Anthem

Prescription Drug

Certificate of Coverage

(Herein called the "Certificate")

Senior Rx Plus

Please Read Your Certificate Carefully

WRP_MCERT_CA 04/2019

Introduction

This Plan is offered by Anthem Blue Cross Life and Health Insurance Company (Anthem), referred to throughout the Certificate as "we," "us" or "our." Senior Rx Plus is referred to as "plan" or "your plan."

Anthem Blue Cross Life and Health Insurance Company
21555 Oxnard Street
Woodland Hills, CA 91367

This Certificate (sometimes called *Evidence of Coverage*) is the legal document explaining your coverage. Please read this Certificate carefully and refer to it whenever you require Prescription Drug services.

This Certificate explains many of the rights and obligations between you and us. It also describes how to obtain prescription drug services, what prescription drugs are covered and not covered, and what portion of the prescription drug costs you will be required to pay. Many of the provisions in this Certificate are interrelated; therefore, reading just one or two sections may not give you an accurate impression of your coverage. We encourage you to set aside some time to look through this Certificate. You are responsible for knowing the terms of this Certificate.

The coverage described in this Certificate is based upon the conditions of the Group Contract issued to the Retiree's former employer, and is based upon the benefit plan that your Group chose for you. The Group Contract, Group Application, this Certificate, and your Application form the Contract under which Covered Services are available under your prescription drug benefits.

Many words used in the Certificate have special meanings. These words are capitalized the first time they are used in this Certificate. If the word or phrase is not explained in the text where it appears, it will be defined in the **"Definitions"** section. Refer to these definitions for the best understanding of what is being stated.

If you have any questions about this Certificate, please call the Member Services number located on the back of your Membership Card (sometimes called Identification Card).

This non-Medicare drug plan supplements benefits paid by the Group Medicare Part D Prescription Drug plan (also known as Group Part D plan), which you also have as part of the group retiree benefits offered by the retiree's former employer. Your Group Part D plan may be a stand-alone drug plan (Part D only plan) or combined with your Medicare medical coverage (Medicare Advantage Prescription Drug plan). Please see the "Outpatient Prescription Drug Benefits" and "Coordination of Benefits" sections of this Certificate for more information about how this plan supplements your Group Part D plan.

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Benefits Chart

This Benefits Chart (sometimes called Schedule of Benefits) describes the costs you must pay after benefits are provided under this Certificate and your Group Part D plan. For a more detailed explanation of the benefits provided, please refer to the appropriate sections of this Certificate.

Benefit Period	**January 1, 2022 – December 31, 2022**
Formulary	**Open**
Covered Services	**What you pay**
Part D Covered Drugs	
After benefits have been paid by your Group Part D plan and this plan for covered drugs, you will be responsible for the amounts shown below.	
Retail Pharmacy	per 30-day supply
• Select Generics	$0 copay
• Generics	$10 copay
• Preferred Brands	$25 copay
• Non-Preferred Drugs and Non-Formulary Drugs	$40 copay
• Specialty Drugs	10% coinsurance per Covered Drug up to a coinsurance maximum of $100
Many of our retail pharmacies can dispense more than a 30-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will need to pay one copay for each full or partial 30-day supply filled.	
Mail-Order Pharmacy	per 90-day supply
• Select Generics	$0 copay
• Generics	$20 copay
• Preferred Brands	$50 copay
• Non-Preferred Drugs and Non-Formulary Drugs	$80 copay
• Specialty Drugs	10% coinsurance per Covered Drug up to a coinsurance maximum of $300

Extra Covered Drugs Benefits Chart

Covered Services	What you pay
Extra Covered Drugs	
These drugs are excluded by law from Part D plans. Some of these may be required on your retiree drug plan by state regulations. These drugs are covered by your Senior Rx Plus plan.	
Cough and Cold **DESI** **Vitamins and Minerals**	Copay or coinsurance per 30-day supply
• Generics	$10 copay
• Preferred Brands	$25 copay
• Non-Preferred Drugs	$40 copay
Erectile Dysfunction (ED)	Immediate dose ED drugs Immediate dose formats are limited to 6 per 30 days.
• Generics	$10 copay
• Preferred Brands	$25 copay
• Non-Preferred Drugs	$40 copay
Contraceptive Devices	Copay or coinsurance per Covered Device
• Prescription	$25 copay

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Outpatient Prescription Drug Benefits

For most Covered Drugs, this plan supplements the benefits paid by the Group Part D plan you also have through the retiree's former employer. This section describes the benefits available under this plan.

