your doctor acting for you, are still not satisfied with the reviewed decision, a written appeal may be sent to us.
- If you are not satisfied with the appeal decision, you may follow the procedures under Section 8, The disputed claims process.

Revoking or Modifying an Authorization

An authorization for services or care that was approved through either the Utilization Review Program or the Authorization Program may be revoked or modified prior to the services being rendered for reasons including but not limited to the following:

- Your coverage under this plan ends;
- The agreement with the group terminates;
- You reach a benefit maximum that applies to the services in question;
- Your benefits under the plan change so that the services in question are no longer covered or are covered in a different way.

Benefit for Pervasive Developmental Disorder or Autism

This plan provides coverage for behavioral health treatment for Pervasive Developmental Disorder or autism. This coverage is provided according to the terms and conditions of this plan that apply to all other medical conditions, except as specifically stated in this section.

You must obtain our approval in advance for all behavioral health treatment services for the treatment of Pervasive Developmental Disorder or autism in order for these services to be covered by this plan (see "Medical Management Programs" above for details). No benefits are payable for these services if our approval is not obtained. You must receive services from an Anthem Blue Cross Select HMO provider in order for these services to be covered, unless you obtain an authorized referral to a non-Anthem Blue Cross Select HMO provider (see "Medical Management Programs" for details).

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in this section, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this "Definitions" provision.

Definitions

Pervasive Developmental Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, includes Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

Applied Behavior Analysis (ABA) means the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.

Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

Qualified Autism Service Provider is either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified; or

- A person licensed as a physician and surgeon (M.D. or D.O.), physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to state law, who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the licensee.

Our network of Anthem Blue Cross Select HMO providers is limited to licensed Qualified Autism Service Providers who contract with us and who may supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.

Qualified Autism Service Professional is a provider who meets all of the following requirements:

- Provides behavioral health treatment,
- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in state regulation, and
- Has training and experience in providing services for Pervasive Developmental Disorder or autism pursuant to applicable state law.

Qualified Autism Service Paraprofessional is an unlicensed and uncertified individual who meets all of the following requirements:

- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Meets the criteria set forth in any applicable state regulations adopted pursuant to state law concerning the use of paraprofessionals in group practice provider behavioral intervention services, and
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

Behavioral Health Treatment Services Covered

The behavioral health treatment services covered by this plan for the treatment of Pervasive Developmental Disorder or autism are limited to those professional services and treatment programs, including Applied Behavior Analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder or autism and that meet all of the following requirements:

- The treatment must be prescribed by a licensed physician and surgeon (an M.D. or D.O.) or developed by a licensed clinical psychologist,
- The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service provider, and
- The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of Applied Behavioral Analysis services and Intensive Behavioral Intervention services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:
  - Describes the patient's behavioral health impairments to be treated,
  - Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported,

- Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or autism,
- Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate, and
- The treatment plan is not used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and is not used to reimburse a parent for participating in the treatment program. No coverage will be provided for any of these services or costs. The treatment plan must be made available to us upon request.

Section 5(f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 63.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage.

There are important features you should be aware of. These include the following.

Who can write your prescription.

A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication. Certain over-the-counter items for smoking cessation, nicotine replacement, FDA-approved contraceptives for women, vitamins, supplements, and health aids, may be covered when obtained with a doctor's prescription. This rule does not apply to pneumonia or seasonal flu vaccinations provided at a member drug store.

Where you can obtain them.

You may fill the prescription at any licensed retail participating or non-participating pharmacy or by the mail service program. **It will cost you more if you go to a non-participating pharmacy.**

Using Participating Pharmacies.

To get medicine your physician has prescribed, go to a participating pharmacy. For help finding a participating pharmacy, call us at (800) 700-2541 (or TTY/TDD: (800) 905-9821). Show your Member ID card to the participating pharmacy and pay your copayment for the covered medicine. You must also pay for any medicine or supplies that are not covered under the Plan.

If you believe you should get some plan benefits for the medicine that you have paid the cost for, have the pharmacist fill out a claim form and sign it. Send the claim form to us (within 90 days) to:

Prescription Drug Program
Attn: Commercial Claims
P.O. Box 2872
Clint, IA 52733-2872

If the member drugstore doesn't have claims forms, or if you have questions, call (800) 700-2541 (or TTY/TDD: (800) 905-9821).

Using Non-Participating Pharmacies.

