Anthem Blue Cross-HMO

http://www.anthem.com/ca

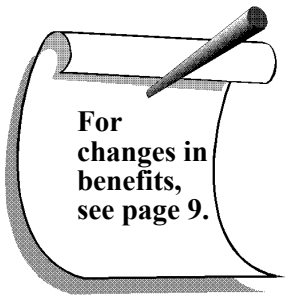
Anthem Blue Cross

2011

A Health Maintenance Organization

Serving: Most of California

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 8 for requirements.



Enrollment codes for this Plan:

M51 Self Only
M52 Self and Family

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Center for
Retirement and Insurance Services
http://www.opm.gov/insure

RI 73-517

Important Notice from Anthem Blue Cross About

Our Prescription Drug Coverage and Medicare

OPM has determined that the Anthem Blue Cross - 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. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit 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 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'll 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 (November 15th through December 31st) 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 1-800-772-1213 (TTY 1-800-486-2048).

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 1-800-MEDICARE (1-800-633-4227). TTY 1-877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of the Anthem Blue Cross - HMO Plan under our contract (CS 2514) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. 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 oral 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. You do not have a right to benefits that were available before January 1, 2011, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2011, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- 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 first.
- Our brochure and other FEHB Plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Operations, Program Planning & Evaluation, 1900 E Street, NW, Washington, DC 20415-3650.

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.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.

- 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

202-418-3300

OR 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); or
  - 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.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or if you are no longer enrolled in the Plan.
- 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.

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 that you take, including non-prescription (over-the-counter) medicines.

- Tell them about any drug allergies you have.
- 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 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.

- www.quic.gov/report/toc.htm. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Never Events

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-HMO provider. This new policy will help protect you from preventable medical errors and improve the quality of care you receive.

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

Section 1. Facts about this HMO Plan

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.

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in-network and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

Questions regarding what protections apply may be directed to us at 800-235-8631. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

Who provides my health care?

When you enroll you should choose a primary care physician. Your primary care physician will be the first doctor you see for all your health care needs. If you need special kinds of care, this physician will refer you to other kinds of health care providers.

Your primary care physician will be part of an Anthem Blue Cross-HMO contracting medical group. There are two types of Anthem Blue Cross-HMO medical groups.

- A primary medical group (PMG) is a group practice staffed by a team of doctors, nurses, and other health care providers.
- An independent practice association (IPA) is a group of doctors in private offices who usually have ties to the same hospital.

You and your family members can enroll in whatever medical group is best for you. You must live or work within 30 miles of the medical group. You and your family members do not have to enroll in the same medical group.

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-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.

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/insure) 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 specific information about us, call 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 818-234-6401, 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 consists of the following counties in California:

Northern California Counties

Alameda, Amador, Contra Costa, Del Norte, Fresno, Humboldt, Kings, Madera, Marin, Mendocino, Merced, Nevada, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tuolumne, Yolo

Southern California Counties

Imperial, Los Angeles, Orange, San Diego, San Luis Obispo, Santa Barbara, Ventura

You may also enroll with us if you live in or work in the Zip Codes of the following counties:

KERN: 93203, 93205-06, 93215-17, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93249-52, 93255, 93263, 93276, 93280, 93283, 93285, 93287, 93300-09, 93311-13, 93380-89, 93399, 93504-05, 93516, 93518-19, 93523-24, 93528, 93531, 93554, 93555, 93556, 93560-61, 93570, 93581-82, 93596

RIVERSIDE: 91718-20, 91752, 91753, 91760, 92201-03, 92210, 92211, 92220, 92223, 92230, 92234-36, 92240, 92241, 92253-55, 92258, 92260-64, 92270, 92276, 92282, 92292, 92303, 92320, 92330-31, 92343-44, 92348, 92353, 92355, 92360-62, 92367, 92370, 92379-81, 92383, 92387-88, 92390, 92395-96, 92500-09, 92513-19, 92521-23, 92530-32, 92542-46, 92548, 92550, 92552-57, 92562-64, 92567, 92570-72, 92581-87, 92589-93, 92595-96, 92599

SAN BERNARDINO: 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758, 91761-64, 91784-86, 91798, 92252, 92256, 92268, 92277-78, 92284-86, 92301, 92305, 92307-08, 92311-13, 92314-18, 92321-22, 92324-27 92329, 92333-37, 92339-42, 92345-47, 92350, 92352, 92354, 92356-59, 92365, 92368-69, 92371-78, 92382, 92385-86, 92391-94, 92397, 92398, 92399, 92400-18, 92420, 92423-24, 92427

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 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. How we change for 2011

Do not rely only on these change descriptions; 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

- Several provisions of the Affordable Care Act (ACA) affect eligibility and benefits under the FEHB Program and FSAFEDS beginning January 1, 2011. For instance, children up to age 26 will be covered under a Self and Family enrollment. Please read the information in Sections 11 and 12 carefully.
- We have reorganized organ and tissue transplant benefit information to clarity coverage.
- We have reorganized mental health and substance abuse benefits to clarify coverage.

Changes to this Plan

- Your share of the non-Postal premium will increase for Self only and Self and Family coverage. Please refer to the rates on the back cover of this brochure.
- You will no longer be required to pay a copayment for preventive care services provided for adults and children. See Section 5(a).
- You must pay 20% coinsurance for durable medical equipment (DME) up to the $3,000 annual benefit maximum. Previously, you paid nothing up to a $2,000 annual benefit maximum. See Section 5(a).
- You will no longer be required to pay a copayment for family planning services. See Section 5(a).
- The copayment for a CT scan, MRI, nuclear cardiac scan and PET scan will be $100 per test. Previously, you did not have a copayment for these services. See Section 5(a).
- Your copayment for chiropractic care services will decrease from $25 to $15 per visit. See Section 5(a).
- Your out-of-pocket maximum for covered services that you receive within our network will increase to from $1,500 to $2,000 for Self only coverage and from $2,000 to $4,000 for a Self and family coverage. See *Section 4. Your costs for covered services*.
- The hospital emergency room copayment will increase from $75 to $100 per visit. Section Section 5(d).
- Your copayment for outpatient hospital and ambulatory surgical center services will increase from $100 to $150 per outpatient surgery admission. See Section 5(c).
- Your copayment for brand name drugs will be increase from $30 to $35 for covered medication from a retail pharmacy and from $60 to $70 for a 90-day supply of covered medication through the mail order program. See Section 5(f).
- We have added the Generic Select Program to the prescription drug benefits. See Section 5(f).
- You will no longer be required to pay a copayment for inpatient facility-based care for mental health and substance abuse benefits. See Section 5(e).
- We will provide benefits for bone marrow/stem cell transplant donor testing. You will not be required to pay a copayment. We will pay up to a maximum benefit of $30,000 per search.
- You will not be required to pay a copayment for counseling sessions in a smoking cessation program, for up to two quit attempts per year with up to four counseling cessation per quit attempt.
- You will not be required to pay a copayment for FDA-approved smoking cessation drugs, both prescription and over-the-counter.

