SISC High Deductible Plan B (HSA Compatible Plan)

PPO Benefits

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

Subject to Utilization Review

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

Explanation of Maximum Allowed Amount

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

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

Non-Participating Providers & Other Health Care Providers-(includes those not represented in the PPO provider network)-Reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.

Participating Pharmacies & Home Delivery Program-members are not responsible for any amount in excess of the prescription drug maximum allowed amount. Non-Participating Pharmacies-members are responsible for any expense not covered under this plan & any amount in excess of the prescription drug maximum allowed amount. When using non-participating providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay. When using the outpatient prescription drug benefits, members are always responsible for drug expense which is not covered under this plan, as well as any deductible, percentage or dollar copay.

Calendar year deductible for all providers (*applicable to medical care & prescription drug benefits)*	
➢ Single Insured Person	$3,000/Insured Person
➢ Family	$5,200/Family
➢ *No last quarter carry-over*	
Annual Out-of-Pocket Maximums *(including calendar year deductibles, copays, prescription drug covered expense)*	
PPO Providers Only*	$5,000/Insured Person/year $10,000/Family/year

**Member copayments and coinsurance for Emergency Medical Care with a Non-PPO Provider also apply to the PPO Out-of-Pocket Maximums.*

The following do not apply to out-of-pocket maximums: Non-covered expenses and for non-PPO providers and Other Health Care Providers, amounts in excess of the covered expense.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay[1]
Hospital Medical Services *(Subject to Utilization Review for Inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	10%	0% *(benefit limited to $600/day)*
➢ Outpatient Hospital medical care, surgical services & supplies	10%	0%
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	10%	0% *(max. $350/admit)*
Hemodialysis		
➢ Outpatient hemodialysis services & supplies	10%	0% *(benefit limited to $350/visit)*
Skilled Nursing Facility *(Subject to Utilization Review)*		
➢ Semi-private room, services & supplies *(limited to 100 days per calendar year; limit does not apply to mental health and substance abuse)*	10%	10% *(benefit limited to $600/day)*
Hospice Care	0%	0%
➢ Inpatient or outpatient services; family bereavement services		

[1]Coverage is 100% of fee schedule. Insured Person is responsible for all charges exceeding the non-par fee schedule.

[2]These providers are not represented in the PPO network.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay[1]
Home Health Care *(Subject to Utilization Review)* Services & supplies from a home health agency *(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care)*	10%	0% *(benefit limited to $150/day)*
Home Infusion Therapy *(Subject to Utilization Review)* ➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	0% *(limited to $600/day)*
Physician Medical Services		
➢ Office Visit	10%	0%
➢ Hospital & skilled nursing facility visits	10%	0%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	0%
➢ Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	10%	0%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	10%	0% *(benefit limited to $800/procedure)*
➢ Other diagnostic x-ray & lab	10%	Not covered
Physical Exams for Members (Adults & Children- all ages)		
➢ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam	0% No co-pay *(deductible waived)*	Not covered
Adult Preventive Services *(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings)*	0% *(deductible waived)*	Not covered
Physical Therapy, Physical Medicine, & Occupational Therapy, including Chiropractic Services	10%	Not covered
Speech Therapy		
➢ Outpatient speech therapy	10%	0%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 12 visits/calendar year)*	10%	50% of maximum allowed amount
Services for the treatment of Temporomandibular Joint Disorder (TMJ)		
➢ Splint Therapy and Surgical Treatment	10%	0%
Pregnancy & Maternity Care *(services cover subscriber, spouse & dependent daughters)*		
➢ Normal delivery, cesarean section, complications of pregnancy & abortion including pre and post natal care	10%	0%
➢ Inpatient physician services	10%	0%
➢ Hospital & ancillary services	10%	0%