It will cost you more if you go to a non-participating pharmacy. Take a claim form with you to the non-member drugstore. If you need a claim form or if you have questions, call (800) 700-2541 (or TTY/TDD: (800) 905-9821). Have the pharmacist fill out the form and sign it. Then send the claim form (within 90 days) to:

Prescription Drug Program
Attn: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

Once the claim is received we will deduct any non-covered costs, including any cost above the non-member drugstore fee schedule (except when drugs are related to urgent care or emergency services) and your copayment. The rest of the cost is covered.

If you are out of state, and you need medicine, call (800) 700-2541 (or TTY/TDD: (800) 905-9821) to find out where there is a member drugstore. If there is no member drugstore, pay for the drug and send the pharmacy benefit manager a claim form.

Getting your medicine through the mail.

To order prescriptions through the mail, **your prescription from your health care provider** should reflect the drug name, how much and how often to take it, how to use it, the provider's name, address and telephone number as well as your name and address. You must complete the order form. The first time you use the mail service program, you must also send a completed Patient Profile questionnaire. Be sure to send your copay along with the prescription, the order form, and the Patient Profile. You can pay by check, money order, or credit card. Send your order to:

Prescription Drug Program
Attn: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

There may be some medicines you cannot order through this program, such as drugs to treat sexual dysfunction. Call (800) 700-2541 (or TTY/TDD: (800) 905-9821) to find out if you can order your medicine through the Mail Service.

Compound Medication is a mixture of prescription drugs and other ingredients of which at least one of the components is commercially available as a prescription product. Compound medications do not include duplicates of existing products and supplies that are mass-produced by a manufacturer for consumers, nor products lacking an NDC number. Compound medications must be dispensed by a member drugstore. Call (800) 700-2541 (or TTY/TDD: (800) 905-9821) to find out where to take your prescription for an approved compound medication to be filled. (You can also find a member drugstore at www.anthem.com/ca.) Some compound medications must be approved before you can get them (see "Drugs that need to be approved" below). You will have to pay the full cost of the compound medications you get from a drugstore that is not a member drugstore.

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. These drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail drugstores. You may obtain a list of medications from our website www.anthem.com/ca.

Getting your medicine through the Specialty Pharmacy.

You can only order specialty drugs through the Specialty Pharmacy Program unless you are given an exception from the Specialty Pharmacy Program. The Specialty Pharmacy Program only fills specialty drug prescriptions and will deliver your medication to you by mail or common carrier. The prescription for the specialty drug must state the drug name, dosage, directions for use, quantity, the doctor's name and phone number, the patient's name and address, and be signed by a doctor. You or your doctor may order your specialty drug by calling (800) 700-2541 (or TTY/TDD: (800) 905-9821). When you call the Specialty Pharmacy Program, a dedicated care coordinator will guide you through the process up to and including actual delivery of your specialty drug to you. If you order your specialty drug by telephone, you will need to pay by credit card or debit card. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase (you can pay by check, money order, credit card or debit card), and a properly completed order form to the Specialty Pharmacy Program at the address shown below. The first time you get a prescription for a specialty drug you must also include a completed Intake Referral Form by calling the toll-free number below. You need only enclose the prescription or refill notice, and the appropriate payment for any subsequent specialty drug prescriptions, or call the toll-free number. Copays can be paid by check, money order, credit card or debit card.

You or your doctor may obtain a list of specialty drugs available through the Specialty Pharmacy Program or order forms by contacting Member Services at the number shown below or online at www.anthem.com/ca.

Specialty Pharmacy Program
Attn: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

If you don't get your specialty drug through the Specialty Pharmacy Program, you might not receive benefits under this plan for them.

Exceptions to Specialty Pharmacy Program. This requirement does not apply to:

A. The first two month's supply of a specialty pharmacy drug which is available through a member drugstore;
B. Drugs, which due to medical necessity, must be obtained immediately; or
C. A member for whom, according to the coordination of benefit rules, this plan is not the primary plan.

How to obtain an exception to the Specialty Pharmacy Program.

If you believe you should not be required to get your medication through the Specialty Pharmacy Program, for any of the reasons listed above, except for C, you must complete an Exception to Specialty Drug Program form and send it to the pharmacy benefits manager by fax or mail. To request an Exception to Specialty Drug Program form, call the pharmacy benefits manager at (800) 700-2541 (or TTY/TDD: (800) 905-9821). You can also get the form on-line at www.anthem.com/ca. If the pharmacy benefits manager has given you an exception, it will be in writing and will be good for 6 months from the time it is given. After 6 months, if you believe you should still not be required to get your medication through the Specialty Pharmacy Program, you must again request an exception. If the pharmacy benefits manager denies your request for an exception, it will be in writing and will explain why it was not approved.