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, 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, and you will not have to file claims. For treatment of a mental health or substance abuse condition you may request an authorized referral to a non-Plan provider. See Mental Health and Substance Abuse Benefits (Section 5(e)) for details.

- **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 publish a directory of Plan providers. You can get a directory which lists all medical groups. You may call our Customer Service number or you may write to us and ask us to send you a directory. You may also search for a Plan provider using the "Provider Finder" function on our Website at www.anthem.com/ca.

If you are a new Anthem Blue Cross-HMO member and are currently receiving treatment for a qualifying medical condition from a provider who is not in our network, you may be eligible to complete the treatment of your condition with the provider. Or, if you are an existing member and are currently receiving treatment for a qualifying medical condition from a provider who is leaving our network, you may be eligible to complete the treatment of your condition with the provider. In order to receive more information about continuity of care and qualifying medical conditions and situations, please contact us at 800-235-8631 and we will assist you.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. The list is located on our Web site.

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. Your primary care physician will be the first doctor you see for all your health care needs. If you need special kinds of care, this doctor will refer you to other kinds of health care providers. This decision is important since your primary care physician provides or arranges for most of your health care. Your primary care physician will be part of an Anthem Blue Cross-HMO contracting medical group. There are two types of Anthem Blue Cross-HMO medical groups:

- A primary medical group (PMG) is a group practice staffed by a team of doctors, nurses, and other health care providers.
- An independent practice association (IPA) is a group of doctors in private offices who usually have ties to the same hospital.

You and your family members can enroll in whatever medical group is best for you.

- You must live or work within 30 miles of the medical group.
- You and your family members do not have to enroll in the same medical group.

- **Primary care** Your primary care physician can be a general or family practitioner, internist or pediatrician. Certain specialists we may approve may also be designated primary care physician. 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 doctor may refer you to another physician if you need special care. Your primary care physician must approve all the care you get except when you have an emergency or need urgent care.

  Your doctor's medical group has to agree that the service or care you will be getting from the other health care provider is medically necessary. Otherwise it won't be covered.

  - You will need to make the appointment at the other doctor's office.
  - Your primary care physician will give you a referral form to take with you to your appointment. This form gives you the approval to get this care. If you don't get this form, ask for it or talk to your Anthem Blue Cross-HMO coordinator.
  - You may have to pay a copayment. You shouldn't get a bill, unless it is for a copayment, for this service. If you do, send it to your Anthem Blue Cross-HMO coordinator at your primary medical group right away. The medical group will see that the bill is paid. If you need additional help you can call our customer service department.

  Standing Referrals. If you have a condition or disease that:

  - Requires continuing care from a specialist; or is
  - Life-threatening;
  - Degenerative; or
  - Disabling;

  your primary care physician may give you a standing referral to a specialist or specialty care center. The referral will be made if your primary care physician, in consultation with you, and a specialist or specialty care center, if any, determine that continuing specialized care is medically necessary for your condition or disease.

  If it is determined that you need a standing referral for your condition or disease, a treatment plan will be set up for you. The treatment plan:

  - Will describe the specialized care you will receive;
  - May limit the number of visits to the specialist; or
  - May limit the period of time that visits may be made to the specialist.

  If a standing referral is authorized, your primary care physician will determine which specialist or specialty care center to send you to in the following order:

  - First, an Anthem Blue Cross-HMO contracting specialist or specialty care center which is associated with your medical group;
  - Second, any Anthem Blue Cross-HMO contracting specialist or specialty care center; and
  - Last, any specialist or specialty care center;

  that has the expertise to provide the care you need for your condition or disease.

  After the referral is made, the specialist or specialty care center will be authorized to provide you health care services that are within the specialist's area of expertise and training in the same manner as your primary care physician, subject to the terms of the treatment plan.

Remember: We only pay for the number of visits and the type of special care that your primary care physician approves. Call your physician if you need more care. **If your care isn't approved ahead of time, you will have to pay for it (except for emergencies or urgent care).**

Ready Access. There are two ways you may get special care without getting an approval from your medical group. These two ways are the "Direct Access" and "Speedy Referral" programs. Not all medical groups take part in the Ready Access program. See your Anthem Blue Cross-HMO Directory for those that do.

Direct Access. You may be able to get some special care without an approval from your primary care physician. We have a program called "Direct Access", which lets you get special care, without an approval from your primary care physician for:

- Allergy
- Dermatology
- Ear/Nose/Throat

Ask your Anthem Blue Cross-HMO coordinator if your medical group takes part in the "Direct Access" program. If your medical group participates in the Direct Access program, you must still get your care from a physician who works with your medical group. The Anthem Blue Cross-HMO coordinator will give you a list of those doctors.

Speedy Referral. If you need special care, your primary care physician may be able to refer you for it without getting an approval from your medical group first. The types of special care you can get through Speedy Referral depend on your medical group.

If You Are A Woman

You can get OB-GYN services from a doctor who specializes in caring for women (OB-GYN) or family practice doctor who does OB-GYN and works with your medical group.

- You can get these services without an approval from your primary care physician.
- Ask your Anthem Blue Cross-HMO coordinator for the list of OB-GYN health care providers you must choose from.

When You Want A Second Opinion

Your medical group is responsible for arranging second opinions and specialty care with health care providers who are part of or who are affiliated with your Anthem Blue Cross-HMO medical group. Working with your medical group supports and improves the coordination and quality of your medical care.

If your primary care physician referred you to a specialist (called a "group" specialist) and you want a second opinion, you have the right to a second opinion by an appropriately qualified health care professional who is part of the Anthem Blue Cross-HMO provider network. If there is no appropriately qualified health care professional in the network, we will authorize a second opinion by another appropriately qualified health care professional, taking into account your ability to travel.

Reasons for asking for a second opinion include, but are not limited to:

- Questions about whether recommended surgical procedures are reasonable or necessary.
- Questions about the diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to a serious chronic condition.
- The clinical indications are not clear or are complex and confusing.
- A diagnosis is in doubt because of test results that do not agree.
- The first doctor is unable to diagnose the condition.

- The treatment plan in progress is not improving your medical condition within an appropriate period of time.
- You have tried to follow the treatment plan or you have talked with the specialist about serious concerns you have about your diagnosis or plan of care.

To ask for a second opinion about recommendations by your primary care physician, call your primary care physician or your Anthem Blue Cross-HMO coordinator at your medical group.

