Anthem Blue Cross - Select HMO

www.anthem.com/federal/ca

800-235-8631

Anthem

2026

A Health Maintenance Organization

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See Page 8 for details. This plan is accredited. See Page 13.

Serving: Most of Southern California

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See Section 1 for requirements.

Postal Employees and Annuitants are no longer eligible for this plan. (unless currently under Temporary Continuation of Coverage)

Enrollment codes for this Plan:

B31 High Option - Self Only
B33 High Option - Self Plus One
B32 High Option - Self and Family

IMPORTANT

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-877

Important Notice from Anthem Blue Cross - Select HMO About

Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

Additional Premium for Medicare's High Income Members
Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return.** You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare Website https ://www. medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:
Visit www. medicare.gov for personalized help.
Call 800-MEDICARE 800-633-4227, TTY 877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of the Anthem Blue Cross - Select HMO Plan under contract (CS 2936) between Blue Cross of California dba Anthem Blue Cross and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This plan is underwritten by Blue Cross of California Inc. dba Anthem Blue Cross. Customer service may be reached at 800-235-8631 (TTY 711 or speech or hearing impaired) or through our website: www. anthem.com/federal/ca. The address for Anthem Blue Cross' administrative offices is:

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or 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, 2026, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2026, and changes are summarized on Rate Information page. Rates are shown at the end of this brochure.

Plain Language

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

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

Stop Healthcare Fraud!

Fraud increases the cost of healthcare 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 phone or to people you do not know, except for your healthcare providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.

- If the provider does not resolve the matter, call us at 800-235-8631 and explain the situation.
- If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE

877-499-7295

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

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

You can also write to:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless they are was disabled and incapable of self-support prior to age 26)

  A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- If you have any questions about the eligibility of a family member, 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 (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information. We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information.

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. 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 take notes, ask questions and understand answers.

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

- Bring the actual medications or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication 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 medications, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understanding both the generic and brand names for all of your medication(s) is important. This helps ensure you do not receive double dosing from taking both a generic and a brand of the same medication. It also helps you avoid taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.

- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

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

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

Patient Safety Links

For more information on patient safety, please visit:

- www. jointcommission.org/speakup.aspx. The Joint Commission’s Speak Up™ patient safety program.
- www. jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www. ahrq.gov/patients-consumers/. 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 healthcare providers and improve the quality of care you receive.
- https://psnet.ahrq.gov/issue/national-patient-safety-foundation. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www. bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.
- http ://www. leapfroggroup.org/. The Leapfrog Group is active in promoting safe practices in hospital care.
- http ://www. ahqa.org/. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions (“Never Events”)

When you enter the hospital for treatment of one medical problem, you do not 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, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called “Never Events” or “Serious Reportable Events.”

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error. Should an event occur and you were required to make payments to the provider you will be reimbursed for your out-of-pocket costs. The list of Never Events or Hospital Acquired Conditions is as follows:

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- Wrong surgical procedure performed on a patient
- Unintended retention of a foreign object in a patient after surgery or other procedure

- Air embolism
- Blood Incompatibility
- Surgical site infection following bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)
- Surgical site infection, mediastinitis, following coronary artery bypass graft
- Surgical site infection following certain orthopedic procedures (spine, neck, shoulder, elbow)
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures (total knee replacement, hip replacement)
- Catheter associated urinary tract infection
- Manifestations of poor glycemic control (diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity)
- Vascular catheter associated infection
- Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)
- Pressure ulcers, stages III and IV

FEHB Facts

Coverage Information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

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

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

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

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

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

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

  We do not 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, disability leave, pensions, etc. you must also contact your employing or retirement office.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

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

If you have a Self Only enrollment, you may change to a Self Plus One or 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 Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of any changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

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

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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

- **Children's Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2026 benefits of your prior plan or option**. If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2025 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 an enrollee, and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

  If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website at https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **Temporary Continuation of Coverage (TCC)** — If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, or if you are a covered child and you turn 26.

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

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

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

- **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 or Tribal service, your employing office will notify you of your right to convert**.** You must contact us in writing 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 contact us in writing 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, a waiting period will not be imposed and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-235-8631 or visit our website at www.anthem.com/federal/ca.

- **Health Insurance Marketplace**

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

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Anthem Blue Cross Select HMO holds the following accreditation: Accredited status with the National Committee for Quality Assurance (NCQA). To learn more about this plan's accreditation(s), please visit the following website: National Committee for Quality Assurance (www. ncqa.org).

We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your healthcare services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our 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.

General Features of our High Option

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies). 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 healthcare facilities are paid a set amount for the kind of service they provide to you or an amount based on a negotiated discount from their standard rates. If you want more information, please call us at 800-235-8631, or you may call your medical group.

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

Preventive care services

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

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than $7,000 for Self Only enrollment, and $14,000 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

Your Rights and Responsibilities

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www. opm.gov/healthcare-insurance/) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Anthem Blue Cross has been serving the health insurance needs of California residents since 1937.
- Profit status - Blue Cross of California is a for-profit California corporation

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, Anthem Blue Cross Select HMO at www. anthem.com/federal/ca. You can also contact us to request that we mail a copy to you.

If you want 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 visit our website at www. anthem.com/federal/ca.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website Anthem Blue Cross Select HMO at www. anthem.com/federal/ca to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

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

Service Area

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

Southern California Counties

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

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

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

Section 2. Changes for 2026

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.

Changes to this Plan

- **Premium**- Your share of the premium will Increase for Self Only, Self Plus One, and Self and Family enrollment. See Rate Information page on the back cover of this brochure.
- **Doula services**- This plan will now cover doula services for no cost when obtained through an Anthem Blue Cross- CA Select HMO contracted network doula. See page 30, Section 5(a) Maternity care for more information.
- **One wig after cancer treatment**- Members who use an Anthem-contracted provider can select a wig from a predetermined list of available wig options at no cost share. See page 35, Section 5(a) Orthopedic and prosthetic devices for more information.
- **Speech Therapy Copay**- Your copay for speech therapy services will increase from $0 to $25 per visit. See page 34, Section 5(a)Speech therapy for more information.
- **Infertility Services Member Cost Changes**- All Infertility services were previously offered at 50% of Plan allowance coinsurance. Infertility services will match copays for similar services (examples: Office Visit $25, Specialist Office Visit $40, Inpatient Surgery- $250/Day for a maximum of 4 days, Outpatient Surgery- $250 per admission, Advanced Diagnostic: $125) See page 32, Section 5(a) Infertility services, page 32 5(b) Surgical procedures, page 50 5(c) Inpatient hospital and page 52 Outpatient hospital for more information.
- **Infertility Services**- This plan will also be adding coverage for In-Vitro Fertilization to the list of available infertility services. See page 32, Section 5(a) Infertility services for more information.
- **Oral Cancer Medications**- Oral Cancer Medications member coinsurance will increase from 25% of plan allowance up to a maximum of $175 per prescription, to 25% of plan allowance up to a maximum of $250 per prescription. These medications will now match the corresponding Tier on our Essential 4-Tier formulary. See page 64, Section 5(d)
- **Exclusion of Chemical and Surgical Sex-Trait Modification Services**- Chemical or surgical modification of an individual's sex traits through medical interventions (to include “gender transition” services), other than mid-treatment exceptions, will be excluded from benefits starting in 2026. See page 17 Section 3. How You Get Care.

Section 3. How You Get Care

Identification cards

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

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

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

- **Plan providers**

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to national standards.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

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

Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex, pregnancy or genetic information.

This plan provides Care Coordinators for complex conditions and can be reached by calling 800-235-8631 or www.anthem.com/federal/ca for assistance.

- **Plan facilities**

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

Balance Billing Protection

FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

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 provider. This decision is important since your primary care provider provides or arranges for most of your healthcare.

- **Primary care**

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

If you want to change primary care providers or if your primary care provider leaves the Plan, call us. We will help you select a new one.

Specialty care

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

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care provider will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care provider will create your treatment plan. The provider may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care provider. If they decide 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 provider, 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
- You may continue seeing your specialist for up to 90 days if you are undergoing treatment for a chronic or disabling condition and you list access to your specialist because:
  - We terminate our contract with y our specialist for other than cause;
  - We drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
  - We reduce our service area and you enroll in another FEHB Plan;

Contact us at 800-235-8631 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.

Note: If you lose access to your specialist because you changed your carrier or plan option enrollment, contact your new plan.