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program.

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, the pharmacy benefits manager may authorize an override of the Specialty Pharmacy Program requirement for 72 hours, or until the next business day following a holiday or weekend. This will allow you to get an emergency supply of medication if your doctor decides it is appropriate and medically necessary. You may have to pay the applicable copay for the 72 hour supply of your drug. If you order your specialty pharmacy drug through the Specialty Pharmacy Program and it does not arrive, and your doctor decides it is medically necessary for you to have the drug immediately, we will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a member drug store near you. A dedicated care coordinator from the Specialty Pharmacy Program will coordinate the exception and you will not be required to make an additional copay.

We use a formulary.

We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. A prescription drug formulary is used to help your doctor make prescribing decisions. The fact that a drug is on this list doesn't guarantee that your doctor will prescribe you that drug. This list, which includes both generic and brand name drugs, is updated quarterly so that the list includes drugs that are safe and effective in the treatment of disease. Some drugs need to be approved - the doctor or drugstore will know which drugs they are. If you have a question regarding whether a particular drug is on our formulary drug list or requires prior authorization please call us at (800) 700-2541 (or TTY/TDD: (800) 905-9821).

New drugs and changes in the prescription drugs covered by the plan.

The National Pharmacy and Therapeutics Committee decides which outpatient prescription drugs are to be included on the prescription drug formulary covered by the plan. The National Pharmacy and Therapeutics Committee is comprised of independent doctors and pharmacists that meet quarterly and decide on changes needed to the prescription drug formulary list based on recommendations and a review of relevant information, including current medical literature. If your current medication changes to a higher Tier level as a result of this review, you will not be responsible for the higher Tier copayment. If the change results in a lower Tier level, you will be responsible for the lower Tier copayment. For example if your current medication is a Tier 2 drug and the National Pharmacy and Therapeutics Committee feels it should be a Tier 3, you will continue to pay the Tier 2 copayment. However, should the committee decide to put your medication in the Tier 1 category, you will begin paying the lower Tier 1 copayment.

These are the dispensing limitations for drugs from a retail pharmacy, Specialty Pharmacy Program, or the mail service program.

You can get a **30-day supply** if you get it at the drugstore or through the Specialty Pharmacy Program. You can get a **60-day supply** of drugs at the drugstore for treating attention deficit disorder if they are FDA approved for the treatment of attention deficit disorder, are federally classified as Schedule II drugs, and require a triplicate prescription form. If the doctor prescribes a 60-day supply for drugs classified as Schedule II for the treatment of attention deficit disorders, you have to pay double the amount of copay for retail drugstores. You can get a **90-day supply** if you get it from our mail service program. If you get the drugs through our mail service program, the copay will be the same as for any other drug.

A generic equivalent will be dispensed if it is available.

When your doctor prescribes a brand-name drug that has a generic option, your pharmacy will automatically fill the prescription using the generic drug. You will pay less for the generic drug. When the brand-name drug has a generic option and you and your doctor still choose the brand-name drug, or your doctor writes "dispense as written," you will be responsible for paying the generic drug copayment plus the difference between the cost of the generic and the brand-name drug.

If your doctor prescribes a brand-name drug and it has no generic option, or if a doctor shows that the brand-name drug is medically necessary for you, you'll only have to pay the brand-name copayment with no extra cost.

Why use generic drugs?

Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs. You can save money by using generic drugs. However, you and your physician have the option to request a name-brand if a generic option is available. Using the most cost-effective medication saves money.

Special Programs

From time to time, we may initiate various programs to encourage you to utilize more cost-effective or clinically-effective drugs including, but, not limited to, generic drugs, mail service drugs, over-the-counter drugs or preferred drug products. Such programs may involve reducing or waiving co-payments for those generic drugs, over-the counter drugs, or the preferred drug products for a limited time. If we initiate such a program, and we determine that you are taking a drug for a medical condition affected by the program, you will be notified in writing of the program and how to participate in it.

Half-tab Program

The Half-Tablet Program allows you to pay a reduced co-payment on selected "once daily dosage" medications. The Half-Tablet Program allows you to obtain a 30-day supply (15 tablets) of a higher strength version of your medication when the prescription is written by the doctor to take "½ tablet daily" of those medications on a list approved by us. The National Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and your decision to participate should follow consultation with and the concurrence of your doctor. To obtain a list of the products available on this program call (800) 700-2541 (or TTY/TDD: (800) 905-9821) or go to our internet website www.anthem.com/ca.