To ask for a second opinion from a specialist outside your medical group, please call us at 800-235-8631. The customer service representative will verify your Anthem Blue Cross-HMO membership, get preliminary information, and give your request to an RN case manager.

A decision is made within five business days from when we get the information necessary to make a decision. Decisions on urgent requests are made within a time frame appropriate to your medical condition and no later than the next business day.

When approved, your case manager helps you with selecting an Anthem Blue Cross-HMO specialist within a reasonable travel distance and makes arrangements for your appointment at a time convenient for you and appropriate to your medical condition. If your medical condition is serious, your appointment will be scheduled within no more than seventy-two (72) hours. Your case manager will work with you and your medical group to make sure the specialist has your medical records before your appointment. Except for your usual co-payment, we cover the specialist's fee.

An approval letter is sent to you and the specialist. The letter includes the services approved and the date of your scheduled appointment. It also includes a toll free number to call your case manager if you have questions or need additional help. Approval is for the second opinion consultation only. It does not include any other services such as lab, x-ray, or treatment by the specialist. You and your primary care physician will get a copy of the specialist's report, which includes any recommended diagnostic testing or procedures. When you get the report, you and your primary care physician or group specialist should work together to determine your treatment options and develop a treatment plan. Your medical group must authorize all follow-up care.

Only our Medical Director may decide when we will not cover the fees for a specialist you choose. This may happen when you choose a specialist who is not part of the Anthem Blue Cross-HMO network and the same kind of specialist is available in the network. If your request is not approved, the letter we send you will include the names of the specialists that can be approved.

You may appeal a disapproval decision by following our complaint process. Procedures for filing a complaint are described later in this booklet under Section 8 and in your denial letter.

If you have questions or need more information about this program, please contact your Anthem Blue Cross-HMO coordinator at your medical group or call us at 800-235-8631.

Here are other things you should know about specialty care:

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. 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. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you have a chronic or 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 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.

- If you are a new Anthem Blue Cross-HMO member and are currently receiving treatment for a qualifying medical condition from a provider who is not in our network, you may be eligible to complete treatment of your condition with the provider. Or, if you are an existing member and are currently receiving treatment for a qualifying medical condition from a provider who is leaving our network, you may be eligible to complete treatment of your condition with the provider. In order to receive more information about continuity of care and qualifying medical conditions and situations, please contact us at 800-235-8631 and we will assist you.

- **Hospital care**

There may be a time when your primary care physician says you need to go to the hospital. If it is not an emergency, the medical group will look into whether or not it is medically necessary. If the medical group approves your hospital stay, you will need to go to a hospital that works with your medical group. The same is true for admissions 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; or
- 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.

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.

Section 4. Your costs for covered services

You must share the costs of some services. You are responsible for:

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.
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.
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 $2,000 for one family member or $4,000 for two or more family members 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: • *Prescription drug benefits* • *Infertility services*
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 9 for how our benefits have changed this year and page 77 for a benefits summary. This benefits section is divided into subsections. Please read *Important things you should keep in mind* at the beginning of each subsection. 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 at our Web site at www.anthem.com/ca.

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 at our Web site 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 care office visit copay
- No office visit copay for family planning visits
- $100 emergency room copay
- $200 per day up to $600 maximum copay per covered inpatient hospital admission
- $150 outpatient facility copay for surgery

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

Here are some 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 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion • At home	$25 per office visit
• During a hospital stay • In a skilled nursing facility	Nothing
• In an urgent care center	$35 per visit
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: • CT Scan • MRI • Nuclear Cardiac Scan • PET Scan	$100 per test performed in a doctor's office, radiology center, outpatient department of a hospital, or ambulatory surgical center.

Benefit Description	You pay
Preventive care, adult	**High Option**
• Full physical exams and periodic check-ups ordered by your primary care physician	Nothing
• Eye exams to determine the need for vision correction. Vision exams include 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 • Ear exams to determine the need for hearing correction. Hearing exams include tests to diagnose and correct hearing	Nothing
• Routine Prostate Specific Antigen (PSA) test	Nothing
Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including, but not limited to - Fecal occult blood test - Sigmoidoscopy - Double contrast barium enema - Colonoscopy	Nothing
• Routine Pap test	Nothing
• Routine mammogram	Nothing
• Adult routine immunizations prescribed by your primary care physician and endorsed by the Centers of Disease Control and Prevention (CDC)	Nothing
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.*	*All charges*
Preventive care, children	**High Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 22), such as: - Full physical exams and periodic check-ups ordered by your primary care physician - Eye exams to determine the need for vision correction. Vision exams include 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 - Ear exams to determine the need for hearing correction. Hearing exams include tests to diagnose and correct hearing	Nothing

Benefit Description	You pay
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care and Postnatal care	$25 per office visit
• Delivery 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 and Family enrollment. Newborn circumcision is covered under Surgery benefits (See 5(b)). • 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)).	Nothing Note: You owe a hospital admission copay for inpatient hospital services.
Family planning	**High Option**
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 • Doctor's services to prescribe, fit and insert an IUD or diaphragm Note: You pay nothing for the IUD or diaphragm dispensed by the doctor. Note: We cover oral contraceptives under the prescription drug benefit.	Nothing
• Shots and implants for birth control (such as Depo provera) • Genetic testing, when medically necessary	Nothing
Not covered: • *Reversal of voluntary surgical sterilization*	*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 and oral fertility drugs under the prescription drug benefit.	50% for all care

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**High Option**
Not covered: • *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*	*All charges*
Allergy care	**High Option**
• Testing and treatment	$25 per office visit
• Allergy injections including serum	Nothing
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) when approved by your primary care physician	Nothing
Physical and occupational therapies and cardiac rehabilitation	**High Option**
• Visits for rehabilitation, such as physical therapy and occupational therapy when prescribed by your physician for the services of each of the following: - qualified licensed physical therapists; and - licensed occupational therapists. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 60 days.	Nothing
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*

Benefit Description	You pay
Speech therapy	**High Option**
• Visits to a licensed speech therapist when prescribed by your physician	Nothing
Hearing services (testing, treatment, and supplies)	**High Option**
• Hearing testing which includes screenings to diagnose and correct hearing	Nothing
• Hearing aid services when ordered by or purchased as a result of a written recommendation from: - An otolaryngologist, or - A state certified audiologist Services include audiological evaluations to: - Measure the extent of hearing loss; and - Determine the most appropriate make and model of hearing aid	$25 per office visit
• Hearing aids (monaural or binaural) including: - Ear mold(s), the hearing aid instrument; and - Batteries, cords and other ancillary equipment Note: We treat hearing aids as durable medical equipment.	20% up to the $3,000 calendar year durable medical equipment maximum; all charges thereafter
Not covered: • *Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss*	*All charges*
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* • *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.	$25 per office visit
Not covered: • *Routine foot care*	*All charges*