Sex-Trait Modification: If you are mid-treatment, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services formerly covered under the 2025 Plan brochure, you may seek an exception to continue care. Our exception process is as follows: Please note that the continuing care for surgical sex-trait modification services are only available for those individuals who first began or received surgical sex-trait modification services prior to January 1, 2026. Contact your Provider, who can obtain authorization from Anthem for continuing care. If you disagree with our decision on your exception, please see Section 8 of your brochure for the disputed claims process.

Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.

Hospital care

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

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

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

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

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

You need prior Plan approval for certain services

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

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **Inpatient hospital admission**

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

- **Other services**

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

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

First, your physician, your hospital, you, or your representative, must call 800-235-8631 before admission or services requiring prior authorization are rendered.
Next, provide the following information:

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

- **Non-urgent care claims**

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

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

- **Urgent care claims**

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

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

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

  You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-235-8631. You may also call OPM's FEHB 3 at 202-606-0755 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-235-8631. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

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

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

- **Emergency inpatient admission**

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

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

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

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

- When services are not reviewed before or during the time you receive the services, we will review those services when we receive the bill for benefit payment. If that review determines that part or all of the services were not medically necessary and appropriate, we **will not provide benefits** for those services.
- If you receive authorized referral services from a non-Plan provider, the Plan provider copay will apply. When you do not get a referral, **no benefits are provide**d for services received from a non-Plan provider

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 833-261-2459.

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

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

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.
In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

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

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your Costs for Covered Services

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

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, if any, coinsurance, and copayments) for the covered care you receive.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services. Example: When you see your primary care provider, you pay a copayment of $25 per office visit.
Deductible	This Plan does not have a deductible.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our Plan, you pay 50% of our allowance for Durable Medical Equipment (DME).
Differences between our Plan allowance and the bill	You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.
Your catastrophic protection out-of-pocket maximum	After your (deductible, copayments and coinsurance) reaches the out-of-pocket maximum you do not have to pay any more for covered services, with the exception of certain cost sharing for the services below which do not count toward your catastrophic protection out-of-pocket maximum. Your out-of-pocket maximum for services rendered during the 2026 calendar year is: High Option Self Only $3,000 in network Self Plus One $3,000 per person Self and Family $6,000 Your out-of-pocket maximum may differ if you changed plans at Open Season. Infertility services do not count toward the out-of-pocket maximum for this plan
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 prior 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 prior 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 prior 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 prior 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.

Important Notice About Surprise Billing - Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services. Anthem Blue Cross - Select HMO requires that all non-emergency care be provided within our Select HMO Network. This HMO does not provide coverage for out of network services other than urgent and emergency care.

A surprise bill is an unexpected bill you receive for:

- Emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- Non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- Air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

In addition, your health plan adopts and complies with the surprise billing laws of California.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to https://www.anthem.com/ca/no-surprise-billing/ or contact the health plan at 800-235-8631.

The Federal Flexible Spending Account Program - FSAFEDS

- **Healthcare FSA (HCFSA)** – Reimburses an FSA participant for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, over-the-counter drugs and medications, vision and dental expenses, and much more) for their tax dependents, and their adult children (through the end of the calendar year in which they turn 26).
- **FSAFEDS** offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan

Section 5. High Option Benefits

See Page 15 for how our benefits changed this year. See page 93 for a benefits summary of our High Option. Make sure that you review the benefits that are available under this Plan.

Section 5. High Option Benefits Overview

This Plan offers a High Option. Our benefit package is described in Section 5. Make sure that you carefully review the benefits that are available.

The High Option 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 High Option benefits, contact us at 800-235-8631 or on our website at www. anthem.com/federal/ca.

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

- No deductibles
- No office visit copay for covered preventive care services
- $25 non-preventive primary care office visit copay
- $25 office visit copay for family planning visits
- $0 Virtual Care Visits- When connecting through the Anthem Sydney Mobile App or www. livehealthonline.com
- $200 emergency room copay
- $250 per day copay up to a maximum of 4 days per covered inpatient hospital admission
- $250 outpatient facility copay for surgery

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office • Home visits • Office medical consultations • Second opinion • Initial examination of a newborn child	$25 per PCP visit $40 per Specialist visit
• During a hospital stay • In a skilled nursing facility	Nothing
• In an urgent care center • In a Retail Health Clinic	$30 per visit
• Injection Administration - other than Allergy Note: If an injection is made in conjunction with a physician office visit, the Office Visit Copay would apply, and there would be no additional charge for the injection.	$5 Per Injection
• Injectable or infused medications given by the doctor in the office (other than Allergy Serum) This does not include immunizations prescribed by your primary care provider nor allergy serum	30% of Plan allowance up to a maximum of $250 per drug
Not covered: • *Consultations given using telephones, facsimile machines, or electronic mail.* • *Services for your personal care, such as: helping in walking, bathing, dressing, feeding, or preparing food. Any supplies for comfort, hygiene or beauty purposes.*	*All charges*

Benefit Description	You pay
Telehealth services	**High Option**
Virtual Telehealth /Telemedicine Visits from our Online Provider - LiveHealth Online - Includes non-preventive Medical Services & non-preventive MH/SA Services Note: To get started visit the website at www. livehealthonline.com or Connect using the Anthem Sydney mobile app	$0 per visit
PCP Medical Virtual Telehealth / Telemedicine Visits	$25 per visit
SPC Medical Virtual Telehealth/Telemedicine Visits	$40 per visit
Virtual Telehealth/Telemedicine Visits for Specialty Care from our Online Provider, LiveHealth Online	$40 per visit
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap test • Pathology • X-ray • Non-routine mammogram • Ultrasound • Electrocardiogram and EEG	Nothing
For the following services: • Advanced imaging procedures Advanced Imaging Procedures are imaging procedures, including, but not limited to: Magnetic Resonance Imaging (MRI), Computerized Tomography (CT/CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography, and nuclear cardiac imaging. For a complete list of advanced imaging procedures or if you need more information, please contact your medical group.	$125 per test performed in a doctor's office, radiology center, outpatient department of a hospital, or ambulatory surgical center.
Preventive care, adult	**High Option**
Routine Physical every year, including coverage for vision and hearing screening. **The following preventive services are covered at the time interval recommended at each of the links below.** • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https ://www. uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
• Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women, go to the Health and Human Services (HHS) website at https ://www. hrsa.gov/womens-guidelines • To build your personalized list of preventive services go to https://health.gov/myhealthfinder • Routine mammogram • Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at https ://www. cdc.gov/vaccines/imz-schedules/index.html • Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: Intensive nutrition and behavioral weight-loss counseling therapy, Covered when Medically Necessary, frequency will be determined by your PCP. Family centered programs when medically identified to support obesity prevention and management by an in-network provider. Covered when Medically Necessary, frequency will be determined by your PCP. Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: When anti-obesity medication is prescribed. See Section 5(f) Note: When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b)	Nothing
Not covered: • *Medications for travel or work-related exposure.* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Wilderness or other outdoor camps and/or programs. This exclusion does not apply to medically necessary services to severe mental disorders or serious emotional disturbances of a child, as required by state or federal law.*	*All charges*

Benefit Description	You pay
Preventive care, children	**High Option**
Routine Physical every year, including coverage for vision and hearing screening. • Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • Children's immunizations endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Cenwebsite at https ://www. cdc.gov/vaccines/schedules/index.html • Vision screenings as recommended under the U.S. Preventive Services Task Force (USPSTF) • You can also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at https ://www. uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: Intensive nutrition and behavioral weight-loss counseling therapy, Covered when Medically Necessary, frequency will be determined by your PCP. Family centered programs when medically identified to support obesity prevention and management by an in-network provider. Covered when Medically Necessary, frequency will be determined by your PCP. Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: When anti-obesity medication is prescribed. See Section 5(f) Note: When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b)	Nothing
Not covered: • *Medications needed for travel or work-related exposure.* • *Routine physical or psychological exams or tests required for obtaining or continuing employment, insurance, attending school, camp, athletic exams, or sports programs.*	*All charges*