Prescription drug tiers are used to classify drugs for the purpose of setting their co-payment. Anthem will decide which drugs should be in each tier based on clinical decisions made by the National Pharmacy and Therapeutics Committee. Anthem retains the right at its discretion to determine coverage for dosage formulation in terms of covered dosage administration methods (for example, by mouth, injection, topical or inhaled) and may cover one form of administration and may exclude or place other forms of administration in another tier (if it is medically necessary for you to get a drug in an administrative form that is excluded you will need to get written prior authorization (see "Drugs that need to be approved above) to get that administrative form of the drug). This is an explanation of what drugs each tier includes:

- **Tier 1 Drugs** are those that have the lowest copay. This tier includes low cost preferred drugs that may be generic, single source brand name drugs or multi-source brand name drugs.
- **Tier 2 Drugs** are those that have higher copays than Tier 1 Drugs, but, lower than Tier 3 Drugs. This tier includes preferred drugs that may be generic, single source brand name drugs or multi-source brand name drugs.
- **Tier 3 Drugs** are those that have the higher copays than Tier 2 Drugs, but, lower than Tier 4 Drugs. This tier includes non-preferred drugs that may be generic, single source brand name drugs, multi-source brand name drugs and compound medications.
- **Tier 4 Drugs** are specialty drugs.

Benefit Description	You pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a physician and obtained from a retail pharmacy or through our mail order program: • Drugs and medicines which need a prescription by law. Formulas prescribed by a doctor for the treatment of phenylketonuria. These formulas are subject to the copay for brand name drugs. • Growth hormone. • Insulin, glucagon, and other prescription drugs for the treatment of diabetes. • Syringes for use with insulin and other medicines you inject yourself. • Drugs that have FDA labeling to be injected under the skin by you or a family member. • Disposable diabetic supplies (that is, testing strips, lancets, and alcohol swabs). • 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. • Off label use of covered drugs if prescribed by a Plan doctor. • Hormone therapy. Note: If your drugstore's retail price for a drug is less than the copay shown, you will not be required to pay more than that retail price. Note: Written prescriptions are valid for 12 months from the date the prescription is written.	**At Participating Pharmacies:** $5 copay for Tier 1 drugs $40 copay for Tier 2 drugs $70 copay for Tier 3 drugs $70 copay for compound medications $10 copay for diabetic supplies **At Non-Participating Pharmacies:** $5 copay plus 50% of the prescription drug maximum allowed amount for Tier 1 drugs $40 copay plus 50% of the prescription drug maximum allowed amount for Tier 2 drugs $70 copay plus 50% of the prescription drug maximum allowed amount for Tier 3 drugs $10 copay plus 50% of the prescription drug maximum allowed amount for diabetic supplies **For drugs through the Mail Service Program:** $12.50 copay for Tier 1 drugs $90 copay for Tier 2 drugs $150 copay for tier 3 drugs $10 copay for diabetic supplies **For drugs through the Specialty Pharmacy Program**: $125 copay for Tier 4 drugs
• FDA approved drugs for the treatment of tobacco use.	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
Note: This includes prescription and physician prescribed over-the-counter medications.	Nothing
• Women's contraceptive drugs and devices, including the morning after pill, if prescribed by a physician and purchased at a network pharmacy Note: Over-the-counter contraceptive drugs and devices approved by the FDA require a written prescription by an approved provider.	Nothing
• Over the counter items and services (ex. aspirin, vitamin D for age 65 and over, etc.) when prescribed by your physician	Nothing
Not covered: • *Immunizing agents, biological sera, blood, blood products or blood plasma. This exclusion doesn't apply to pneumonia or seasonal flu vaccinations provided at a member drugstore.* • *Drugs and medicines used to induce spontaneous and non-spontaneous abortions.* • *Professional charges for giving and injecting drugs. While not covered under this prescription drug benefit, they are covered as specified in Section 5(a).* • *Drugs and medicines you can get without a doctor's prescription, except insulin or niacin for cholesterol lowering.* • *Drugs labeled "Caution, Limited by Federal Law to Investigational Use," or Non-FDA approved investigational drugs. Drugs and medicines prescribed for experimental indications. If you are denied a drug because we determine that the drug is experimental or investigative, you may ask that the denial be reviewed by an external independent medical review organization.* • *Drugs which haven't been approved for general use by the state or Food and Drug Administration (FDA). This does not apply to drugs that are medically necessary for a covered condition.* • *Drugs and medicines dispensed or given in an outpatient setting; including, but not limited to inpatient facilities and doctors' offices. While not covered under this prescription drug benefit, if you need these drugs, they are covered as specified throughout Section 5.* • *Cosmetics, health and beauty aids.* • *Drugs and medicines dispensed by or while you are confined in a hospital, skilled nursing facility, rest home, sanitarium, convalescent hospital or similar facility. While not covered under this prescription drug benefit, if you need these drugs, they are covered as specified throughout Section 5.* • *Drugs used mainly for cosmetic purposes (for example, Retin-A for wrinkles). But, 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.*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• *Drugs used mainly for treating infertility (for example, Clomid, Pergonal, and Metrodin) unless medically necessary for another covered condition.* • *Drugs for losing weight, except when needed to treat morbid obesity (for example, diet pills and appetite suppressants).* • *Drugs you get outside the United States unless related to emergency services or urgent care.* • *Herbal, nutritional and diet supplements.* • *Compound medications unless all the ingredients are FDA-approved and require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants. Compound medications must be obtained from a member drugstore. You will have to pay the full cost of the compound medications you get from a non-member drugstore.*	*All charges*