Your Group Part D plan is the primary payer plan for all covered Medicare Part D-eligible drugs and this plan will supplement benefits provided by that plan in the form of reduced cost sharing. If your Group Part D plan covers a Medicare Part D-eligible drug, then this plan will supplement benefits paid by your Group Part D plan up to, but not including, the Deductible, Coinsurance or Copay (Copayment) amounts shown in this plan's benefits chart. If your costs change during the Group Part D plan's Gap phase, the **"Part D Covered Drugs"** section of this plan's benefits chart will describe the cost you pay during the Part D Gap phase.

All outpatient drugs covered under the **"Extra Covered Drugs"** benefit, as outlined in the benefits chart in the front of this Certificate, will be covered only by this plan. The **"Extra Covered Drugs"** benefit includes outpatient drug coverage required under California State Laws.

No deductible applies to the **"Extra Covered Drugs"** benefits provided by this plan.

When the Group Part D plan is the primary payer plan, it will determine whether a drug you are taking will be covered or whether coverage will be subject to any Quantity Limit, Prior Authorization or Step Therapy restrictions. When this plan provides benefits for **"Extra Covered Drugs"**, it will determine whether a drug you are taking is covered or whether coverage will be subject to any quantity limit or prior authorization restrictions. You may find out if a drug you are taking has any restrictions by checking your Group Part D plan and Senior Rx Plus *Drug List* (also called *Formulary*). You can access your Drug List by visiting www.anthem.com/ca/pharmacyinformation/groupmedicare.html. Please refer to the benefits chart in your Group Part D *Evidence of Coverage* to obtain the *Drug List* name. You can also call Member Services at the number on the back of your membership card if you have any questions about your drug coverage.

Coinsurance/Copayment

The coinsurance or copayment amount shown in the benefits chart in this Certificate is the amount you will have to pay for covered drugs after your Group Part D plan and this plan have paid benefits and you have met your deductible, if you have one. A separate coinsurance or copayment will apply to each covered drug that you fill when you go to a Pharmacy. When you owe a flat copayment, your prescription drug copayment will be the lesser of your plan's copayment amount or the Maximum Allowable Amount for the covered drug.

Tiers

Your coinsurance or copayment amount may vary based on the tier in which your drug is covered. The determinations of which tier a drug will be on is made by us based upon clinical information, and where appropriate the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition and the availability of over-the-counter alternatives. The types of drugs covered by your plans in each tier are shown in the benefits chart in the front of this Certificate.

You can find the tier of a specific covered drug by checking your Group Part D plan and Senior Rx Plus *Drug List* (*Formulary*).

You can access your *Drug List* by visiting www.anthem.com/ca/pharmacyinformation/groupmedicare.html. Please refer to the benefits chart in your Group Part D *Evidence of Coverage* to obtain the *Drug List* name. You can also call Member Services at the number on the back of your membership card if you have any questions about your drug coverage.

Exception request for a drug not on the *Drug List* (non-formulary exceptions)

Your retiree drug plan covers those drugs listed on the *Drug List* (*Formulary*). In cases where your provider prescribes a medication that is not on the *Drug List*, you or your provider may request a non-formulary exception in order for the prescription drug to be covered by your plan. Your provider will need to explain the medical reasons why you need the exception approved. You or your provider may call Member Services at the number on the back of your membership card or mail your request to:

Anthem Blue Cross – Senior Appeals and Grievances
Mailstop: OH0205-A537
4361 Irwin Simpson Rd
Mason, OH 45040

When we receive a non-formulary exception request, we will make a coverage decision within a certain period of time, depending on whether exigent circumstances exist. Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug not covered by the plan. In this case, we will make a coverage decision within 24 hours of receiving your request. If we approve the coverage of the drug, coverage of the drug will be provided for the duration of the exigency. If we deny coverage of the drug, you have the right to request an external review by an IRO. The IRO will make a coverage decision within 24 hours of receiving your request. If the IRO approves the coverage of the drug, coverage of the drug will be provided for the duration of the exigency.

When exigent circumstances do not exist, we will make a coverage decision within 72 hours of receiving your request. If we approve the coverage of the drug, coverage of the drug will be provided for the duration of the prescription, including refills. If we deny coverage of the drug, you have the right to request an external review by an Independent Review Organization (IRO). The IRO will make a coverage decision within 72 hours of receiving your request. If the IRO approves the coverage of the drug, coverage of the drug will be provided for the duration of the prescription.