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**High Option**
• *Wilderness or other outdoor camps and/or programs. This exclusion does not apply to medically necessary services to severe mental disorders or serious emotional disturbances of a child, as required by state or federal law.*	*All charges*
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care and Postpartum care • Screening and counseling for prenatal and postpartum depression • Breastfeeding and lactation support, supplies and counseling for each birth	Nothing for Prenatal and Postpartum care. For delivery- See Section 5c for Inpatient Hospital Copays
• Screening for gestational diabetes • Delivery Note: You owe a hospital admission copay for inpatient hospital services.	Nothing
Note: • As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period. Your coverage also includes access to our "Building Healthy Families" Program in the Anthem Sydney App using a computer or your smartphone. • Your coverage includes Certified doula coverage when using an Anthem Blue Cross CA Select HMO Contracted Doula for 1 initial visit and 8 prenatal/postnatal visits. • You do not need to pre-certify your vaginal delivery; see page 50 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	Nothing
Not covered:	*All charges*

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**High Option**
• *Any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).*	*All charges*
Family planning	**High Option**
Contraceptive counseling	Nothing
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories in the HRSA supported guidelines. This list includes: • Diaphragms • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Surgically implanted contraceptives • Voluntary female sterilization • Voluntary male sterilization Note: See additional Family Planning and Prescription drug coverage in Section 5(f) or 5(f)(a), if applicable. Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below: If your Provider determines that a Brand Drug with an available Generic therapeutic equivalent commercially available in the market is Medically Necessary because a Generic equivalent drug is not appropriate for you, you may obtain coverage of the Brand Drug with $0 Cost Sharing if your Provider submits an exception request. Your Doctor must complete a contraceptive exception form and return it to us. Your Doctor can locate the form in their Anthem Provider Portal. If Medical Necessity has been determined by your Provider, an exception will be granted and coverage of the Drug will be provided at $0 Cost Sharing. Otherwise, Brand Drugs will be covered as a Preventive Care benefit when Medically Necessary according to your attending Provider, otherwise they will be covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.” In order to be covered as Preventive Care, contraceptive Prescription Drugs must be Generic oral contraceptives. Brand Drugs will be covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.” For FDA-approved, Self-Administered Hormonal Contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies.	Nothing

Family planning - continued on next page

Benefit Description	You pay
Family planning (cont.)	**High Option**
The Plan will not impose any restrictions or delays on your coverage of FDA-approved contraceptive Drugs, devices, and other products, including prior authorization requests, any utilization controls or any other form of medical management restrictions. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	Nothing
• Family planning visits	$25 per office visit
Genetic testing, when medically necessary	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Over-the-counter contraceptives will not be covered unless a prescription is provided*	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of infertility specific to: • Artificial insemination (AI) When deemed medically necessary and prior authorization requirements are met: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Assisted reproductive technology (ART) procedures when medically necessary and prior authorization requirements are met • IVF Services: Maximum of 3 oocyte retrievals per benefit period when medically necessary and prior authorization requirements are met • Fertility procurement, preservation and storage services for up to one year to prevent iatrogenic infertility when medically necessary. Note: IVF & ART services must be medically necessary and require prior authorization. Note: We cover injectable fertility drugs under medical benefits. See Section 5(f) Prescription drugs benefits for oral fertility drugs. Note: See Section 10 for Definition and qualification of Infertility. You can also visit www. anthem.com/federal/ca to learn more	Member Costs to be determined by location of service(s): Examples: Inpatient Surgery: $250/Day for a maximum 4 days Outpatient Surgery: $250 per admission Specialist Office Visit: $40 Advanced Diagnostics: $125
• When authorized as medically necessary, coverage is provided for medical and prescription drugs of IVF related fertility drugs administered for 3 cycles per benefit period. • Fertility Drugs (See Section 5(f).) Note: We cover injectable fertility drugs under medical benefits. See Section 5(f) Prescription drugs benefits for oral fertility drugs.	Member Costs to be determined by location of service(s): Examples: Inpatient Surgery: $250/Day for a maximum 4 days Outpatient Surgery: $250 per admission Specialist Office Visit: $40 Advanced Diagnostics: $125
Not covered: • *Infertility services after voluntary sterilization*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**High Option**
• *Costs related to donor sperm* • *Costs related to donor egg*	*All charges*
Allergy care	**High Option**
• Testing	$25 per office visit
• Allergy injections administration- including serum	$5 Per Injection
Treatment therapies	**High Option**
• Chemotherapy	$40 per visit
• Radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on page 45.	$40 per visit
• Cardiac rehabilitation following qualifying event/condition is provided for up to 36 visits	$40 per visit
• Respiratory/inhalation therapy	$40 per visit
• Pulmonary rehabilitation	$40 per visit
• Hemodialysis or peritoneal dialysis, including treatment at home if approved by the medical group	$40 per visit
• Intravenous (IV)/Infusion Therapy (Home IV and antibiotic therapy)	$40 per visit
• Applied Behavior Analysis (ABA) – Children with autism spectrum disorder	$25 per visit
• Medical social services • Growth hormone therapy (GHT) Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on page 20.	Nothing
Physical and occupational therapies	**High Option**
• Visits for rehabilitative and habilitative physical and occupational therapy You have **up to 40 days per benefit period**. If you need more than 40 days, your primary care provider must get the approval from your medical group or Anthem. It must be shown that more care is medically necessary. Your medical group or Anthem will approve the extra visits or treatments. Note: We only cover therapy when a physician: • orders the care	$40 per visit

Physical and occupational therapies - continued on next page

Benefit Description	You pay
Physical and occupational therapies (cont.)	**High Option**
• identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed.	$40 per visit
Not covered: • *Treatment of frequent recurrences of pain, over a long period of time, that is not related to an active medical condition currently being treated.* • *Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a doctor. This exclusion also applies to health spas.* • *Programs to help you change how you live, like fitness clubs or dieting programs. This does not apply to cardiac rehabilitation programs approved by your medical group*	*All charges*
Speech therapy	**High Option**
• Visits for rehabilitative and habilitative speech therapy by a licensed speech therapist when prescribed by your physician	$25 per visit
Not covered: • *Aids for Non-verbal Communication. Devices and computers to assist in communication and speech except for speech aid devices and tracheoesophageal voice devices approved by Anthem are not covered.*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
• Vision screening includes a vision check by your primary care provider 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 provider, this may include an exam with diagnosis, a treatment program and refractions. • See *Preventive care, children* for vision screening for children.	Nothing
Not covered: • *Eyeglasses or contact lenses. Contact lens fitting is not covered. Except as stated under Orthopedic and prosthetic devices* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*

Benefit Description	You pay
Foot care	**High Option**
• We cover medically necessary care for the diagnosis and treatment of conditions of the foot, when prescribed by your physician. Note: See durable medical equipment for information on podiatric shoe inserts.	$40 per office visit
Not covered: • *Routine foot care*	*All charges*
Orthopedic and prosthetic devices	**High Option**
You can get devices to take the place of missing parts of your body. • Surgical implants • Artificial limbs and eyes • Breast prostheses following a mastectomy • The first pair of contact lenses or eyeglasses when needed after a covered and medically necessary eye surgery • Prosthetic devices to restore a method of speaking when required as a result of a laryngectomy • Colostomy supplies • Therapeutic shoes and inserts designed to prevent foot complications due to diabetes • Orthopedic footwear used as an integral part of a brace. Podiatric devices, such as therapeutic shoes and shoe inserts (custom molded orthotics), to prevent and treat diabetes-related complications. • Supplies needed to take care of these devices • Breast prostheses and surgical bras following a mastectomy • One wig after cancer treatment – Covered as Prosthetics up to maximum allowable amount when using an Anthem-contracted vendor. Note: When using an Anthem-approved provider, members may select a wig from a predetermined list of available wig options at no cost. If the member wants a more-expensive wig, they will pay 100% of any upgrade costs. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5 (c) Services provided by a hospital or other facility, and ambulance services.	Nothing
Not covered: • *Orthopedic shoes (except when joined to braces) or shoe inserts (including custom molded orthotics). This does not apply to shoes and inserts designed to prevent or treat foot complications due to diabetes..*	*All charges*