Section 5(g). Dental benefits

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with Medicare and other coverage .
- Your medical group must provide or arrange for your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below. See Hospital benefits (Section 5(c)).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage .

Benefit Description	You Pay
Accidental injury benefit	**High Option**
We will cover emergency care for accidental injury to natural teeth. The care is not covered if you hurt your teeth while chewing or biting. We will also cover medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate. **Important:** If you decide to receive dental services that are not covered under this plan, a dentist who participates in an Anthem Blue Cross - Select HMO network may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this plan, please call the Customer Service number on your Member ID card.	Nothing
Not covered: • *Braces or other appliances or services for straightening the teeth (orthodontic services) except as specifically stated in "Reconstructive Surgery".* • *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:* - *Extraction, restoration, and replacement of teeth;* - *Services to improve dental clinical outcomes.* *This exclusion does not apply to the following:* • *Services which we are required by law to cover;* • *Services specified as covered in this booklet;*	*All charges*

Accidental injury benefit - continued on next page

Benefit Description	You Pay
Accidental injury benefit (cont.)	**High Option**
• *Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.*	*All charges*

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefit decision under the OPM disputed claim process (see Section 8).
24/7 Nurse Line (24-hour nurse assessment service)	Health concerns don't follow a 9-to-5 weekday schedule. Sometimes you need answers to your health questions right away-and that can be in the middle of the night or while you're away on vacation. That's why the 24/7 NurseLine is there for you and your family 24 hours a day, seven days a week. You can call the 24/7 NurseLine any time to speak with a registered nurse who is trained to help you make more informed decisions about your health situation. For accurate, confidential health information, call the number on the back of you member ID card. A nurse is just a phone call away. **Sensitive Topic?** No problem. Not everyone is comfortable discussing their health concerns with someone else. If you prefer, you can call and listen to confidential recorded messages about hundreds of health topics in English and Spanish by accessing the AudioHealth Library. Call the number on the back of you member ID card.
Reciprocity	**BlueCard® Program**

	With the BlueCard® Program, Plan members have access to benefits when traveling outside the Plan's service area for urgent care and emergency room services. To find a nearby health care provider, members can simply call BlueCard Access at (800) 810-BLUE (2583). **Guest Membership Program** We offer guest memberships at affiliated HMO Plans through the Guest Membership Program. Whenever you or a family member is away from our service area for more than 90 days, you may become a guest member at an affiliated HMO near your destination. Reasons to consider a guest membership include extended out-of-town business, children away at school, dependent children in another state, or a winter “snowbird” residency in the South. To determine if a guest membership is available at your destination, call (800) 827-6422.
Centers of Excellence	We use the Blue Distinction Center for Transplants as our transplant network. The network consists of leading medical facilities throughout the nation. For a list of transplant hospitals near you, call (800) 824-0581. Blue Distinction Centers for Cardiac Care provide a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization and cardiac surgery (including coronary artery bypass graft surgery). To date, we have designated more than 410 Blue Distinction Centers for Cardiac Care across the country.

Non-FEHB benefits available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB copayments or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at (800) 235-8631 or visit their website at www.anthem.com/ca.

Optional Dental Benefits – These are separate benefit packages that require additional premiums.