Benefit Description	You pay
Orthopedic and prosthetic devices	**High Option**
• 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 • Hearing aids and testing to fit them • Prosthetic devices to restore a method of speaking when required as a result of a laryngectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Colostomy supplies • Supplies needed to take care of these devices • Therapeutic shoes and inserts designed to prevent foot complications due to diabetes	Nothing
Not covered: • *Scalp hair prosthesis including wigs and any other form of hair replacement.* • *Therapeutic shoes and inserts that are not related to complications from diabetes.*	*All charges*
Durable medical equipment (DME)	**High Option**
You can rent or buy up to **$3,000 (per calendar year)** of long-lasting medical equipment (called durable medical equipment) and supplies if they are: - Ordered by your Plan physician. - Used only for the health problem. - Used only by the person who needs the equipment or supplies. - Made only for medical use. We cover items such as: • Hospital beds • Wheelchairs • Insulin pumps • Surgical bras • Speech generating devices **Note:** Pediatric asthma equipment and supplies such as nebulizers (including face masks and tubing) are covered but are not subject to the $3,000 DME calendar year maximum.	20% up to the $3,000 calendar year maximum for durable medical equipment; all charges thereafter
*Durable Medical Equipment is **not covered** if:* • *It is needed only for your comfort or hygiene.* • *It is for exercise.*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**High Option**
• *It is needed for making the room or home comfortable, such as air conditioning or air filters.*	*All charges*
Home health services	**High Option**
You can get the following home health care, furnished by a home health agency (HHA): • Care from a registered nurse • Physical therapy, occupational therapy, speech therapy, or respiratory therapy • Visits with a medical social service worker • Care from a health aide who works under a registered nurse with the HHA • Services include oxygen therapy, intravenous therapy and medications	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication*	*All charges*
Chiropractic	**High Option**
• Covered up to 20 visits in a year when you see a chiropractor in the American Specialty Health Plans (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, back, thoracic, lumbar, rib or wrist supports; (2) cervical collars or pillows; (3) ankle, knee, lumbar, or wrist braces; (4) heel lifts; (5) hot or cold packs; (6) lumbar cushions; (7) 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 and approved by the medical group, for the treatment of chronic pain	$25 per office visit
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 self-management programs supervised by a doctor to teach you and your family members about the disease and how to take care of it. This includes training, education and nutrition therapy to enable you to use the equipment, supplies and medicines needed to manage the disease • Childhood obesity education • Other health education programs given by your primary care physician or the medical group. Ask about our many programs to: - Educate you about living a healthy life - Get a health screening - Learn about your health problem	Copayments may apply to some programs. Call us at 800-235-8631 for more information.
• Smoking cessation program includes: - individual, group, and telephone counseling - coverage for physician prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. Note: The smoking cessation program is limited to two quit attempts per year, with four counseling sessions per quit attempt. See Section 5 (f) Prescription benefits for information on physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing
Cancer clinical trials	**High Option**
We will cover 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 U.S. 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 office visit Nothing for all other services

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 physician after deciding it will help you • 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 Routine patient care 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 office visit Nothing for all other services
Not covered: • *Drugs or devices not approved by the U.S. 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*	*All charges*

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

Here are some 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 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

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
• 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.	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
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
• Voluntary sterilization for female (tubal ligation)	$150
• Voluntary sterilization for male (vasectomy)	$50
Not covered: • *Reversal of voluntary sterilization* • *Radial Keratotomy and other refractive surgeries*	*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 • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas - breast prostheses and surgical bras and replacements (see Orthopedic and prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form. This does not apply to surgery you might need to:* - *give you back the use of a body part* - *have a breast reconstruction after a mastectomy* - *correct or repair a deformity caused by birth defects, abnormal development, injury or illness in order to improve function, symptomatology or create a normal appearance* • *Cosmetic surgery does not become reconstructive because of psychological or psychiatric reasons.* • *Surgeries related to sex transformation*	*All charges*

Benefit Description	You pay
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • 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*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Simulatenous pancreas-kidney • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Nothing
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors - Waldenstrom's macroglobulinemia	Nothing
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic lymphocytic leukemia	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders (MSDs) - Myelodysplasia/Myelodysplastic Syndromes - Sarcomas - Sickle cell anemia • Mini-transplants (non-myeloblative autologous, reduced intensity conditioning or RIC) for - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma	Nothing
National Transplant Program (NTP) – We are a member of the Blue Distinction Center for Transplant.	Nothing
• Donor testing for bone marrow/stem cell transplants. • Unrelated donor searches via the National Donor Marrow Program (NMDP) for bone marrow/stem cell transplants for a Covered Transplant Procedure	Nothing up to a $30,000 benefit maximum per search; all charges thereafter.
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

Anesthesia - continued on next page

Benefit Description	You pay
Anesthesia (cont.)	**High Option**
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

Here are some 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 about coordinating benefits with other coverage, including with Medicare.
- 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).

Benefit Description	You pay
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • 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.	$200 per day to a maximum of $600 per inpatient admission.
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
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, convalescent care facilities, schools, etc.* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*

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. 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. $150 per outpatient surgery admission.
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
Not Covered: • *Custodial care*	*All charges*
Hospice care	**High Option**
We cover the following hospice care if you have an illness that may lead to death within one year. 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	Nothing

Hospice care - continued on next page

Benefit Description	You pay
Hospice care (cont.)	**High Option**
• 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
Not covered: • *Independent nursing, homemaker services*	*All charges*
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 IN SOME AREAS, THERE IS A 9-1-1 EMERGENCY RESPONSE SYSTEM. THIS SYSTEM IS TO BE USED ONLY WHEN THERE IS AN EMERGENCY.	Nothing

Section 5(d). Emergency services/accidents

Here are some 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.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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 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.

You may need to pay a copayment for emergency room services. We cover the rest.

If You Are In-Area.

You are in-area if you are 20 miles or less from your medical group (or 20 miles 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 20 miles away from your medical group.