Benefit Description	You pay
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of prescribed durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors • Insulin pumps Note: Call us at 800-235-8631 as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	50% of Plan allowance
• You can get certain diabetic equipment and supplies as prescribed by a physician	50% of Plan allowance
• You can also get nebulizers, including face masks and tubing for treatment of pediatric asthma. Note: These items are not subject to any limits or maximums that apply to coverage for medical equipment.	Nothing
• Special food products and formulas that are part of a diet prescribed by a doctor for the treatment of phenylketonuria (PKU). Durable Medical Equipment (DME): Special food products and formulas that are part of a diet prescribed by a provider or registered dietician for the treatment of conditions associated with an in-born error of metabolism, such as phenylketonuria (PKU). You can obtain special food products and formulas from a network pharmacy. These are covered under your Plan's benefits for prescription drugs (see Section 5 (f)). Special food products and formulas that are not obtained from a network pharmacy are covered as medical supplies under your Plan's medical benefits.	Nothing
Equipment and supplies are not covered if they are: • *Only for your comfort or hygiene.* • *For exercise.* • *Only for making the room or home comfortable, such as air conditioning or air filters.* • *Scalp hair prostheses, including wigs or any form of hair replacement.*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**High Option**
• *Nutritional and/or dietary supplements, except as provided in this Plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.* • *Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered.* • *Consumer wearable/personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.*	*All charges*
Hearing services (testing, treatment, and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D. or audiologist. Note: For routine hearing screenings performed during a preventive care visit, see Section 5(a) *Preventive care services, children.*	$40 per office visit
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids and cochlear implants. Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.* Note: Services covered for OTC Hearing Aids when using an Anthem, Inc. Preferred Provider.	50% of Plan allowance up to one hearing device every 36 months
Home health services	**High Option**
We will cover home healthcare furnished by a home health agency (HHA) for up to 100 visits in a calendar year. • Care from a registered nurse or licensed vocational nurse who works under a registered nurse or a doctor • Private duty nursing	$40 per visit
• Physical therapy, occupational therapy, speech therapy, or respiratory therapy	$40 per visit
• Visits with a medical social service worker	$40 per visit
• Care from a health aide who works under a registered nurse with the HHA (one visit equals four hours or less)	$40 per visit
• Oxygen therapy, intravenous therapy and medications	$40 per visit
• Medically necessary supplies from the HHA Note: In-home intensive behavioral health visits are covered if available in your area. See Section 5(e).	Nothing

Benefit Description	You pay
Chiropractic	**High Option**
Covered up to 20 visits in a year when you see a chiropractor in the American Specialty Health Plans of California, Inc. (ASH Plans) network. Also up to $50 per calendar year in rental or purchase charges are covered for medical equipment and supplies ordered by an ASH Plans chiropractor, and approved as medically necessary by ASH Plans. Such medical equipment includes: (1) elbow supports, back supports (thoracic), lumbar braces and supports, rib supports, or wrist supports; (2) cervical collars or cervical pillows; (3) ankle braces, knee braces, or wrist braces; (4) heel lifts; (5) hot or cold packs; (6) lumbar cushions; (7) rib belts or orthotics; and (8) home traction units for treatment of the cervical or lumbar regions. **Note:** The *ASH Plans* chiropractor is responsible for obtaining the necessary approval from the Plan.	$15 per office visit
Not covered: • *Any services provided by ASH Plans that are not approved by us, except for the first visit* • *The services of a non-ASH Plans chiropractor*	*All charges*
Alternative treatments	**High Option**
Acupuncture – 20 visits per calendar year if referred by your primary care provider to a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner.	$40 per session
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**
Educational Classes: Coverage is provided for: • Diabetes self management	$40 per class
• Nutritional counseling for the treatment of obesity for persons at or above the USPSTF obesity prevention risk factor level.	Nothing
• Tobacco Cessation programs for nicotine dependency. Well-Being Coach digital support and over-the-counter (OTC) prescription drugs approved by the FDA to treat tobacco dependence.	Nothing
• Pediatric asthma education program	$40 per class

Benefit Description	You pay
Cancer clinical trials	**High Option**
Routine patient care costs, as defined below, for phase I, phase II, phase III and phase IV cancer clinical trials. All of the following conditions must be met: • The treatment you get in a clinical trial must either: - Involve a drug that is exempt under federal regulations from a new drug application, or - Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration. • You must have cancer to be able to participate in these clinical trials. • Participation in these clinical trials must be recommended by your primary care doctor after deciding it will help you. If the clinical trial is not provided by or through your medical group, your primary care doctor will refer you to the doctor or healthcare provider who provides the clinical trial. Please see "When You Need a Referral" in the section called "When You Need Care" for information about referrals. You will only have to pay your normal copays for the services you get. • For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.	$25 per PCP office visit $40 per Specialist office visit
Routine patient care cancer clinical trials costs are the costs associated with the services provided, including drugs, items, devices and services which would otherwise be covered under the plan, including healthcare services which are: • Typically provided absent a clinical trial. • Required solely to provide the investigational drug, item, device or service. • Clinically appropriate monitoring of the investigational item or service. • Prevention of complications arising from the provision of the investigational drug, item, device, or service. • Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or care of the complications.	$25 per PCP office visit $40 per Specialist office visit
Routine patient care cancer clinical trials costs do not include any of the costs associated with any of the following: • Drugs or devices not approved by the Federal Food and Drug Administration that are part of the clinical trial. • Services other than healthcare 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.	$25 per PCP office visit $40 per Specialist office visit

Cancer clinical trials - continued on next page

Benefit Description	You pay
Cancer clinical trials (cont.)	**High Option**
• Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient. • Healthcare services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the plan. • Healthcare services usually provided by the research sponsors free of charge to members enrolled in the trial. Note: You will pay for costs of services that are not covered.	$25 per PCP office visit $40 per Specialist office visit
Routine patient care costs for individual participation in phase I, phase II, phase III and phase IV clinical trial conducted to prevent, detect or treat life-threatening diseases or conditions that are federally funded; conducted under investigational new drug application reviewed by FDA; or conducted as a drug trial exempt from the requirement of an investigational new drug application.	$25 per PCP office visit $40 per Specialist office visit
Not covered: • *Any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a covered service under this plan for non-Investigative treatments, unless specifically stated.*	*All charges*

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Routine pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • 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: For female surgical family planning procedures see Family Planning Section 5(a) Note: For male surgical family planning procedures see Family Planning Section 5(a) 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 severe 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:	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
• 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. • For more information, you can search our Clinical Guidelines Here: https://bit.ly/46nO5l2 Note: Before the bariatric surgery can be approved, your medical group must address post-operative expectations and give you a thorough explanation of the risks and benefits of the procedure.	Nothing
Not covered: • *Any eye surgery just for correcting vision (like nearsightedness and/or astigmatism). Contact lenses and eyeglasses needed after this surgery* • *Reversal of voluntary sterilization* • *Services not stated above as covered* • *Routine treatment of conditions of the foot (see Section 5(a) Foot care)*	*All charges*
Reconstructive surgery	**High Option**
• Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function, reducing symptoms or creating a normal appearance; including medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate. • Surgery to correct a functional defect. • Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema. • Reconstructive surgery of both breasts performed to restore symmetry following a mastectomy. • Breast prosthesis; and surgical bras (see Section 5(a) Prosthetic devices for coverage) 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:	*All charges*

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**High Option**
• *Cosmetic Services. Treatments, services, Prescription Drugs, equipment, or supplies given for Cosmetic Services. Cosmetic Services are meant to preserve, change, or improve how you look. This exclusion does not apply to services mandated by state or federal law, or listed as covered.* *This does not apply to reconstructive surgery you might need to a) give you back the use of a body part; b) have for breast reconstruction after a mastectomy; and c) correct or repair a deformity caused by birth defects, abnormal development, injury or illness in order to improve function, symptomatology or create a normal appearance. (See Section 5(d) Accidental Injury)* Cosmetic surgery does not become reconstructive because of psychological or psychiatric reasons. • *Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.* • *Surgery for Sex-Trait Modification to treat gender dysphoria: If you are mid-treatment, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services formerly covered under the 2025 Plan brochure, you may seek an exception to continue care. Our exception process is as follows: Please note that the continuing care for surgical sex-trait modification services are only available for those individuals who first began or received surgical sex-trait modification services prior to January 1, 2026. Contact your Provider, who can obtain authorization from Anthem for continuing care. If you disagree with our decision on your exception, please see Section 8 of your brochure for the disputed claims process.* *Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Splint therapy or surgical treatment for disorders of the joints linking the jawbones and the skull (the temporomandibular joints); including the complex of muscles, nerves and other tissues related to those joints; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing
Not covered:	*All charges*