HERE'S AN OPPORTUNITY TO ENHANCE YOUR TOTAL HEALTH CARE PACKAGE BY

ADDING COMPREHENSIVE DENTAL BENEFITS

Dental SelectHMO & Dental Net - Dental Maintenance Organization Options: These are plans that offer members broad ranges of dental coverage at a lower cost. Under either plan, members choose their own dentist from a network of providers, and may change their dentist at any time. Once you have enrolled in Dental SelectHMO or Dental Net, your provider will perform preventive and diagnostic services and other dental services free of charge or at a greatly reduced rate.

Key Dental SelectHMO & Dental Net Advantages

- Diagnostic and Preventive Services are FREE
- No Deductibles and No Claim Forms
- Benefits include Orthodontic Coverage

HealthyExtensions Discount Program for Anthem Blue Cross-Select HMO Members at no extra premium

As a Federal Employee and a member of the Anthem Blue Cross-Select HMO you are now entitled to special discounts on products and services to help support and encourage your healthy lifestyle. The information provided through the HealthyExtensions program allows you to take advantage of discounts of 5-50 percent on the following services:

•Prescription eyewear	•Contact lenses
•Laser vision correction	•Fitness club memberships
•Massage therapy and yoga	•Nutritional supplements
•Skin care products	•Weight loss programs
•Hearing aids	•And much more

For more information go to www.anthem.com/ca and click on “Healthy Living”, then “HealthyExtensions”.

Anthem Blue Cross Senior Secure - Medicare prepaid plan (HMO) provides complete coverage for medically necessary hospital and doctor services with no monthly premium, no deductibles and a prescription drug benefit.

Coverage includes:

•Prescription Drug	•Chiropractic Care
•Vision	•Hearing
•Dental	•Podiatry

Anthem Blue Cross Senior Secure features all of the health coverage services offered by Medicare plus some extra services Medicare does not offer. Contact Customer Service, toll free (888) 230-7338 to obtain detailed benefits and a list of providers in your area. As indicated on page 82, you may remain enrolled in FEHBP when you enroll in a Medicare Advantage plan.

Benefits on this page are not part of the FEHB contract

Section 6. General exclusions – services, drugs, and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Section 5(d) for Emergency services).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services or supplies that are not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Care you got from a health care provider without the approval of your primary care doctor or a doctor specializing in OB-GYN in your medical group, except for emergency services or urgent care.
- Services not listed as being covered by this Plan.
- Any services actually given to you by a local, state or federal government agency, or by a public school system or school district, except when this Plan's benefits, must be provided by law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.
- Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed doctor, except as specifically provided or arranged by us. This exclusion does not apply to the medically necessary treatment of pervasive developmental disorder or autism, to the extent stated in the section "Benefits for Pervasive Developmental Disorder or Autism".
- Services you are not required to pay for or are given to you at no charge, except services you got at a charitable research hospital (not with the government). This hospital must:
  - Be known throughout the world as devoted to medical research.
  - Have at least 10% of its yearly budget spent on research not directly related to patient care.
  - Have 1/3 of its income from donations or grants (not gifts or payments for patient care).
  - Accept patients who are not able to pay.
  - Serve patients with conditions directly related to the hospital's research (at least 2/3 of their patients).
- 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.
- 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.
- 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.
- This plan does not cover educational or academic services as follows:

- Educational or academic counseling, remediation, or other services that are designed to increase academic knowledge or skills.
- Educational or academic counseling, remediation, or other services that are designed to increase socialization, adaptive, or communication skills.
- Academic or educational testing.
- Teaching skills for employment or vocational purposes.
- Teaching art, dance, horseback riding, music, play, swimming, or any similar activities
- Teaching manners and etiquette or any other social skills.
- Teaching and support services to develop planning and organizational skills such as daily activity planning and project or task planning

This exclusion does not apply to the medically necessary treatment of pervasive developmental disorder or autism, to the extent stated in the section “Benefits for Pervasive Developmental Disorder or Autism”.

- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and you pay your copayment, coinsurance or deductible, if applicable.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and Hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. To obtain claim forms, or for claims questions and assistance, call us at (800) 235-8631 or at our website at www.anthem.com/ca.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to: Anthem Blue Cross, P.O. Box 60007 Los Angeles, CA. 90060-0007.

Prescription drugs

You normally won't have to submit claims to us unless you receive prescriptions from a non-participating pharmacy. You need to take a claim form with you to the non-participating pharmacy. If you need a claim form or if you have questions, call us at (800) 700-2541 or at our website at www.anthem.com/ca. Have the pharmacist fill out the form and sign it. Then send the claim form (within 90 days).