Requesting a non-formulary exception or having an IRO review your request for a non-formulary exception does not affect your right to submit an appeal or request an Independent Medical Review. Please see the section entitled **"Complaint and Appeals Procedures"** for details.

Coverage of a drug approved as a result of your request or your provider's request for an exception will only be provided if you are an insured person enrolled under the plan.

Reminder: Your Group Part D plan will be reviewing your request to cover a non-formulary drug if that drug is covered by the Group Part D plan first. This plan will automatically supplement your cost on any non-formulary drug approved for coverage under your Group Part D plan. This plan will review your request to cover non-formulary drugs that this plan covers first in the manner described in this section.

How to Obtain Prescription Drug Benefits

Your membership card covers both your Group Part D plan and this plan. Just give the pharmacist your membership card when you get your prescription filled. We will process benefits under your Group Part D plan and/or this plan automatically when you use a Participating Pharmacy. So long as your drug is covered under your Group Part D plan or your Senior Rx Plus plan, you do not need to take any additional steps.

If you receive outpatient drugs from a pharmacy that does not have a contract with us, you will need to pay the full cost of your outpatient drug(s). You can ask us to reimburse you for our share of the cost.

Please send us your request for payment. Your request should include your name and address, your plan membership number, your receipt documenting the outpatient drug(s) you received, and the payment you have made. It's a good idea to make a copy of your receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment. You don't have to use the form, but it's helpful for your plan to process the information faster.

Mail your request for payment together with any receipts to us at this address:

IngenioRx
ATTN: Claims Department - Part D Services
P.O. Box 52077
Phoenix, AZ 85072-2077

If you need assistance or have any questions, please call Member Services at the number listed on the back of your membership card. If you don't know what you owe, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

Non-Covered Services/Exclusions

This plan supplements the benefits paid by the Group Part D plan you also have through the retiree's former employer. This plan also provides coverage for drugs offered under the **"Extra Covered Drugs"** benefit.

This plan does not provide benefits for:

1. Drugs not covered by your Group Part D plan, except costs for drugs covered under the **"Extra Covered Drugs"** benefit, or when a drug is approved for coverage under this plan's non-formulary exception request process.
2. Drugs covered under Medicare Part A or Part B.
3. Costs you pay toward meeting your deductible, if you have one.
4. Drugs when used for cosmetic purposes or to promote hair growth. 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.
5. Drugs when used to promote fertility, unless medically necessary for another covered condition.
6. Drugs when used for treatment of anorexia, weight loss or weight gain, unless used to treat morbid obesity, HIV and cancer wasting, or medically necessary for another covered condition.

Coordination of Benefits

Medicare

Any benefits covered under both this Certificate and Medicare will be paid pursuant to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services (CMS) guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Certificate provisions and federal law.

The benefits under this Certificate for Members age 65 and older, or otherwise eligible for Medicare, do not duplicate any prescription benefit for which members are entitled under Medicare, including Parts B and/or D. We will reduce our payment under this plan by the amount you are eligible to receive for the same service under Medicare or under any other federal, state or local government programs, unless the government program benefits are by law excess to any private insurance or other non-governmental program. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to members shall be reimbursed by or on behalf of the members to the plan, to the extent the plan has made payment for such services. No prescription drug benefits will be payable under this Certificate unless you are enrolled in the Group Medicare Part D plan or Group Medicare Advantage Prescription Drug plan available as part of the group retiree benefit plans offered by the retiree's former employer.

Non-Medicare

If you are covered by more than one group health plan your benefits under this plan will be coordinated with benefits of those other plans. These coordination provisions apply separately to each insured person, per calendar year, and are largely determined by California law. Any coverage you have for medical or dental benefits will be coordinated as shown below.

Definitions

The meaning of key terms used in this section are shown below.

Allowed Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one other plan covering the person for whom the claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person for whom claim is made is not an allowable expense.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trustee plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

Primary Plan is the plan which will have its benefits determined first.
This Plan is that portion of this plan which provides benefits subject to this provision.

Effect on Benefits

This provision will apply in determining a person's benefits under this plan for any calendar year if the benefits under this plan and any other plans, exceed the allowable expenses for that calendar year.

1. If this plan is the primary plan, then its benefits will be determined first without taking into account the benefits or services of any other plan.
2. If this plan is not the primary plan, then its benefits may be reduced so that the benefits and services of all plans do not exceed the allowable expense.
3. The benefits of this plan will never be greater than the sum of the benefits that would have paid if you were covered under this plan only.