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay
Oral and maxillofacial surgery (cont.)	**High Option**
• *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 and tissue transplants** are covered, and are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart-lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung - single/bilateral/lobar • Pancreas	Nothing
Blood or Marrow Stem Cell Transplants: The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia)	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- 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 • Autologous transplant for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma recurrence - relapsed or refractory - Advanced Non-Hodgkin's lymphoma recurrence - relapsed or refractory - Aggressive non-Hodgkin lymphomas - Amyloidosis - Breast cancer - Epithelial ovarian cancer - Neuroblastoma	Nothing
Blood or marrow stem cell transplants: Not subject to medical necessity: • Allogeneic transplant for: - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for: - Multiple myeloma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	Nothing
Blood or marrow stem cell transplants: Not subject to Medical Necessity. • Autologous transplants for: - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) - Breast cancer	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Childhood rhabdomyosarcoma - Hematopoietic Stem Cell Transplant (HSCT) - Epithelial ovarian cancer - Mantle Cell (Non-Hodgkin lymphoma)	Nothing
Mini-transplants performed in a Clinical Trial Setting (non-myeloablative, reduced intensity conditioning, or RIC) for members with a diagnosis listed below: subject to medical necessity review by the Plan. Refer to Other services in Section 3 for prior authorization procedures: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Hemoglobinopathy - Hodgkin's lymphoma – relapsed - Marrow Failure and Related Disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic Syndromes - Myeloproliferative Disorders (MPDs) - Non-Hodgkin's lymphoma – relapsed - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Amyloidosis - Hodgkin's lymphoma – relapsed - Neuroblastoma - Non-Hodgkin's lymphoma – relapsed	Nothing
Tandem transplants for covered transplants: subject to medical necessity review by the Plan. • Autologous tandem transplants: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Nothing
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 if approved by the Plan's medical director in accordance with the Plan's protocols.	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
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: - Advanced Hodgkin's lymphonma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Mutiple myeloma (after a previous autologous stem cell transplant or due to primary graft failure, failure to engraft or rejection) - Multiple sclerosis - Sickle cell anemia • Non-myeloablative allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced Non-Hodgkin's lymphoma - relapsed or refractor - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma (after a previous autologous stem cell transplant or due to primary graft failure, failure to engraft or rejection) - Multiple sclerosis - Myeloproliferative Disorders - Myeloproliferative/Myelodysplastic Syndromes - Sickle Cell disease • Autologous transplants for the following autoimmune diseases: - Multiple sclerosis - Scleroderma - Scleroderma-SSc (severe, progressive) - Systemic lupus erythematosus - Systemic sclerosis • Autologous transplants for: - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) (after allogeneic transplant)	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Chronic myelogenous Leukemia (after allogeneic transplant) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma (after allogeneic transplant)	Nothing
Blood or marrow stem cell transplants • Allogeneic transplants for: - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Ependymoblastoma - Ewing's sarcoma - Medulloblastoma - Pineoblastoma - Waldenstrom's macroglobulinemia National Transplant Program (NTP) – We are a member of the Blue Distinction Center for Transplant.	Nothing
Donor testing for up to four bone marrow transplant donors from individuals unrelated to the patient in addition to testing of family members.	Nothing
Not covered: • *Implants of artificial organs* • *Transplants not listed as covered* • *Donor screening tests and donor search expenses, except as shown above*	*All charges*
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 coordinating benefits with 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 Section 5(a).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Note: Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.	$250 per day for a maximum of 4 days
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • 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: 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

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High Option**
Services are limited to a 3 day hospital stay. We will not cover the dental procedure itself or any of the professional services of a dentist to perform the procedure.	Nothing
Not covered: • *Services rendered by hospital resident doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of hospitals, labs or other institutions, and charges included in other duplicate billings.* • *Private duty nursing services given in a hospital or skilled nursing facility.*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • 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 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 unless surgery is performed. $250 per outpatient surgery admission
Other outpatient hospital services supplies, including physical therapy, occupational therapy, or speech therapy. Note: These rehabilitative services are limited to 40 days per benefit period. If you need more than 40 days per benefit period, your primary care provider must obtain approval from your medical group or Anthem. (See Section 5(a) Rehabilitative Care.)	$40 per visit
• Chemotherapy • Radiation therapy • Hemodialysis treatment • Infusion therapy	$40 per visit

Benefit Description	You pay
Skilled nursing care facility benefits	**High Option**
We cover the following care for a combined benefit of up to 150 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 medications given during your stay. This includes oxygen. • Blood transfusions • Needed medical supplies and appliances	Nothing
• Inpatient rehabilitation care	$250 per day for a maximum of 4 days
Not covered: • *Private duty nursing services given in a hospital or skilled nursing facility.*	*All charges*
Hospice care	**High Option**
You are eligible for hospice care if your Doctor and the Hospice medical director certify that you are terminally ill and likely have less than twelve (12) months to live. • 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 medications prescribed by a doctor • Medical supplies, oxygen and respiratory therapy supplies • Care which controls pain and relieves symptoms • Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties, for one year after the member's death.	Nothing

Benefit Description	You pay
Ambulance	**High Option**
You can get these services from a licensed ambulance in an emergency or when ordered by your primary care provider. (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	$200 per trip Nothing for all other services and supplies

Section 5(d). Emergency Services/Accidents

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan doctors must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 coordinating benefits with 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 Section 5(a).

What is a medical emergency?

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

What is urgent care?

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

If you need urgent care you should seek medical attention immediately. If you are admitted to a hospital for urgently needed care, you should contact your primary care provider 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 provider must approve any care you need after that.

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

Emergencies within our service area

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

If you need emergency services, get the medical care you need right away. If you want, you may also call your primary care provider and follow their instructions.

Your primary care provider 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.

Emergencies outside our service area

You can still get emergency services if you are more than 15-miles or 30-minutes away from your primary care provider or 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 will not cover services that do not fit what we mean by emergency services.
- Your primary care provider must approve care you get once you are stabilized, unless Anthem Blue Cross Select HMO approves it.
- Once your medical group or Anthem Blue Cross-Select HMO give an approval for emergency services, they cannot withdraw it.

Benefit Description	You pay
Emergency within or outside of our service area	**High Option**
• Emergency care at a doctor's office	$30 per office visit
• Emergency care at an urgent care center	$30 per visit
• Emergency care on an outpatient basis at a hospital (if care results in admission to a hospital, the emergency services copayment will not apply)	$200 per visit
• Emergency care at a hospital on an inpatient basis	$250 per day for a maximum of 4 days
Ambulance	**High Option**
You can get these services from a licensed ambulance in an emergency. (We will provide benefits for these services if you receive them as a result of a 9-1-1 emergency response system call for help if you think you have an emergency.) Air ambulance is also covered, but, only if ground ambulance service can't provide the service needed. Air ambulance service, if medically necessary, is provided only to the nearest hospital that can give you the care you need. • Base charge and mileage • Disposable supplies • Monitoring, EKG's or ECG's, cardiac defibrillation, CPR, oxygen, and IV Solutions	$200 per trip Nothing for all other services and supplies
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *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*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 coordinating benefits with other coverage, including with Medicare.
- You can get care for outpatient professional treatment of mental health and substance use 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.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

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 use disorder treatment 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 substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy • Behavioral health treatment for pervasive developmental disorder or autism • Intensive in-home behavioral health services, when available in your area. These services do not require confinement to the home. • Online visits	Your cost-sharing responsibilities are no greater than for other illnesses or conditions. $25 per office visit

Professional services - continued on next page

Benefit Description	You pay
Professional services (cont.)	**High Option**
Note: For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating healthcare provider, completion of covered services for the maternal mental health condition shall not exceed twelve (12) months from the diagnosis or from the end of pregnancy, whichever occurs later. A maternal mental health condition is a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions. $25 per office visit
Inpatient hospital physician visit	Nothing
Individual and group psychotherapy for the treatment of smoking cessation	Nothing
Nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa	Nothing
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility. • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Residential treatment center Before you get services for facility-based care for the treatment of mental or nervous disorders or substance use, you must get our approval first.	$250 per day for a maximum of 4 days
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility. • Services in approved treatment programs, such as partial hospitalization, half-way house, full-day hospitalization, or facility-based intensive outpatient treatment	Nothing
Not covered: • *Academic or educational testing or counseling. Remedying an academic or education problem. Any educational treatment or any services that are educational, vocational, or training in nature except as specifically provided or arranged by us.*	*All charges*

Outpatient hospital or other covered facility - continued on next page

Benefit Description	You pay
Outpatient hospital or other covered facility (cont.)	**High Option**
• *Treatment of any sexual problems unless due to a medical problem, physical defect, or disease.*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart under Covered medications and supplies.
- 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.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 coordinating benefits with other coverage, including with Medicare.
- **The exclusion for hormone treatments for Sex-Trait Modification for gender dysphoria** only pertains to chemical and surgical modification of an individual's sex traits (including as part of "gender transition" services). **We do not exclude coverage for entire classes of pharmaceuticals,** e.g., GnRH agonists may be prescribed during IVF, for reduction of endometriosis or fibroids, and for cancer treatment or prostate cancer/tumor growth prevention.