If you need emergency services, get the medical care you need right away (follow the instructions above for *What to do in case of 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 do not fit the description of medical emergency on page 38.
- Your primary care physician must approve care you get once you are stabilized, unless Anthem Blue Cross-HMO approves it.
- Once your medical group or Anthem Blue Cross-HMO gives 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	$35 per visit
• Emergency care on an outpatient basis at a hospital (if care results in admission to a hospital, the copayment will not apply)	$100 per visit
• Emergency care at a hospital on an inpatient basis	$200 per day to a maximum of $600 per admission
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*

Benefit Description	You pay
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 IN SOME AREAS, THERE IS A 9-1-1 EMERGENCY RESPONSE SYSTEM. THIS SYSTEM IS TO BE USED ONLY WHEN THERE IS AN EMERGENCY.	Nothing

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

Cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some 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.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- 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 42 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	Your cost-sharing responsibilities are no greater than for other illnesses or conditions. $25 per office visit
Inpatient hospital physician visit	Nothing

Benefit Description	You pay
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental heatlh 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	Nothing
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, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment.	Nothing
Not covered	**High Option**
Services that are not part of a preauthorized approved treatment plan.	*All charges*

Medical Management Programs for Mental Health and Substance Abuse Conditions

Medical Management Programs apply only to the treatment of mental health and substance abuse conditions for the following services:

- inpatient and outpatient facility based care (facility based care is care provided in a hospital, psychiatric health facility, or residential treatment center) and
- authorized referrals to non-Plan providers.

The medical management programs are set up to work together with you and your physician 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 physician when you go to a Plan provider for professional services, such as counseling, for the treatment of mental health and substance abuse conditions. You can get a directory of Plan providers who specialize in the treatment of mental health and substance abuse conditions from us by calling 800-235-8631.

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

We have two medical management programs for treatment of mental health and substance abuse conditions:

- The Utilization Review Program applies to inpatient and outpatient facility-based care for the treatment of mental health and substance abuse conditions.
- The Authorization Program applies to referrals to non-Plan providers.

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 physician 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.

You need to make sure that your physician 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 inpatient and outpatient facility-based care for the treatment of mental health and substance abuse conditions and decide if the proposed facility-based care is medically necessary and appropriate.
- **Concurrent review.** We look at and decide whether services 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: Retrospective review may also be done for services that continued longer than originally certified.
  - When a pre-authorization, pre-service or concurrent review was not completed; or
  - To examine and audit medical information after services were provided.

Effect on Benefits

- When you don't get the required pre-service review before you get inpatient and outpatient facility-based care for the treatment of mental health and substance abuse conditions, we **will not provide benefits** for those services.
- Inpatient and outpatient facility-based care for the treatment of mental health and substance abuse conditions 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.

<u>Pre-Service Reviews</u>

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

- You must tell your physician that this Plan requires pre-service review. Physicians who are Plan providers will ask for the review for you. The toll-free number to call for pre-service review is 800-274-7767.
- For all scheduled services that require utilization review, you or your physician 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 inpatient and outpatient facility-based care for the treatment of mental health and substance abuse conditions we will, if appropriate, certify the type and level of services, as well as a specific length of stay. You, your physician and the provider of the service will get a written notice showing this information.

- If you do not get the certified service within 60 days of the certification, or if the type of the service changes, you must get a new pre-service review.

Concurrent Reviews

- If pre-service review was not done, you, your physician or the provider of the service must contact us for concurrent 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 physician by telephone no later than 24 hours after the decision. You and your physician will receive written notice no later than one business day after the decision.

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 concurrent 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 concurrent 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 treatment of mental health and substance abuse conditions. 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 copayment 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 physician 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 physician 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 physician 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 physician 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*.

Section 5(f). Prescription drug benefits

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 49.
- 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.
- You must obtain specialty medication from the Anthem Blue Cross Specialty Pharmacy Program.
- Some drugs need to be approved by us before you can get them. Be sure to read, *Drugs that need to be approved*, in this section.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** Drugs must be prescribed by a health care provider licensed to prescribe such medication, and must be given to you within one year of being prescribed.
- **Where you can obtain them.** You may fill the prescription at any licensed retail participating or non-participating pharmacy or by our 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 1-800-700-2541. 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. When your prescription is for a brand name drug, the pharmacist will substitute it with a generic drug unless your physician writes “dispense as written” on the prescription. If you receive brand name drugs when there is no generic equivalent, you will still have to pay the brand name drug copayment. When the physician has not indicated "dispense as written," you must pay 45% of the cost of the prescription. If a member requires an interim supply of medication due to an active military duty assignment or if there is a national emergency, call us at 1-800-700-2541 for immediate assistance.
- **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-participating pharmacy. If you need a claim form or if you have questions, call 1-800-700-2541. Have the pharmacist fill out the form and sign it. Then send the claim form (within 90 days) to: Prescription Drug Program, P.O. Box 4165, Woodland Hills, CA 91365-4165. When we first get your claim, we take out costs for medicine or supplies not covered under the Plan and any cost more than the limited fee schedule we use for non-participating pharmacies. We then apply your copayment and reimburse you directly.
- **If you are out of state.** If you are out of state, and need medicine, call **1-800-700-2541** to locate a participating pharmacy. If there is no participating pharmacy, pay for the drug and send us a claim form.
- **Getting your medicine through the mail.** When you order medicines through the mail, you will need to take the following steps. First, get your prescription from your health care provider. He or she should be sure to sign it. It must have the drug name, how much and how often to take it, how to use it, the provider’s name and address and telephone number along with your name and address. You must complete an order form. The first time you use the mail service program, you must also send a filled out Patient Profile questionnaire about yourself. Call 1-866-274-6825 for order forms and the Patient Profile questionnaire. Be sure to send the copayment along with the prescription and the order form and the Patient Profile. You can pay by check, money order, or credit card. Send your order to: Anthem Blue Cross Prescription Drug Program - Mail Service, P.O. Box 961025, Fort Worth, TX 76161-0025. The phone number is 1-866-274-6825. There are some medicines you cannot order through this program. Please call 1-866-274-6825 to find out if you can order your medicine through the mail service program.