Order of Benefits Determination

The first of the following rules which applies will determine the order in which benefits are payable:

1. A plan which has no coordination of benefits provision pays before a plan which has a coordination of benefits provision.
2. A plan which covers you as an employee pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before the plan which covers you as a retired employee.

   For example: You are covered as a retired employee under this plan and eligible for Medicare (Medicare would normally pay first). You are also covered as a dependent of an active employee under another plan (in which case Medicare would pay second). In this situation, the plan which covers you as a dependent will pay first and the plan which covers you as a retired subscriber would pay last.
3. For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the calendar year pays before the plan of the parent whose birthday falls later in the calendar year. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

Exception to rule 3: If a dependent child of parents who are divorced or separated, the following rules will be used in place of rule 3:

a. If the parent with custody of that child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that child as a dependent pays first.

b. If the parent with custody of that child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

   i. The plan which covers that child as a dependent of the parent with custody.

   ii. The plan which covers that child as a dependent of the stepparent (married to the parent with custody).

   iii. The plan which covers that child as a dependent of the parent without custody.

   iv. The plan which covers that child as a dependent of the stepparent (married to the parent without custody).

c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that child's health care coverage, a plan which covers that child as a dependent of that parent pays first.

4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But if either plan does not have a provision regarding laid-off or retired employees, rule 6 applies.
5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the other plan do not agree under these circumstances with the order of benefit determination provisions of this plan, this rule will not apply.
6. When the rules above do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, allowable expense is split equally between the two plans.

Our Rights Under This Provision

Responsibility for Timely Notice. We are not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

Reasonable Cash Value. If any other plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered allowable expense. The reasonable cash value of such service will be considered a benefit paid, and our liability reduced accordingly.

Facility of Payment. If payments which should have been made under this plan have been made under any other plan, we have the right to pay that other plan any amount we determine to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under this plan, and such payment will fully satisfy our liability under this provision.

Right of Recovery. If payments made under this plan exceed the maximum payment necessary to satisfy the intent of this provision, we have the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

Eligibility and Enrollment

You must satisfy certain requirements to participate in this plan. We describe general eligibility requirements in this Certificate. Please contact your Human Resources or Benefits department if you have questions regarding your or your Dependent's eligibility for the group retiree benefit plan options offered by the retiree's former employer.

Eligibility

To be eligible to enroll under this Certificate, you must:

- Be a retiree or dependent of the retiree of the group.
- Be entitled to participate in the retiree benefit plan arranged by the group.
- Be entitled to Medicare Part A and/or enrolled in Medicare Part B.
- Be enrolling in or enrolled in the Group Part D plan (Part D or Medicare Advantage Prescription Drug plan) that is also part of the group retiree benefit plan arranged by the retiree's former employer for Medicare-eligible retirees and their Medicare-eligible dependents.
- Live in the service area in which we can provide retired group members access to participating pharmacies. Our service area includes the 50 United States, District of Columbia (DC) and all US Territories.
  - We cannot service retirees or their dependents if they live outside the service area. If you plan to move out of the service area, please contact Member Services or your Human Resources or Benefits department.

Subject to meeting all the eligibility provisions listed in this **"Eligibility"** section, Medicare-eligible dependent children who may be eligible to enroll in this plan include:

- The Covered Retiree's or the covered retiree's spouse's or domestic partner's children, including natural children, stepchildren and legally adopted children and children who the group has determined are covered under a "Qualified Medical Child Support Order (QMCSO)" as defined by ERISA or any applicable state law.
- Children for whom the covered retiree or the covered retiree's spouse or domestic partner is a legal guardian or as otherwise required by law.

This non-Medicare retiree drug plan is part of the group retiree benefit plan offering for retirees and their dependents that are Medicare-eligible. Please contact your Human Resources or Benefits department if you need information on group retiree benefit plan options for yourself or your dependents who are not Medicare-eligible.

Enrollment

An eligible retiree or dependent must meet all eligibility requirements to enroll.

Initial Enrollment

An eligible retiree or dependent can enroll for coverage under this Certificate when they first become eligible for this plan. You must submit your completed application for enrollment. You can enroll in this plan when you are first eligible if you are already enrolled in or are concurrently enrolling in the Group Part D plan that is

also part of the group retiree benefit plan arranged by the retiree's former employer for Medicare-eligible retirees and their Medicare-eligible dependents.

If you do not enroll when you are first eligible, you can only enroll for coverage during a Special Enrollment period or during an Open Enrollment period, if the retiree's former employer offers an annual open enrollment opportunity. Please contact your Human Resources or Benefits department if you need information on the timeframes in which to enroll.