There are important features you should be aware of. **These include:**

Who can write your prescription

A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication. Certain over-the-counter items for tobacco cessation, nicotine replacement, FDA-approved contraceptives for women, vitamins, supplements, and health aids, may be covered when obtained with a doctor's prescription. This rule does not apply to pneumonia or seasonal flu vaccinations provided at a member drug store.

Where you can obtain them

You may fill the prescription at any licensed retail participating pharmacy, by the mail service program or from our Specialty Pharmacy. When using a plan pharmacy you have two levels to choose from. Level 1 pharmacies will have lower copayments and Level 2 pharmacies will have higher copayments. Call us at 800-235-8631 or visit our website at www. anthem.com/federal/ca for information on how to obtain a listing of the Level 1 and Level 2 pharmacies. It will cost you more if you go to a non-participating pharmacy.

Using Participating Pharmacies

To get medication your physician has prescribed, go to a participating pharmacy. For help finding a participating pharmacy, call us at 800-235-8631 or the Pharmacy Member Services number on the back of your identification card. Show your Member ID card to the participating pharmacy and pay your copayment for the covered medication. You must also pay for any medication or supplies that are not covered under the Plan.

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

Claims Department
P.O. Box 52065
Phoenix, AZ 85072-2065

If the member drugstore doesn't have claims forms, or if you have questions, call 800-235-8631 or the Pharmacy Member Services number on the back of your identification card.

If you are out of state, and you need medication, call us at 800-235-8631 or the Pharmacy Member Services phone number on the back of your identification card to find out where there is a member drugstore.

Getting your medication through the Home Delivery Pharmacy

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

Home Delivery Pharmacy
P.O. Box 94467
Palatine, IL 60094-4467

There may be some medications you cannot order through this program, such as drugs to treat sexual dysfunction. Call 800-235-8631 or the Pharmacy Member Services phone number on the back of your identification card to find out if you can enroll to receive your medication through the Home Delivery Pharmacy.

Compound Medication Compound medications do not include duplicates of existing products and supplies that are mass-produced by a manufacturer for consumers, nor products lacking an NDC number. Compound medications must be dispensed by a member drugstore. Call 800-235-8631 or the Pharmacy Member Services number on the back of your identification card to find out where to take your prescription for an approved compound medication to be filled. (You can also find a member drugstore at www. anthem.com/federal/ca) Some compound medications must be approved before you can get them (see "Drugs that need to be approved" below). You will have to pay the full cost of the compound medications you get from a drugstore that is not a member drugstore.

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

Getting your medication through the Specialty Pharmacy

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

You or your doctor may obtain a list of specialty drugs available through the Specialty Pharmacy Program or order forms by contacting Member Services at 800-235-8631 or online at www. anthem.com/federal/ca.

Claims Department
P.O. Box 52065
Phoenix, AZ 85072-2065

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

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

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

How to obtain an exception to the Specialty Pharmacy Program

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

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

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

We use a formulary

The fact that a drug is on this list doesn't guarantee that your doctor will prescribe you that drug. This list, which includes both generic drugs and brand name drugs, is updated quarterly so that the list includes drugs that are safe and effective in the treatment of disease. The Essential prescription drug list is a list of pharmaceutical products, developed in consultation with physicians and pharmacists, approved for their quality and cost effectiveness. The covered prescription drug list is subject to periodic review and amendment. Except as otherwise stated, certain drugs may not be covered if they are not on the Essential prescription drug list. Some drugs need to be approved - the doctor or drugstore will know which drugs they are. If you have a question regarding whether a particular drug is on our formulary drug list or requires prior authorization please call us at the telephone number on the back of your identification card. Information about the drugs on our formulary drug pricing and search tools are also available on our internet website www. anthem.com/federal/ca.

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

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

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

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

A generic equivalent will be dispensed if it is available.

When your doctor prescribes a brand-name drug that has a FDA-approved generic option, your pharmacy will automatically fill the prescription using the generic drug. You will pay less for the generic drug.

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

Why use generic drugs?

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

Special Programs

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

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

- Tier 1 Drugs are those that have the lowest co-payment. This tier contains low cost preferred drugs that may be generic, single source brand name drugs, biosimilars, interchangeable biologic products or multi-source brand name drugs.
- Tier 2 Drugs are those that have higher copayments than Tier 1 Drugs, but, lower than Tier 3 Drugs. This tier may contain preferred drugs that may be generic, single source brand name drugs, biosimilars, interchangeable biologic products or multi-source brand name drugs.
- Tier 3 Drugs are those that have the higher copayments than Tier 2 Drugs, but, lower than Tier 4 Drugs. This tier may contain higher cost preferred drugs and non-preferred drugs that may be generic, single source brand name drugs, biosimilars, interchangeable biologic products or multi-source brand name drugs.
- Tier 4 Drugs are those that have the higher copayments than Tier 3 Drugs. This tier may contain higher cost preferred drugs and non-preferred drugs that may be generic, single source brand name drugs, biosimilars, interchangeable biologic products or multi-source brand name drugs.

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: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Formulas prescribed by a doctor for the treatment of phenylketonuria. These formulas are subject to the copay for brand name drugs. • Growth hormone • Insulin, glucagon, and other prescription drugs for the treatment of diabetes • Syringes for use with insulin and other medications you inject yourself • Drugs that have FDA labeling to be injected under the skin by you or a family member • Disposable diabetic supplies (that is, testing strips, lancets, and alcohol swabs) • Prescription drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes • Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copay for brand name drugs. • Off label use of covered drugs if prescribed by a Plan doctor • Hormone therapy • Medications prescribed to treat obesity • Drugs used mainly for treating infertility as determined to be Medically Necessary. • IVF drugs when authorized as medically necessary for up to 3 cycles per benefit period Note: If your drugstore's retail price for a drug is less than the copay shown, you will not be required to pay more than that retail price. Note: Written prescriptions are valid for 12 months from the date the prescription is written. Note: A 90-day supply of maintenance drugs can be obtained at a maintenance drugstore. For more details contact the member services number on the back of your identification card.	**Level 1 Retail Pharmacy (up to 30-day supply):** Tier 1- $10 Tier 2-$50 Tier 3 - $80 **Level 2 Retail Pharmacy (up to 30-day supply):** Tier 1- $20 Tier 2- $60 Tier 3 - $90 If your retail prescription is for a 90-day supply, you pay three times the copay listed above. **Tier 4 (Specialty Pharmacy Only):** 25% of our allowance up to a maximum out-of-pocket of $250 per prescription for a 30-day supply **Home Delivery Pharmacy (up to 90-day supply):** Tier 1- $20 Tier 2- $100 Tier 3 - $160
• Oral anti-cancer medications	25% of our allowance up to a maximum out-of-pocket of $250 per prescription for a 30-day supply
• FDA approved drugs for the treatment of tobacco cessation use. Note: This includes prescription and physician prescribed over-the-counter medications.	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https ://www. hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to FEHB/PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. Note: The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below: If your Provider determines that a Brand Drug with an available Generic therapeutic equivalent commercially available in the market is Medically Necessary because a Generic equivalent drug is not appropriate for you, you may obtain coverage of the Brand Drug with $0 Cost Sharing if your Provider submits an exception request . Your Doctor must complete a contraceptive exception form and return it to us. Your Doctor can locate the form in their Anthem Provider Portal. If Medical Necessity has been determined by your Provider, an exception will be granted and coverage of the Drug will be provided at $0 Cost Sharing. Otherwise, Brand Drugs will be covered as a Preventive Care benefit when Medically Necessary according to your attending Provider, otherwise they will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy." If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. Note: For additional Family Planning benefits see Section 5(a) Note: Over-the-counter contraceptive drugs and devices approved by the FDA require a written prescription by an approved provider. Call 800-235-8631 for more information, or to obtain a claim form for reimbursement. Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation education classes and programs in Section 5(a) . (See page 38.)	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
Opioid rescue agents are covered under this Plan with no cost sharing when obtained with a prescription from a Network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https ://www. fda. gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https ://www. findtreatment.samhsa.gov/	Nothing
***Not covered**:* • *Drugs and medications used to induce spontaneous and non-spontaneous abortions* • *Professional charges for giving and injecting drugs. While not covered under this prescription drug benefit, they may be covered as specified in Section 5(a).* • *Drugs and medications you can get without a doctor's prescription, except insulin or niacin for cholesterol lowering* • *Drugs labeled "Caution, Limited by Federal Law to Investigational Use," or Non-FDA approved investigational drugs. Drugs and medications prescribed for experimental indications. If you are denied a drug because we determine that the drug is experimental or investigative, you may ask that the denial be reviewed by an external independent medical review organization.* • *Drugs which haven't been approved for general use by the state or Food and Drug Administration (FDA). This does not apply to drugs that are medically necessary for a covered condition.* • *Drugs and medications dispensed or given in an outpatient setting; including, but not limited to inpatient facilities and doctors' offices. While not covered under this prescription drug benefit, if you need these drugs, they are covered as specified throughout Section 5.* • *Cosmetics, health and beauty aids* • *Drugs and medications dispensed by or while you are confined in a hospital, skilled nursing facility, rest home, sanitarium, convalescent hospital or similar facility. While not covered under this prescription drug benefit, if you need these drugs, they are covered as specified throughout Section 5.* • *Drugs and supplies for cosmetic purposes (for example, Retin-A for wrinkles). But, this will not apply to the use of this type of drug for medically necessary treatment of a medical condition other than one that is cosmetic.* • *Drugs for losing weight, except when needed to treat morbid obesity (for example, diet pills and appetite suppressants)* • *Drugs you get outside the United States unless related to emergency services or urgent care* • *Herbal, nutritional and diet supplements*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• *Compound medications unless all the ingredients are FDA-approved and require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants. Compound medications must be obtained from a member drugstore. You will have to pay the full cost of the compound medications you get from a non-member drugstore.* • *Vitamins, nutrients and food supplements* not listed as a covered benefit *even if a physician prescribes or administers them* • *Any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a covered service under this plan for non-Investigative treatments, unless specifically stated.* • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications unless specifically indicated elsewhere* • *Drugs prescribed in connection with Sex-Trait Modification for treatment of gender dysphoria* *Sex-Trait Modification: If you are mid-treatment, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services formerly covered under the 2025 Plan brochure, you may seek an exception to continue care. Our exception process is as follows: Please note that the continuing care for surgical sex-trait modification services are only available for those individuals who first began or received surgical sex-trait modification services prior to January 1, 2026. Contact your Provider, who can obtain authorization from Anthem for continuing care. If you disagree with our decision on your exception, please see Section 8 of your brochure for the disputed claims process.* *Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.*	*All charges*
Preventive medications	**High Option**
Preventive care medications Preventive medications with a USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www. uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing: when prescribed by a network provider and filled at a network pharmacy.
Preventive drugs for the following conditions: • Heart disease • Congestive heart failure	Nothing