[1]Coverage is 100% of fee schedule. Insured Person is responsible for all charges exceeding the non-par fee schedule.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay[1]
Organ & Tissue Transplants *(subject to utilization review; specified transplants covered only when performed at Centers of Medical Excellence [CME] and Blue Distinction Centers for Specialty Care [BDCSC] for California; Blue Distinction Centers for Specialty Care [BDCSC] for out of California)*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	10%	Not covered
➢ Transplant travel expense for an authorized, specified transplant at a *CME (recipient & companion transportation limited to $10,000 per transplant)*	No copay *(deductible waived)*	Not covered
➢ Unrelated donor search, limited to $30,000 per transplant		
Bariatric Surgery *(subject to utilization review; covered only when performed at a designated Blue Distinction Center for Specialty Care – Bariatric Surgery)*		
o Acute care hospital (inpatient or outpatient) and Ambulatory Surgery Center services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	10% (deductible waived)	Not covered
o Travel expenses when member's home is 50 miles or more from the nearest designated Blue Distinction Center for Specialty Care	No copay	Not covered
o Bariatric Surgery *($3,000 maximum travel benefit per surgery)*		
Hip/Knee/Spine *(subject to utilization review; covered only when performed at a designated Blue Distinction Plus Center for Specialty Care)*		
o Inpatient services provided in connection with medically necessary surgery for hip/knee/spine	10%	Not covered
o Travel expenses when member's home is 50 miles or more from the nearest hip/knee/spine Blue Distinction Plus Center (*$6,000 maximum travel benefit)*	No copay *(deductible waived)*	Not covered
Diabetes Education Programs *(requires physician supervision)* Teach insured persons & their families about the disease process, the daily management of diabetic therapy & self-management training	10%	0%
Prosthetic Devices		
➢ Coverage for breast prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; & the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts for members with diabetes (2 pairs each/calendar year)	10%	Not covered
Durable Medical Equipment		
➢ Rental or purchase of DME , dialysis equipment & supplies, & therapeutic shoes & inserts for insured persons with diabetes	10%	Not covered
➢ Hearing Aid supplies and equipment (limited to $700 per 24 months)	10%	0%
Related Outpatient Medical Services & Supplies[2]		
➢ Ground or air ambulance transportation, services & disposable supplies *(air ambulance in a non-medical emergency is subject to pre-service review and benefit limited to $50,000 for non-PPO)*	10%[2]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	10%[2]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	10%[2]	

[1]Coverage is 100% of fee schedule. Insured Person is responsible for all charges exceeding the non-par fee schedule.

[2]These providers are not represented in the PPO network.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay[1]
Emergency Care		
➢ Emergency room services & supplies *($100 co-pay waived if admitted)*	10% after $100 co-pay	0% after $100 co-pay
➢ Inpatient hospital services & supplies	10%	10% first 48 hours; 0% limited to $600/day after 48 hours (unless member cannot be moved safely)
➢ Physician services	10%	10%[3]
Mental or Nervous Disorders and Substance Abuse		
➢ Inpatient facility care *(subject to utilization review; waived for emergency admissions)*	10%	0% *(benefit limited to $600/day)*
➢ Inpatient physician visits	10%	0%
➢ Outpatient facility care	10%	0%
➢ Physician office visits *(Behavioral Health treatment for Autism or Pervasive Development disorders requires pre-service review)*	10%	0%

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. Member is responsible for all charges exceeding the scheduled amount.

[2] 20% copay if member or non-PPO physician obtains drug from Specialty Pharmacy Program; otherwise, not covered.

[3] The allowable rate for emergency within 48 hours is based on a reasonable charge, not the scheduled amount.

Medical Exclusions and Limitations

0 **Not Medically Necessary.** Services or supplies that are not medically necessary, as defined.

1 **Experimental or Investigative.** Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Evidence of Coverage (EOC).

2 **Crime or Nuclear Energy.** Conditions that result from (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

3 **Not Covered.** Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the EOC.

4 **Excess Amounts.** Any amounts in excess of covered expense or the lifetime maximum.

5 **Work-Related.** Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.

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

7 **Services of Relatives.** Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

8 **Voluntary Payment.** Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

0 **Not Specifically Listed.** Services not specifically listed in the plan as covered services.

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

2 **Inpatient Diagnostic Tests.** Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

3 **Mental or Nervous Disorders.** Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

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5 **Orthodontia.** Braces, other orthodontic appliances or orthodontic services.