When the initial enrollment application is accepted, coverage will begin on the Effective Date requested on the application or the first of the month following acceptance of the application, whichever comes later. The effective date of this plan may not be prior to the effective date of the Group Part D plan which this plan supplements.

This non-Medicare retiree drug plan is part of the group retiree benefit plan offering for retirees and their dependents that are Medicare-eligible. Please contact your Human Resources or Benefits department if you need information on group retiree benefit plan options for yourself or your dependents that are not Medicare-eligible.

Special Enrollment/Special Enrollees

If you meet all the eligibility requirements listed in this Certificate, but did not enroll in this plan because of other health insurance coverage, you may in the future be able to enroll in this plan provided that you submit a completed application within 31 days after other coverage ends.

In addition, if a covered retiree has a new Medicare-eligible dependent as a result of marriage, domestic partnership, adoption or placement for adoption, the new dependent may be able to enroll in this plan, provided that a completed application is submitted within 31 days after the marriage, adoption or placement for adoption and the dependent meets all the other eligibility requirements listed in this Certificate.

When a special enrollment application is accepted, coverage will begin on the effective date requested on the application or the first of the month following acceptance of the application, whichever comes later. The effective date of this plan may not be prior to the effective date of the Group Part D plan which this plan supplements.

Open Enrollment

Some group retiree benefit plans offer an annual open enrollment period. An open enrollment period is a period of time when an eligible retiree or dependent who did not request enrollment for coverage during their initial enrollment period or a special enrollment period can apply for coverage.

Please contact your Human Resources or Benefits department to find out whether your group retiree benefit plan offers open enrollment periods.

When an open enrollment application is accepted, coverage will begin on the effective date requested on the application or the first of the month following acceptance of the application, whichever comes later. The effective date of this plan may not be prior to the effective date of the Group Part D plan which this plan supplements.

Notice of Changes

The covered retiree is responsible to notify the group of any changes which will affect his or her eligibility or that of dependents for services or benefits under this Certificate. The plan must be notified of any changes as soon as possible but no later than within 31 days of the event. This includes changes in address, marriage, domestic partnership, divorce, death, change of dependent disability or dependency status, enrollment or disenrollment in another health plan or Medicare plan. Failure to notify us of persons no longer eligible for services will not obligate us to pay for such services.

Acceptance of payments from the group for persons no longer eligible for services will not obligate us to pay for such services.

All notifications by the group must be in writing and on approved forms. Such notifications must include all information reasonably required to effect the necessary changes.

A member's coverage terminates on the last day of the month in which the member ceases to be in a class of members eligible for coverage. The plan has the right to bill the covered retiree for the cost of any services provided to such person during the period such person was not eligible for coverage**.**

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability or age.

Statements and Forms

The eligible retiree or dependent must complete and submit their applications for this plan which is part of the group retiree benefit plan offering for retirees and their dependents who are Medicare-eligible.

Applicants for membership understand that all rights to benefits under this Certificate are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by a member may result in termination of coverage as provided in the **"Changes in Coverage: Termination & Continuation of Coverage" section.**

Delivery of Documents

We will provide a membership card and Certificate for each enrolled member.

Please carry your membership card with you at all times and remember to show your card when you get covered drugs. If your plan membership card is damaged, lost or stolen, call Member Services right away and we will send you a new membership card.

Changes in Coverage:
Termination & Continuation of Coverage

Termination of the Member

The member's enrollment in this plan shall terminate:

1. The date the group contract with us terminates.
2. On the date stated in the notice mailed by us to the group contract holder if we do not receive the group contract holder's Premium on time. Your payment of charges to the group contract holder does not guarantee coverage unless we receive full payment when due. If the premium is not paid on time, we will not make any payments for any service given to you after the plan terminates. The group contract holder is entitled to a 31-day Grace Period, for the payment of any premium or other amounts due. The contract will remain in force during the grace period.
3. The date that coverage under the Group Part D plan which this plan supplements ends, whether you voluntarily or involuntarily terminate your Group Part D plan.
4. If the group offers an open enrollment period for retiree benefits, the covered retiree may voluntarily terminate coverage effective as of the renewal date of the group retiree benefit plan.
5. The day following the covered retiree's death. When a covered retiree dies, dependents shall be terminated the last day of the month in which the covered retiree died, unless the group retiree benefit plan allows dependents to remain enrolled.
6. The last day of the month in which the covered retiree or dependent no longer meets the eligibility requirements of the retiree drug plan as defined in the **"Eligibility"** section of this Certificate.
7. When a member ceases to be a covered retiree or dependent, or the required contribution, if any, is not paid, the member's coverage will terminate the last day of the month for which payment was made.
8. Termination of an enrolled dependent's coverage will occur on the last day of the month in which one of the following events occurs:
    a. Divorce or legal separation of the spouse or domestic partner.
    b. Other enrolled dependents' criteria are no longer met by the spouse or domestic partner or other enrolled dependents as defined in the **"Eligibility"** section.
    c. Death of an enrolled dependent.
9. Upon written request through the group, a covered retiree may cancel the enrollment of any dependent from the plan. If this happens, no benefits will be provided for covered services provided after the dependent's termination date.
10. If the covered retiree or dependent lets someone else use the membership card to get prescription drugs.
11. On the date stated in the notice mailed by us to you if we do not receive your direct-billed portion of the premium on time. If the premium is not paid on time, we will not make any payments for any service given to you after the plan terminates. You are entitled to a 31-day Grace Period, for the payment of any premium or other amounts due. The contract will remain in force during the grace period.