- **The Specialty Pharmacy Program.** Specialty Pharmacy Program is a full-service specialty pharmacy created to more effectively manage and monitor the distribution of specialty drugs. Specialty medications are complex in both design and administration. They are used to treat conditions such as multiple sclerosis, cancer, hepatitus c, Gaucher's disease, HIV, and certain forms of rheumatoid arthritis. You may obtain a list of medications from our Web site. These medications can cost as much as $200,000 per year and are costly to ship, store, and administer. The Specialty Pharmacy Program offers a complete support program including a team of nurses, pharmacists and care coordinators to help members taking specialty medications achieve the best possible outcomes from their treatments. Specialty Pharmacy Program requires the collaboration of the prescribing physician, pharmacist and member to more effectively manage specialty medications and conditions.
- **Getting your medicine through the Specialty Drug Program.** You can only order your prescription for a specialty pharmacy drug through the Specialty Pharmacy Program unless you are given an exception (see below, How to obtain an exception to the Specialty Pharmacy Program). Anthem Blue Cross - Specialty Pharmacy Program only fills specialty pharmacy drug prescriptions. You or your doctor may order your specialty pharmacy drug by calling 1-800-870-6419. When you call Anthem Blue Cross - Specialty Pharmacy Program, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your specialty pharmacy drug. (If you order your specialty pharmacy drug by telephone, you will need to use a credit card or debit card to pay for it.) You may also submit your specialty pharmacy 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 at the address shown below. Your medication will be delivered to you by mail or common carrier (you cannot pick up your medication at Anthem Blue Cross). The prescription for the specialty pharmacy 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. The first time you get a prescription for a specialty pharmacy drug you must also include a completed Intake Referral Form. The Intake Referral Form is to be completed by calling the toll-free number below. You need only enclose the prescription or refill notice, and the appropriate payment for any subsequent specialty pharmacy drug prescriptions, or call the toll-free number below. You or your doctor may obtain a list of specialty pharmacy drugs available through the Specialty Pharmacy Program or order forms by contacting customer service at the number shown below or online at www. anthem.com/ca.

  Anthem Blue Cross - Specialty Pharmacy Program
  2825 W. Perimeter Road
  Indianapolis, IN 46241
  Phone 1-800-870-6419
  Fax 1-800-824-2642

  If you obtain a specialty pharmacy drug through a retail drugstore, you will have to pay the full cost of the specialty pharmacy drug. If you order a specialty pharmacy drug through the mail service program, it will be forwarded to the Specialty Pharmacy Program for processing and will be processed according to Specialty Pharmacy Program rules.
- **Exceptions to Specialty Pharmacy Program.** This requirement does not apply to:
  - The first two month's supply of a specialty pharmacy drug which is available through a member drugstore;
  - Drugs, which due to medical necessity, must be obtained immediately; or
  - A member who is unable to pay for delivery of their medication (i.e., no credit card).
- **How to obtain an exception to the Specialty Pharmacy Program.** If you believe that you should not be required to get your medication through the Specialty Pharmacy Program, for any reasons listed above, you must complete an Exception to Specialty Drug Program form to request an exception and send it to Anthem Blue Cross. The form can be faxed or mailed to Anthem Blue Cross. If you need a copy of the form, you may call 1-800-700-2541 to request one. You can also get the form on-line at www. anthem.com/ca. If Anthem Blue Cross gives you an exception, it will be in writing and will be good for 12 months from the time it is given. After 12 months, if you believe that you should still not be required to get your medication through the Specialty Pharmacy Program, you must again request an exception. If Anthem Blue Cross denies your request for an exception, it will be in writing and will tell you why the exception was not approved.

- **Urgent or emergency need of a specialty pharmacy drug subject to the Specialty Pharmacy Program.** If you are out of a specialty pharmacy drug which must be obtained through the Specialty Pharmacy Program, Anthem Blue Cross will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend, to allow you to get an emergency supply of medication, if your doctor decides that 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 if your doctor decides that it is medically necessary for you to have the drug immediately, Anthem Blue Cross 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.** A Preferred drug list, sometimes called a formulary, is used to help your physician make prescribing decisions. This list of drugs is updated quarterly by a committee of doctors and pharmacists so that the list includes drugs that are safe and effective in the treatment of disease. If you are prescribed a non-preferred drug without "dispense as written", you will have to pay the higher copayment listed on the next page. You can get drugs not listed as preferred drugs for the lower copayment if the physician writes "do not substitute" or "dispense as written" on the prescription. Some drugs need to be approved - the physician or pharmacy will know which drugs they are. If you have questions about whether a drug is on the preferred drug list or needs to be approved, please call us at 1-800-700-2541. If we don't approve a request for a drug that is not part of our preferred drug list, you or your physician can appeal the decision by calling us at 1-800-700-2541. If you are not satisfied with the result, please see Section 8, *The disputed claims process*.

- **Drugs that need to be approved.** Some drugs need to be approved by us - the physician or pharmacy will know which drugs they are. If you have any questions regarding whether a drug needs to be approved, please call us at 1-800-700-2541 or visit our website at www.anthem.com/ca. In order for you to get a drug that needs to be approved, your physician must complete our Outpatient Prescription Drug Prior Authorization of Benefits form. If your physician needs a copy of the form, he or she may contact us at 1-800-700-2541 to request one. The form can also be obtained on-line at www.anthem.com/ca. Once your physician has completed the form, it can be faxed to us at 1-888-831-2243 or mailed to us at Prescription Drug Program, P.O. Box 4165, Woodland Hills, CA. 91365-4165.

- **Dispensing limitation for drugs from a retail pharmacy or the mail service program.** You can get a 30-day or 100 unit supply, whichever is less, if you get the drug at a retail pharmacy. You can get a 60-day supply of drugs at a retail pharmacy for treating attention deficit disorder if they are: 1) FDA approved for treating attention deficit disorder; 2) federally classified as Schedule II drugs; and 3) require a triplicate prescription form. If the physician prescribes a 60-day supply for the treatment of attention deficit disorders, you have to pay double the amount of copay for retail pharmacy. If you get the drugs through our mail service program, the copay will be the same as for any other drug. You can get a 90-day supply if you get the drug from our mail service program. Drugs for the treatment of impotence and/or sexual dysfunction are limited to six tablets or treatments) for a 30-day period and available at retail pharmacies only. You must give us proof that a medical condition has caused the problem.

- **GenericSelect.** GenericSelect offers you a 30-day supply of select generic medications at a retail pharmacy and up to a 90-day supply through home delivery with no copay the first time you fill a new prescription. The program will be available to you if you have not tried GenericSelect medications before. If you have tried them in the past, they will not be eligible for the copay waiver.

- **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.