Preventive medications - continued on next page

Benefit Description	You pay
Preventive medications (cont.)	**High Option**
• Coronary artery disease • Diabetes • Hypertension • Asthma • Liver disease • Depression • Bleeding disorders Note: You may obtain a copy of the drug list by calling the customer service number on the back of your identification card or visit the web site at www. anthem.com/federal/ca.	Nothing
Not covered • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications*	*All charges*

Section 5(g). Dental Benefits

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9. coordinating benefits with other coverage, including with Medicare.
- 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.
- Be sure to read Section 4. *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9. coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. We will also cover medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate. **Important:** If you decide to receive dental services that are not covered under this Plan, a dentist who participates in an Anthem Blue Cross - Select HMO network may charge you their usual and customary rate for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this Plan, please call Customer Service at 800-235-8631.	Nothing
Not covered: • *Braces or other appliances or services for straightening the teeth (orthodontic services) except as specifically stated in "Reconstructive Surgery".* • *Dental devices and oral appliances for snoring.* • *Dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventative care and fluoride treatments; dental x-rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:* - *Extraction, restoration, and replacement of teeth;* - *Services to improve dental clinical outcomes.* *This exclusion does not apply to the following:* • *Services which we are required by law to cover;* • *Services specified as covered in this booklet;*	*All charges*

Accidental injury benefit - continued on next page

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

Section 5(h). Wellness and Other Special Features

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

Discount Programs

You can receive negotiated savings on selected health and wellness services and programs simply by being an eligible Anthem Blue Cross Select HMO member. To obtain information about these programs please call us at 800-235-8631 or visit our website at www. anthem.com/federal/ca. Services available through the discount program includes but are not limited to:

Vision, Hearing & Dental

- 1-800-CONTACTS – latest brand-name frames and contacts at a fraction of the cost for similar items at other retailers
- EyeMed – Discounts on glasses and accessories
- Premier LASIK – Save when selecting a "Featured" Premier LASIK network provider
- TruVision – Preferred pricing on LASIK eye surgery
- Nations Hearing – Receive hearing screenings and in-home services
- Hearing Care Solutions – Offers digital instruments and hearing exams
- Amplifon – Discounts on hearing aids
- ProClear Aligners – Improve your smile without metal braces and time-consuming dental visits

Fitness & Health

- Active Discounts on gym memberships
- FitBit – Discounts on FitBit devices
- Jenny Craig- Discounts on Jenny Craig weight loss programs
- GlobalFit – Discounts on gym memberships, fitness equipment, coaching and other services

Family and Home

- Safe Beginnings – Discounts off safety gates, outlet covers and more
- Nationwide Pet Insurance – Discounts available when enrolling multiple pets
- WINFertility – Discounts on infertility treatments
- LifeMart – Discount on beauty & skin care, diet plans, fitness club memberships, personal care, spa services, yoga classes, sports gear, and vision care

Medicine and treatment

- SelfHelpWorks – Discount off Online Living Programs to help you lose weight, stop smoking, manage stress or diabetes, restore sound sleep, or face an alcohol problem
- Brevena – Discount on skin care products
- Puritan's Pride – Discounts on various vitamins, minerals, and supplements
- Allergy Control Products and National Allergy Supply – Discounts on allergy friendly products

Questions? Please contact the number listed on your ID card or visit www. anthem.com/federal/ca to learn more.

Section 6. General Exclusions – Services, Drugs, and Supplies We Do Not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- 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 you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Care you got from a healthcare provider without the approval of your primary care doctor or a doctor specializing in OB-GYN in your medical group, except for emergency services or urgent care.
- Services not listed as being covered by this Plan.
- Any benefits or services required solely for your employment are not covered by this plan.
- Chemical or surgical modification of an individual's sex traits through medical interventions (to include "gender transition" services), other than mid-treatment exceptions, see Section 3. How You Get Care.
- Any services actually given to you by a local, state or federal government agency, or by a public school system or school district, except when this Plan's benefits, must be provided by law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.
- Treatment or services rendered by non-licensed healthcare providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed doctor, except as specifically provided or arranged by us. This exclusion does not apply to the medically necessary treatment of pervasive developmental disorder or autism, to the extent stated in the section "Benefits for Pervasive Developmental Disorder or Autism".
- Services you are not required to pay for or are given to you at no charge, except services you got at a charitable research hospital (not with the government). This hospital must:
  - Be known throughout the world as devoted to medical research.
  - Have at least 10% of its yearly budget spent on research not directly related to patient care.
  - Have 1/3 of its income from donations or grants (not gifts or payments for patient care).
  - Accept patients who are not able to pay.
  - Serve patients with conditions directly related to the hospital's research (at least 2/3 of their patients).
- Care for health problems that are work-related if such health problems are or can be covered by workers' compensation, an employer's liability law, or a similar law. We will provide care for a work-related health problem, but, we have the right to be paid back for that care.
- Weight loss programs, whether or not they are pursued under medical or doctor supervision, unless specifically listed as covered in this Plan. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or for treatment of anorexia nervosa or bulimia nervosa.

- Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.
- This plan does not cover educational or academic services as follows:
  - Educational or academic counseling, remediation, or other services that are designed to increase academic knowledge or skills.
  - Educational or academic counseling, remediation, or other services that are designed to increase socialization, adaptive, or communication skills.
  - Academic or educational testing.
  - Teaching skills for employment or vocational purposes.
  - Teaching art, dance, horseback riding, music, play, swimming, or any similar activities
  - Teaching manners and etiquette or any other social skills.
  - Teaching and support services to develop planning and organizational skills such as daily activity planning and project or task planning
  - Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based

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

- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.
- Autopsies and post-mortem testing are not covered.