Grace Period

A grace period of 31 days will be granted for the payment of premiums accruing after the first premium, during which grace period the policy shall continue in force, but the group contract holder shall be liable to us for the payment of the premium accruing for the period the policy continues in force.

Consent

No event of termination, expiration, non-renewal or cancellation of this retiree drug plan shall affect the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of any such event. The member hereby acknowledges that the termination, expiration, non-renewal or cancellation of the contract will automatically result in the termination of this retiree drug plan.

Unfair Termination of Coverage

If you believe that your coverage has been or will be improperly terminated, you may request a review of the matter by the California Department of Insurance (CDI). You may contact the CDI using the address and telephone numbers listed in the **"Complaint and Appeals Procedure"** chapter. You must make your request for review with the CDI within 180 days from the date you receive notice that your coverage will end, or the date your coverage is actually cancelled, whichever is later, but you should make your request as soon as possible after you receive notice that your coverage will end. This 180 day timeframe will not apply if, due to substantial health reasons or other incapacity, you are unable to understand the significance of the cancellation notice and act upon it. If you make your request for review within 30 days after you receive notice that your coverage will end, or your coverage is still in effect when you make your request, we will continue to provide coverage to you under the terms of this plan until a final determination of your request for review has been made by the CDI (this does not apply if your coverage is cancelled for non-payment of premium). If your coverage is maintained in force pending outcome of the review, premium must still be paid to us on your behalf.

Continuation of Coverage

Federal Continuation of Coverage (COBRA)

If you or your covered dependents no longer qualify for coverage under this plan, you or your dependents may be eligible to continue group coverage under federal COBRA. Please contact your Human Resources or Benefits department for information on COBRA prior to coverage under this plan ending.

Complaint and Appeals Procedures

The following complaint and appeals process applies only to prescription drugs not covered by Medicare.

Anthem wants your experience with Anthem to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your health benefit plan or a service you have received. If you have a question or complaint about your eligibility, (including if you believe your coverage under this plan has been or will be improperly terminated), your benefits under this plan, concerning a claim or about us, please contact Member Services by calling the number on the back of the membership card. Anthem will try to resolve your complaint informally by talking to your provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file a complaint, appeal or grievance, which is defined below.

INDEPENDENT MEDICAL REVIEW OF DENIALS OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT

If coverage for a proposed treatment is denied because we determine that the treatment is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization contracting with the California Department of Insurance ("CDI"). Your request for this review may be submitted to the CDI. You pay no application or processing fees of any kind for this review. You have the right to provide information in support of your request for review. A decision not to participate in this review process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service. We will send you an application form and an addressed envelope for you to use to request this review with any grievance disposition letter denying coverage for this reason. You may also request an application form by calling us at the telephone number listed on your identification card or write to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 4310, Woodland Hills, CA 91365-4310. To qualify for this review, all of the following conditions must be met:

- You have a life-threatening or seriously debilitating condition, described as follows:
  - A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
  - A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- Your physician must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate or (c) there is no more beneficial standard treatment covered by this plan than the proposed treatment.
- The proposed treatment must either be:
  - Recommended by a participating provider who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
  - Requested by you or by a licensed board certified or board eligible *physician* qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:
    - Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;
    - Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database of Health Services Technology Assessment Research (HSTAR);

- Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
- Either of the following: (i) The American Hospital Formulary Service's Drug Information or (ii) the American Dental Association Accepted Dental Therapeutics;
- Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;
- Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and
- Peer reviewed abstracts accepted for presentation at major medical association meetings.