Submit your claims to: Prescription Drug Program, Attn: Commercial Claims P.O. Box 2872, Clinton, IA 52733-2872.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.anthem.com/ca/fep.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-services claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing to Anthem Blue Cross-Select HMO, P.O. Box 4310, Woodland Hills, CA 93167 or calling (800) 235-8631.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Anthem Blue Cross-Select HMO, P.O. Box 4310, Woodland Hills, CA. 91367; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for members), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stare described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or

	c) Ask you or your provider for more information You or your provider must send information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 2, 1900 E Street, NW, Washington, DC 20415. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physician's letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letter we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (800) 235-8631. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at www.NAIC.org.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our Plan providers.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we pay benefits for that injury or illness, you must agree to the provisions listed below. In addition, if you are injured and no other person or entity is responsible but you receive (or are entitled to) a recovery from another source, and if we provide benefits for that injury, you must agree to the following provisions:

- All recoveries you obtain (whether by lawsuit, settlement, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or, if applicable, to your heirs, administrators, successors, or assignees.
- Reimbursement to us out of your recoveries shall take first priority (before any of the rights of any other parties are honored). Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine. Our right of reimbursement is fully enforceable regardless of whether you are "made whole" (you are fully compensated for the full amount of damages claimed). We will not reduce our share of any recovery unless we agree in writing to a reduction, because (1) you do not receive the full amount of damages that you claimed, or (2) you had to pay attorneys' fees. This is our right of recovery.
- If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.
- If we pursue a recovery of the benefits we have paid, you must cooperate in doing what is reasonably necessary to assist us. You must not take any action that may prejudice our rights to recover.

You must tell us promptly if you have a claim against another party for a condition that we have paid or may pay benefits for, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay.

We may request that you assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the assignment.

Note: We will pay the costs of any covered services you receive that are in excess of any recoveries made.

The following are examples of circumstances in which we may subrogate or assert a right of recovery:

- When you or your dependent are injured on premises owned by a third party; or
- When you or your dependent are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to:

  - Personal injury protection benefits
  - Uninsured and underinsured motorist coverage (does not include no-fault automobile insurance)
  - Workers' compensation benefits
  - Medical reimbursement coverage

Contact us if you need more information about subrogation.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB Plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, or by phone (877) 888-3337, (TTY (877) 889-5680), you will be asked to provide information on your FEHB Plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by the Plan.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan does not cover these costs.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis or results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs.

When you have Medicare

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact (800) MEDICARE (TTY: (877) 486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan called Anthem Blue Cross Senior Secure. Please review the information on coordinating benefits with Medicare Advantage on page 82.

- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Adminstration online at www.socialsecurity.gov, or call them at (800) 772-1213 (TTY: (800) 325-0778).

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number (800) 772-1213 (TTY: (800) 325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payor, we process the claim first.
- When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something about filing your claims, call us at (800) 235-8631 or see our website at www.anthem.com/ca.

We waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

When Medicare Part A is primary – we will waive the Inpatient hospital copayments**.**

Note: Once you have exhausted your Medicare Part A benefits then you will pay the inpatient hospital copayment**.**

When Medicare Part B is primary – we will waive copayments and coinsurance for care received from covered professional and facility providers**.**

Note: We do not waive benefit limitations. In addition, we do not waive any coinsurance or copayments for prescription drugs**.**

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

Benefit Description	**Member Cost without Medicare**	**Member Cost with Medicare Parts A and/or B**
Deductible	$0	$0
Out of Pocket Maximum	$3,000 for Self Only or $3,000 per person for Self Plus One or $6,000 for Family	$0
Primary Care Physician	$25	$0
Specialist	$40	$0
Inpatient Hospital	$250 per day for a maximum of 4 days	$0
Outpatient Hospital	$250 per visit for surgical admissions or $40 per visit for other services	$0
Rx	Tier 1 -$5 Tier 2 -$40 Tier 3 - $70 Tier 4 – Specialty (30 day supply) - $125	Tier 1 -$5 Tier 2 -$40 Tier 3 - $70 Tier 4 – Specialty (30 day supply) - $125
Rx – Mail Order (90 day supply)	2½ x retail copay	2½ x retail copay

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at (800) MEDICARE ((800) 633-4227), (TTY: (877) 486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments or coinsurance for your FEHB coverage.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB Plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments or coinsurance. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium). For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB Plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical Trials Cost Categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab test, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See Section 4, page 22.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See Section 4, page 22.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Custodial care is care for your personal needs. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, giving medicine which you usually do yourself or any other care for which the services of a professional health care provider are not needed.