Benefit Description	You pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a retail pharmacy or through our mail order program: • Outpatient Drugs and medicines which require a prescription by law. Formulas prescribed by a physician for the treatment of phenylketonuria. These formulas are subject to the brand name copayment. • Oral and injectable contraceptive drugs. • Prescribed contraceptive drugs and devices which are approved by the U.S. Food and Drug Administration. • Insulin, with a copayment charge applied to each vial. • Diabetic supplies including insulin syringes, needles, glucose test tablets and test tape. Benedict's solution or equivalent and acetone test tablets. • Disposable needles and syringes needed for injecting covered prescribed medication. • Drugs used primarily for the purpose of treating infertility. • Smoking cessation drugs and medications, only if a prescription is required by law. • Drugs that have FDA labeling to be injected under the skin by you or a family member. • Drugs for sexual dysfunction (see limits on page 48). • Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copayment for brand name preferred drugs. Note: Specialty drugs must be obtained from the Specialty Pharmacy Program. You cannot obtain specialty drugs from a retail pharmacy unless we have granted an exception. You cannot obtain a 90-day supply of specialty drugs because they are not available under the Mail Service Program.	**At Anthem Blue Cross Participating Pharmacies:** **$10 copay** per prescription or refill of Preferred generic drugs; **$35 copay** per prescription or refill of Brand name drugs and generic, non-preferred drugs, if the physician writes "dispense as written"; **45%** of the cost of the prescription or refill for all non-preferred drugs if the physician HAS NOT written "dispense as written" on the prescription. **At Non-participating Pharmacies:** **$10 plus 50%** of the drug limited fee schedule for generic drugs; **$20 plus 50%** of the drug limited fee schedule for brand name drugs; **For drugs through the Mail Service Program:** **$20 copay** per prescription or refill for Preferred generic drugs; **$70 copay** per prescription or refill for Brand name drugs and generic, non-preferred drugs if the physician writes "dispense as written"; **45%** of the cost of the prescription or refill for all non-preferred drugs if the physician DOES NOT write "dispense as written."
• FDA approved drugs for the treatment of tobacco use. Note: This includes prescription and physician prescribed over-the-counter medications.	Nothing
GenericSelect Program includes: • 30-day supply of select generic medications at a retail pharmacy • 90-day supply of select generic medications through home delivery For a listing of the GenericSelect drugs please contact customer service. Note: the copay waiver is only available when you fill a new prescription for a GenericSelect drug. Note: This program is only available to members who have not tried any of the GenericSelect medications in the past.	Nothing for the first time you fill a new prescription for a GenericSelect drug. The copay waiver applies to the first fill of a 30-day supply at a retail pharmacy or a 90-day supply through home delivery.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
Not covered: • *Immunizing agents, biological sera, blood, blood products or blood plasma.* • *Drugs and medicines you can get without a physician's prescription, except insulin or niacin for cholesterol lowering.* • *Drugs labeled "Caution, Limited by Federal Law to Investigational Use," experimental drugs. Drugs and medicines prescribed for experimental indications.* • *Any cost for a drug or medicine that is higher than what we cover.* • *Cosmetics, health and beauty aids.* • *Drugs used mainly for cosmetic purposes.* • *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.* • *Infusion drugs, except drugs you inject under the skin yourself.* • *Herbal, nutritional and diet supplements.* • *Drugs to enhance athletic performance.* • *Specialty drugs purchased through non-specialty pharmacy program providers that don't satisfy the criteria for an exception.*	*All charges*

Section 5(g). Dental benefits

Here are some 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 benefit with 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 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary for the initial repair (but not replacement) of sound natural teeth. The need for these services must result from an accidental injury. Care is not covered if you damage or injure your teeth while chewing or biting.	Nothing
Dental benefits	**High Option**
We have no other dental benefits	*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 traditional care and coordinate other benefits as a less costly alternative benefit. 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. 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 cannot 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 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.
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.

Feature	Description
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-HMO Members at no extra premium

As a Federal Employee and a member of the Anthem Blue Cross-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 1-888-230-7338 to obtain detailed benefits and a list of providers in your area. As indicated on page 63, 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 – things we don't 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 we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, 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 related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services provided by non-Plan providers unless you receive a referral or the services are for emergency or urgent care (see Emergency services/accidents); or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

There are four types of claims. Three of the four types - Urgent care claims, Pre-service claims, and Concurrent review claims - usually involve access to care where you need to request and receive our advance approval to receive coverage for a particular service or supply covered under this Brochure. See Section 3 for more information on these claims/requests and Section 10 for the definitions of these three types of claims.

The fourth type - Post-service claims - is the claim for payment of benefits after services or supplies have been received.

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. For claims questions and assistance, call us at 800-235-8631.

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 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); and
- Receipts, if you paid for your services.

You normally won't have to submit claims to us unless you receive emergency or urgent care services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. Submit your claims to: Anthem Blue Cross, P.O. Box 60007 Los Angeles, CA. 90060-0007. To obtain claim forms or other claims filing advice or answers about our benefits, contact us at 800-235-8631, or at our Website at www.anthem.com/ca.

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 1-800-700-2541. Have the pharmacist fill out the form and sign it. Then send the claim form (within 90 days) to Prescription Drug Program P.O. Box 4165 Woodland Hills, CA 91365-4165.

Deadline for filing your claim

Most claims will be submitted for you. However, there is a deadline for filing claims yourself. You must submit claims by December 31 of the year after the year you received the service. OPM can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Urgent care claims procedures

If you have an urgent care claim, please contact our Customer Service Department at 800-235-8631. Urgent care claims must meet the definition found in Section 10 of this brochure, and most urgent care claims will be claims for access to care rather than claims for care already received. We will notify you of our decision not later than 24 hours after we receive the claim as long as you provide us with sufficient information to decide the claim. If you or your authorized representative fails to provide sufficient information to allow us to, we will inform you or your authorized representative of the specific information necessary to complete the claim not later than 24 hours after we receive the claim and a time frame for our receipt of this information. We will decide the claim within 48 hours of (i) receiving the information or (ii) 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 a written or eletronic notification within three days of oral notification.

Concurrent care claims procedures

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 as an appealable decision. 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.

Pre-service claims procedures

As indicated in Section 3, certain care requires Plan approval in advance. We will notify you of our decision within 15 days after the 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 before the expiration 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.

If you fail to follow these pre-service claim procedures, then we will notify you of your failure to follow these procedures as long as (1) your request is made to our customer service department and (2) your request names you, your medical condition or symptom, and the specific treatment, service, procedure, or product requested. We will provide this notice within five days following the failure or 24 hours if your pre-service claim is for urgent. Notification may be oral, unless you request written correspondence.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review as long as we 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.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claims if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

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.

Section 8. The disputed claims process

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3. You may be able to appeal to the U.S. Office of Personnel Management (OPM) immediately if we do not follow the particular requirements of this disputed claims process. For more information about situations in which you are entitled to immediately appeal and how to do so, please visit www.anthem.com/ca/fep.

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.

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, 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), 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. For additional review information regarding Review of Denials of Experimental or Investigative Treatment - go to page 59. Anthem Blue Cross will only initiate this additional review if you have not proceeded to step 4 below.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care or precertify your hospital stay or grant your request for prior approval for a service, drug, or supply); or b) Write to you and maintain our denial - go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	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. In the case of an appeal of an urgent care claim, we will notify you of our decision not later than 72 hours after receipt of your reconsideration request. We will hasten 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.
4	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, Insurance Operations, Health Insurance 2, 1900 E Street, NW, Washington, DC 20415-3620 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 physicians' 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 letters we sent to you about the claim; • Your daytime phone number and the best time to call; and • 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 a 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 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.
5	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 sue, 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 preauthorization 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 sue 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 800-235-8671. We will hasten 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.