In all cases, the certification must include a statement of the evidence relied upon. You are not required to go through our grievance process for more than 30 days. If your grievance needs expedited review, you are not required to go through our grievance process for more than three days.

You must request this review within six months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30-day or three-day grievance period, whichever applies. This application deadline may be extended by the CDI for good cause.

Within three business days of receiving notice from the CDI of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your physician. Any newly developed or discovered relevant medical records identified by us or by a participating provider after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days if your physician determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

Please note: If you have a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less) and proposed treatment is denied because the treatment is determined to be experimental, you may also meet with our review committee to discuss your case as part of the grievance process (see grievance procedures).

Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an independent medical review ("IMR") of disputed health care services from the CDI if you believe that we have improperly denied, modified, or delayed health care services. A "disputed health care service" is any health care service eligible for coverage and payment under your plan that has been denied, modified, or delayed by us, in whole or in part because the service is not medically necessary.
The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We must provide you with an IMR application form and an addressed envelope for you to use to request IMR with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service.

Eligibility: The CDI will review your application for IMR to confirm that:

1. One or more of the following conditions has been met.
    a. Your provider has recommended a health care service as medically necessary, or
    b. You have received urgent care or emergency services that a provider determined was medically necessary, or
    c. You have been seen by a participating provider for the diagnosis or treatment of the medical condition for which you seek independent review;
2. The disputed health care service has been denied, modified, or delayed by us, based in whole or in part on a decision that the health care service is not medically necessary; and
3. You have filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you need not participate in our grievance process for more than three days. The CDI may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

You must apply for IMR within six months of the date you receive a denial notice from us in response to your grievance or from the end of the 30-day or three-day grievance period, whichever applies. This application deadline may be extended by the CDI for good cause.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist or specialists who will make an independent determination of whether or not the care is medically necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is medically necessary, we will provide benefits for the health care service.

For non-urgent cases, the IMR organization designated by the CDI must provide its determination within 30 days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within 3 days.

For more information regarding the IMR process, or to request an application form, please call us at the Member Services telephone number listed on your ID card.

If your problem is not resolved, you may also contact the California Department of Insurance at:

California Department of Insurance
Consumer Services Division, 11th Floor
300 South Spring Street
Los Angeles, California 90013
1-800-927-HELP (4357) – In California
1-213-897-8921 – Out of California
1-800-482-4833 – Telecommunication Device for the Deaf
E-mail Inquiry: “Consumer Services” link at www.insurance.ca.gov

General Provisions

Entire Contract

The Group Policy and this Certificate constitute the entire contract between the parties, and no statement made by the employer or by any employee whose eligibility has been accepted by the insurer shall (avoid the insurance or reduce the benefits under this policy or) be used in defense to a claim hereunder.

No change in this Certificate shall be valid unless approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Certificate or to waive any of its provisions.

Terms of Coverage

1. In order for you to be entitled to benefits under the Certificate, both the Certificate and your coverage under the Certificate must be in effect on the date the expense giving rise to a claim for benefits is incurred.
2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.
3. The Certificate is subject to amendment, modification or termination according to the provisions of the Certificate without your consent or concurrence.

Protection of Coverage

We do not have the right to cancel your coverage under this plan while: (1) this plan is in effect; (2) you are eligible; and (3) your premiums are paid according to the terms of the Certificate.

Benefits Not Transferable

Only insured persons are entitled to receive benefits under this plan. The right to benefits cannot be transferred.

Payment of Benefits

You authorize us to make payments directly to providers for covered services. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a covered retiree who is recognized, under a Qualified Medical Child Support Order (QMCSO), as having a right to enrollment under the Group's Contract), or that person's custodial parent or designated representative. Any payments made by us will discharge our obligation to pay for covered services. You cannot assign your right to receive payment to anyone else, except as required by a QMCSO as defined by ERISA or any applicable state law.

Once a provider performs a covered service, we will not honor a request for us to withhold payment of the claims submitted.

Notice of Claim

If the pharmacy will not submit your claim electronically at the time your prescription is filled, you, the pharmacy or someone on your behalf, must give us written notice of a claim within 20 days after you incur covered charges under this plan, or as soon as reasonably possible thereafter. Notice given by or on behalf of the claimant to the insurer or to any authorized agent of the insurer, with information sufficient to identify the insured employee, shall be deemed notice to the insurer. Please see the "Outpatient Prescription Drug Benefits" section of this Certificate for more information about how to submit written notice of a claim to us. All network pharmacies will electronically submit claims when you get your prescription filled.