Experimental or investigational services

Experimental procedures are those that are mainly limited to laboratory and/or animal research. Investigative procedures or medications are those that have progressed to limited use on humans, but which are not generally accepted as proven and effective within the organized medical community. Any experimental or investigative procedures or medications are not covered under this Plan. Your medical group or we will determine whether a service is considered experimental or investigative.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity

Medically necessary procedures, services, supplies or equipment are those that your medical group or Anthem Blue Cross decides are:

- Appropriate and necessary for the diagnosis or treatment of the medical condition.
- Provided for the diagnosis or direct care and treatment of the medical condition.
- Within standards of good medical practice within the organized medical community.

- Not primarily for your convenience, or for the convenience of your *doctor* or another provider.
- Not more costly than an alternative service or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of the patient's illness, injury, or condition.
- The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
  - There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, equipment, service or supply are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
  - Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
  - For hospital stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. In most cases, our Plan allowance is equal to a rate we negotiate with providers. This rate is normally lower than what they usually charge and any savings are passed on to you.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order the apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Urgent care claims

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at (800) 235-8631. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We Us and We refers to Blue Cross of California, doing business under the trade name Anthem Blue Cross (Anthem).

You You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** - Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?	Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at (877) FSAFEDS ((877) 372-3337), Monday through Friday, 9 a.m. until 9 p.m. Eastern Time. TTY: (800) 952-0450.

The Federal Employees Dental and Vision Insurance Program - *FEDVIP*

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.** FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.
Dental Insurance	All dental plans provide a comprehensive range of services, including: • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures. • Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**
Vision Insurance	All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional Information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call (877) 888-3337 (TTY: (877) 889-5680).

The Federal Long Term Care Insurance Program - *FLTCIP*

It's important protection	The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living - such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call (800) LTC-FEDS ((800) 582-3337) (TTY: (800) 843-3557), or visit www.ltcfeds.com.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Notes

Notes

Summary of benefits for Anthem Blue Cross-Select HMO - 2016

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, unless you receive an authorized referral or the services are for emergency or urgent care.

Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	PCP office visit copay: $25 Specialist office visit copay: $40	26
Services provided by a hospital:		
• Inpatient	$250 per day for a maximum of 4 days.	44
• Outpatient	Nothing unless surgery is performed. $250 per outpatient surgery admission.	45
Emergency visit to a hospital emergency room:		
• In-area or out-of-area	$125 per visit	50
Mental health and substance abuse treatment:		
• Inpatient	$250 per day for a maximum of 4 days	52
• Outpatient	Regular cost-sharing	52
Prescription drugs:		
• **Retail pharmacy** - Up to a 30-day supply. Note: You must obtain specialty drugs from the Specialty Pharmacy Program unless we have granted a written exception.	Network pharmacy: $5 for Tier 1; $40 for Tier 2; $70 for Tier 3; $70 for compound medications; $125 for Tier 4. Non-Network pharmacy: $5 plus 50% of drug maximum allowed amount for Tier 1; $40 plus 50% of drug maximum allowed amount for Tier 2; $70 plus 50% of drug maximum allowed amount for Tier 3	63
• **Mail-order Program -** up to a 90-day supply	$12.50 for Tier 1; $90 for Tier 2; $150 for Tier 3 and $10 for diabetic supplies.	63
Dental care: Restorative services for accidental injury only	Nothing	66
Vision care:	Annual eye refraction; you pay nothing.	32
Special features: 24/7 Nurse Line		68
Protection against catastrophic costs: (your catastrophic protection out-of-pocket maximum)	Nothing after $3,000/Self Only or $6,000/Self and Family enrollment per year	22

2016 Rate Information for Anthem Blue Cross - Select HMO

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, contact the agency that maintains your health benefits enrollment.

Postal rates apply to United States Postal Service employees.

Postal Category 1 rates apply to career bargaining unit employees.

Postal Category 2 rates apply to career non-bargaining unit employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center: (877) 477-3273, option 5, (TTY: (866) 260-7507)

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees.

Premiums for Tribal employees are shown under the monthly non-postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Most of Southern California							
High Option Self Only	B31	$213.37	$123.70	$462.30	$268.02	$111.84	$123.70
High Option Self Plus One	B33	$461.02	$213.19	$998.88	$461.91	$187.58	$213.19
High Option Self and Family	B32	$488.50	$227.13	$1,058.42	$492.11	$199.99	$227.13