Section 7. Filing a Claim for Covered Services

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

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

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

Medical and Hospital benefits

In most cases, providers and facilities file HIPAA compliant electronic claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. In cases where a paper claim must be used, the facility will file on the UB-04 form. To obtain claim forms, or for claims questions and assistance, call us at 800-235-8631 or at our website at www.anthem.com/federal/ca.

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

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

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

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

Prescription drugs

You normally won't have to submit claims to us unless you receive prescriptions from a non-participating pharmacy. You need to take a claim form with you to the non-participating pharmacy. If you need a claim form or if you have questions, call us at 800-235-8631 or visit our website at www.anthem.com/federal/ca. Have the pharmacist fill out the form and sign it. Then send the claim form (within 90 days).

Submit your claims to: Claims Department, P.O. Box 52065, Phoenix, AZ 85072-2065.

Deadline for filing your claim

Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a one-year limitation on the re-issuance of uncashed checks.

Post-service claims procedures

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

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

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

Authorized Representative

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

Notice Requirements

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

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

Overseas claims

For covered emergency and urgent care services you receive by providers and hospitals outside the United States and Puerto Rico, send a completed Overseas Claim Form and the itemized bills to: **Anthem Blue Cross, P.O. Box 60007 Los Angeles, CA. 90060-0007**. Obtain Overseas Claim Forms from: www.anthem.com. If you have questions about the processing of overseas claims, contact 800-235-8631.

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim 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.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact us by writing to Anthem Blue Cross-Select HMO, 3075 Vandercar Way, OH3402-B014, Cincinnati, OH 45209 or calling 800-235-8631.

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

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

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

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Anthem Blue Cross-Select HMO Appeals, 3075 Vandercar Way, Mail Loc. OH3402-B014, Cincinnati, OH 45209; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for members), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stare described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or

	b) Write to you and maintain our denial or c) Ask you or your provider for more information You or your provider must send information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employees Insurance Operations, FEHB 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physician's letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letter we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM's review within 60 days. There are no other administrative appeals. If you do not agree with OPM’s decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

	You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 800-235-8631. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at 202-606-0755 between 8 a.m. and 5 p. m. Eastern Time.

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

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

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

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

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

TRICARE and CHAMPVA

TRICARE is the healthcare 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

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

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.

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 or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

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

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

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

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

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

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

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

  - Personal injury protection benefits

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

Contact us if you need more information about subrogation.

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

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

Clinical Trials

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

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

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

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

The Original Medicare Plan (Part A or Part B)

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

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

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

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

- When we are the primary payor, we process the claim first.

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

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

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

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

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

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

Please review the following examples which illustrate your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description: Deductible

High Option You pay without Medicare: $0
High Option You pay with Medicare Part B: $0

Benefit Description: Catastrophic Protection Out-of-Pocket Maximum

High Option You pay without Medicare: $3,000 self only/$6,000 family
High Option You pay with Medicare Part B: $3,000 self only/$6,000 family

Benefit Description: Part B Premium Reimbursement Offered

High Option You pay without Medicare: N/A
High Option You pay with Medicare Part B: N/A

Benefit Description: Primary Care Provider

High Option You pay without Medicare: $25
High Option You pay with Medicare Part B: $0

Benefit Description: Specialist

High Option You pay without Medicare: $40
High Option You pay with Medicare Part B: $0

Benefit Description: Inpatient Hospital

High Option You pay without Medicare: $250 per day for a maximum of 4 days
High Option You pay with Medicare Part B: $0

Benefit Description: Outpatient Hospital

High Option You pay without Medicare: $250 per visit for surgical admissions or $40 per visit for other services
High Option You pay with Medicare Part B: $0

Benefit Description: Incentives offered

High Option You pay without Medicare: N/A
High Option You pay with Medicare Part B: NA

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 healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800 MEDICARE (800-633-4227), TTY:877-486-2048 or at www.medicare.gov.

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

This Plan and our Medicare Advantage plan: You may enroll in an Anthem Medicare Advantage plan and also remain enrolled in our FEHB plan. In this case, we will waive any of our copayments or coinsurance for your FEHB coverage.

In the Anthem Medicare Advantage plan we offer benefits, such as wellness programs like SilverSneakers®.

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

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium). For information on suspending your FEHB enrollment, contact your retirement or employing 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.

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

This plan has limited coverage for accidental dental and vision screening 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.gov or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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		✓*
9) Are a Federal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

Section 10. Definitions of Terms We Use in This Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

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

Clinical Trials Cost Categories

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

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

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

Coinsurance

See Section 4, page 21

Copayment

See Section 4, Page 21

Cost-sharing

See Section 4, page 21

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 medication which you usually do yourself or any other care for which the services of a professional healthcare 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.

Healthcare professional

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

Infertility

Infertility is a condition of the reproductive system that results in a failure to achieve a successful pregnancy within 12 months of non-artificial insemination methods or attempted egg-sperm contact through artificial insemination methods, for individuals under age 35 and 6 months for individuals aged 35 and older. Infertility may also be established through an evaluation based on medical history and diagnostic testing.

Maintenance drugs

Drugs you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure the prescription drug you are taking is a maintenance medication or need to determine if your pharmacy is a maintenance pharmacy, please call Member Services at the number on the back of your Identification Card or check our website for more details.

Maintenance drugstore

A member drugstore that is contracted with our pharmacy benefit manager to dispense a 90-day supply of maintenance drugs.

Medical necessity

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

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

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. 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.

You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.

Post-service claims

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

Pre-service claims

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

Reimbursement

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

Subrogation

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

Surprise bill

An unexpected bill you receive for:

- Emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Urgent care claims

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

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

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

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

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

Us/We

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

You

You refers to the enrollee and each covered family member.

Index

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

Summary of Benefits for the High Option of Anthem Blue Cross - Select HMO - 2026

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www. anthem.com/federal/ca.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, unless you receive an authorized referral or the services are for emergency or urgent care.

Benefits	You Pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	PCP office visit copay: $25 or Specialist office visit copay: $40	28
Services provided by a hospital: • Inpatient	$250 per day for a maximum of 4 days.	52
Services provided by a hospital: • Outpatient	Nothing unless surgery is performed. $250 per outpatient surgery admission.	54
Emergency visit to a hospital emergency room: In-area or out-of-area	$200 per visit	54
Mental health and substance use disorder treatment: Inpatient	$250 per day for a maximum of 4 days	61
Mental health and substance use disorder treatment: Outpatient	Regular cost-sharing	54
Prescription drugs: Retail Pharmacy: Up to a 30-day supply. Note: You must obtain specialty drugs from the Specialty Pharmacy Program unless we have granted a written exception.	**Level 1 Retail Pharmacy (up to 30-day supply):** Tier 1- $10 Tier 2-$50 Tier 3 - $80 **Level 2 Retail Pharmacy (up to 30-day supply):** Tier 1- $20 Tier 2- $60 Tier 3 - $90 If your retail prescription is for a 90-day supply, you pay three times the copay listed above. **Tier 4 (Specialty Pharmacy Only):** 25% of our allowance up to a maximum out-of-pocket of $250 per prescription for a 30-day supply	63
Prescription drugs: • **Home Delivery Pharmacy -** up to a 90-day supply	Tier 1- $20 Tier 2- $100 Tier 3 - $160	64
Dental care: Restorative services for accidental injury only	Nothing	72

Benefits	You Pay	Page
Vision care:	Annual eye refraction; you pay nothing.	36
Special features:	24/7 Nurse Line	74
Protection against catastrophic costs: (your catastrophic protection out-of-pocket maximum)	Nothing after $3,000/Self Only or $3,000 per person/Self Plus One or $6,000/Self and Family per year	13

Notes

2026 Rate Information for Anthem Blue Cross - Select HMO

To compare your FEHB health plan options please go to www. opm.gov/fehbcompare. To review premium rates for all FEHB health plan options please go to www. opm.gov/FEHBpremiums or www. opm.gov/Tribalpremium.

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

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
California					
High Option Self Only	B31	$309.17	$103.05	$669.86	$223.28
High Option Self Plus One	B33	$668.10	$222.70	$1,447.55	$482.52
High Option Self and Family	B32	$736.12	$245.37	$1,594.92	$531.64