ADDITIONAL COMPLAINT INFORMATION

Review of Denials of Experimental or Investigative Treatment. If coverage for a proposed treatment is denied because we or your medical group determine that the treatment is experimental or investigative, you may ask that the denial be reviewed by an external independent medical review organization which has a contract with the California Department of Managed Health Care. To request this review, please call us at the telephone number listed on your identification card or write to us at Anthem Blue Cross, 21555 Oxnard Street, Woodland Hills, CA 91367. To qualify for this review, all of the following conditions must be met:

- You have a life threatening or seriously debilitating condition. The condition meets either or both of the following descriptions:
  - A life threatening condition or a disease is one where the likelihood of death is high unless the course of the disease is interrupted. A life threatening condition or disease can also be one with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
  - A seriously debilitating condition or disease is one that causes major irreversible morbidity.
- The proposed treatment must be recommended by either (a) a Plan provider or (b) a board certified or board eligible physician qualified to treat you who certifies in writing that the proposed treatment is more likely to be beneficial than standard treatment. This certification must include a statement of the evidence relied upon.
- If this review is requested either by you or by a qualified provider, other than an Anthem Blue Cross-HMO provider, as described above, the requester must supply two items of acceptable medical and scientific evidence. This evidence consists of the following sources:
  - Peer-reviewed scientific studies published in medical journals with nationally recognized standards;
  - Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, and MEDLARS database Health Services Technology Assessment Research;
  - Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
  - The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
  - Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and
  - Peer reviewed abstracts accepted for presentation at major medical association meetings.

Within five days of receiving your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your physician. Information we receive subsequently will be sent to the review panel within five business days. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days in the case of an expedited review). This timeframe may be extended by up to three days for any delay in receiving necessary records.

Section 9. Coordinating benefits with 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' guidelines.

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

When we are the secondary payor, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payor, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

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; and
- 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 1-800-MEDICARE (TTY 1-877-486-2048) 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 plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-486-2048). 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. The notice will give you guidance on enrolling in Medicare Part D.

- **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 1-800-772-1213 (TTY 1-800-325-0778) 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 800-235-8531 or see our Web site at www.anthem.com/ca.

We will not waive any copayments or coinsurance when you have both our Plan and Medicare.

- **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 1-800-MEDICARE (1-800-633-4227) 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), but 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.

Private Contracts

A physician may ask you to sign a private contract agreeing that you can be billed directly for service ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment.

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.
- We will not reduce our share of any recovery unless we agree in writing to a reduction, (1) because you do not receive the full amount of damages that you claimed or (2) because 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, 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

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.

Section 10. Definitions of terms we use in this brochure

Anthem Blue Cross-HMO Coordinator	Anthem Blue Cross-HMO coordinator is the person at your medical group who can help you with understanding your benefits and getting the care you need.
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	• 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.
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 15.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See Section 4, page 15.
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. Please see page 59 for more information.
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 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 physician or another provider; and

- 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.

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 junction; 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 judgement 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. 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.

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

See www.opm.gov/insure/health 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 who 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 a *Guide to Federal Benefits,* 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; and
- 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

Several provisions of the Affordable Care Act (ACA) affect the eligibility of family members under the FEHB Program effective January 1, 2011.

Children	Coverage
Between ages 22 and 26	Children between the ages of 22 and 26 are covered under their parent's Self and Family enrollment up to age 26.
Married Children	Married children (but NOT their spouse or their own children) are covered up to age 26. This is true even if the child is currently under age 22.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are eligible for coverage up to age 26.
Stepchildren	Stepchildren do not need to live with the enrollee in a parent–child relationship to be eligible for coverage up to age 26.
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.
Foster Children	Foster children are eligible for coverage up to age 26.

You can find additional information at www.opm.gov/insure.

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children or stepchildren your employing or retirement office authorizes coverage for. 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 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 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 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 when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 26 turns 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.

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 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 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 and Family coverage 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 and Family 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 and Family 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. 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 2011 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 2010 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), or a conversion policy (a non-FEHB individual policy).

- **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 RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

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

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal 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 job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual 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 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. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of 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. The result can be a discount of 20% to more than 40% on services/products you 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 $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** - Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin products, 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) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **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 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) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** - Reimburses you for eligible **non-medical** day care expenses for your child(ren) 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 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m. Eastern time. TTY: 1-800-952-0450.

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 and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

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

Dental plans provide a comprehensive range of services, including all of the following:

- 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 24-month waiting period.

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and 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/insure/vision and www.opm.gov/insure/dental. 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 1-877-888-3337 (TTY 1-877-889-5680).

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 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) 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

Summary of benefits for Anthem Blue Cross - HMO - 2011

- **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	Office visit copay: $25	19
Services provided by a hospital:		
• Inpatient	$200 per day to a maximum of $600 per admission.	35
• Outpatient	Nothing unless surgery is performed. $150 per outpatient surgery admission.	36
Emergency visit to a hospital emergency room:		
• In-area or out-of-area	$100 per visit	39
Mental health and substance abuse treatment:		
• Inpatient	Nothing	41
• Outpatient	Regular cost-sharing	42
Prescription drugs:		
• **Retail pharmacy** - Up to a 30-day or 100 unit supply, whichever is less. Note: You must obtain specialty drugs from the Specialty Pharmacy Program unless we have granted a written exception.	Network pharmacy: $10 per preferred generic; $35 per brand name drug; 45% for non-preferred drugs. Non-Network pharmacy: $10 plus 50% of drug limited fee per generic; $20 plus 50% of drug limited fee per brand name drug.	49
• **Mail-order Program -** up to a 90-day supply of maintenance medication	$20 per preferred generic; $70 per brand name drug;and 45% for non-preferred drugs.	49
Dental care: We cover restorative services for accidental injury only and no other dental benefits.	Nothing	51
Vision care:	Annual eye refraction; you pay nothing.	23
Special features: 24/7 NurseLine		52
Protection against catastrophic costs: (your catastrophic protection out-of-pocket maximum)	Nothing after $2,000/Self Only or $4,000/ Family enrollment per year	15

2011 Rate Information for Anthem Blue Cross - HMO

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the *Guide to Benefits for Career United States Postal Service Employees*, RI 70-2, and to the rates shown below.

The rates shown below do not apply to Postal Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

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. Refer to the applicable *Guide to Federal Benefits*.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Most of California							
High Option Self Only	M51	$180.66	$90.83	$391.43	$196.80	$203.24	$68.25
High Option Self and Family	M52	$403.98	$258.52	$875.29	$560.13	$454.48	$208.02