6 **Dental Services or Supplies.** Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

7 **Hearing Aids or Tests.** Hearing aids and routine hearing tests, except as specified as covered in the EOC.

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

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

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

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

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

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).

12 **Sterilization Reversal.**

13 **Infertility Treatment.** Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

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

0 **Orthopedic Supplies.** Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related feet complications as specified as covered in the EOC.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 **Private Duty Nursing.** Inpatient or outpatient services of a private duty nurse.

10 **Lifestyle Programs.** Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

11 **Wigs.**

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

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

Prescription Drugs ****** Prescription drugs are subject to combined Medical/Pharmacy deductible ******	**Per Member Copay for Each Prescription or Refill**
Retail Participating Pharmacies	
➢ Generic drugs *(includes self-injectable drugs)*	$9
➢ Generic drugs obtained at Costco Pharmacy *(Excludes narcotics, pain relievers and cough syrup with pain reliever)*	$0
➢ Brand name drugs[1] *(includes self-injectable drugs)*	$35
➢ Compound Drugs[1]	$35
➢ Diabetic Supplies	$9
➢ Preventive vaccines and immunizations administered by a retail pharmacy *(including, but not limited to, flu shot and shingles vaccine)*	$0 *(deductible waived)*
➢ Female oral contraceptives generic and single source brand	$0 *(deductible waived)*
Home Delivery Program	
➢ Generic drugs *(includes self-injectable drugs)*	$18
➢ Brand name drugs[1] *(includes self-injectable drugs)*	$90
➢ Female oral contraceptives generic and single source brand	$0 *(deductible waived)*
Specialty Pharmacy Drugs *(may only be obtained through the specialty pharmacy program; split fill applies)*	
➢ Generic drugs *(includes self-injectable drugs)*	$9
➢ Brand name drugs[1, 2] *(includes self-injectable drugs)*	$35
Non-participating Pharmacies *(compound drugs & specialty pharmacy drugs not covered at retail participating pharmacies)*	*Member pays the above retail participating pharmacies copay plus:* 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount
Supply Limits[2]	
➢ Retail Pharmacy *(participating and non-participating)*	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies); 90-day supply for eligible prescriptions obtained through a retail pharmacy, but will require a triple copay
➢ Home Delivery	90-day supply
➢ Specialty Pharmacy	30-day supply

[1] **Preferred Generic Program.** A generic drug will always be dispensed if one is available. If you purchase a brand-name drug or a compound drug with a brand component when a generic alternative is available, you will pay the generic co-payment plus the difference in cost between the brand and the generic, even if your doctor writes "dispense as written" (DAW) on the prescription

[2] Supply limits for certain drugs may be different. Please refer to the EOC/Certificate for complete information.

The Prescription Drug Benefit covers the following:

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

Prescription Drug Exclusions & Limitations

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

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

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

Professional charges in connection with administering, injecting or dispensing drugs

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

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

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

Services or supplies for which the member is not charged

Oxygen

Cosmetics & health or beauty aids.

Drugs labeled "Caution, Limited by Federal Law to Investigational Use," or Non-FDA approved investigational drugs. Any drugs or medications prescribed for experimental indications

Any expense for a drug or medication incurred in excess of the prescription drug maximum allowed amount

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

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

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

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

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

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

Allergy desensitization products or allergy serum

Infusion drugs, except drugs that are self-administered subcutaneously

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

Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin and OTC Non-Sedating Antihistamines (Claritin, Claritin-D, Zyrtec, Zyrtec-D and generics) This does not apply if an over-the-counter equivalent was tried and was ineffective.

Compound medications unless:

a. There is at least one component in it that is a prescription drug; and
b. It is obtained from a participating pharmacy. **Member will have to pay the full cost of the compound medications if member obtains drug at a non-participating pharmacy.**

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

Growth Hormones

Legend Prescription Vitaimins except Oral Rocaltrol/calcitrol, oral vitamin D ; legend pediatric fluoride vitamins covered up to 50 day supply;

Third Party Liability

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