Claims Forms

After we receive a written notice of claim, we will give you any forms you need to file proof of loss. If we do not give you these forms within 15 days after you have filed your notice of claim, you will not have to use these forms, and you may file proof of loss by sending us written proof of the occurrence giving rise to the claim. Such written proof must include the extent and character of the loss.

Proof of Loss

If the pharmacy will not submit your claim electronically at the time your prescription is filled, you or the pharmacy must send us properly and fully completed claim forms within 90 days of the date you receive the service or supply for which a claim is made. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. Except in the absence of legal capacity, we are not liable for the benefits of the *plan* if you do not file claims within the required time period.

Timely Payment of Claims

Any benefits due under this plan shall be payable, as soon as practical, but no later than 30 working days after we have received proper, written proof of loss, together with such reasonably necessary additional information we may require to determine our obligation. If a claim is contested or denied, Anthem shall notify you in writing, within 30 working days after receipt of the claim, that the claim is contested or denied. This will be done through a letter or an *Explanation of Benefits* (*EOB*), identifying the portion of the claim that is contested or denied and describing the reasons for the contention or denial of the claim.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program.

If you fail to cooperate (including if you fail to enroll under Part B and/or Part D of the Medicare program where Medicare is the responsible payer), you will be responsible for any charge for services.

Explanation of Benefits (EOB)

The month after you receive your prescription drugs, you will receive an *Explanation of Benefits (EOB)*. The *EOB* is a summary of the coverage you receive. The *EOB* is not a bill, but a statement from us to help you understand the coverage you are receiving. The *EOB* shows:

- Total amounts charged for services/supplies received.
- The amount of the charges satisfied by your coverage.
- The amount for which you are responsible, if any.
- General information about your appeals rights.

Workers' Compensation

The benefits under this Certificate are not designed to duplicate benefits that members are provided under the Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to a member shall be paid back by, or on behalf of, the member to the plan if the plan has made or makes payment for the services received. It is understood that coverage under this Certificate does not replace or affect any Workers' Compensation coverage requirements.

Other Government Programs

The benefits under this Certificate shall not duplicate any benefits that members are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require the plan to be the primary payer. If the plan has duplicated such benefits, all money paid by such programs to members for services they have or are receiving, shall be paid by or on behalf of the member to the plan.

Right of Recovery

Whenever payment has been made in error, we will have the right to make appropriate adjustment to claims or recover such payment from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event we recover a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, we will only recover such payment from the provider within 365 days of the date we made the payment on a claim submitted by the provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

Under certain circumstances, if we pay your healthcare provider amounts that are your responsibility, such as deductibles, copayments or coinsurance, we may collect such amounts directly from you. You agree that we have the right to recover such amounts from you.

We have oversight responsibility for compliance with provider, vendor and subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a provider, vendor or subcontractor resulting from these audits if the return of the overpayment is not feasible.

We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and whether to settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by us or you if the recovery method makes providing such notice administratively burdensome.

Relationship of Parties (Group-Member Plan)

Neither the group nor any member is the agent or representative of the plan. We and your group are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Certificate. We will not be liable for any act or omission of any group or any agent or employee of a group.

The group is responsible for passing information to the member. For example, if the plan gives notice to the group, it is the group's responsibility to pass that information to the member. The group is also responsible for passing eligibility data to the plan in a timely manner. If the group does not provide the plan with timely enrollment and termination information, the plan is not responsible for the payment of covered services for members.

Modifications
This Certificate allows the group to make the plan coverage available to eligible members. However, this Certificate shall be subject to amendment, modification, and termination in accordance with any of its provisions, the group contract or by mutual agreement between the plan and the group without the permission or involvement of any member. Changes will not be effective until 30 days after we provide written notice to the group about the change. By electing coverage under the plan or accepting the plan benefits, all members who are legally capable of entering into a contract, and the legal representatives of all members that are incapable of entering into a contract, agree to all terms, conditions, and provisions in this Certificate.

Physical Examination
At our expense, we have the right and opportunity to examine any insured person claiming benefits when and as often as reasonably necessary while a claim is pending.

Legal Actions
No attempt to recover on the plan through legal or equity action may be made until at least 60 days after the written proof of loss has been furnished as required by this plan. No such action may be started later than three years from the time written proof of loss is required to be furnished.

Conformity with Law
Any provision of this plan which is in conflict with the laws of the state in which the group contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Clerical Error
A clerical error will never disturb or affect a member's coverage, as long as the member's coverage is valid under the rules of this Certificate. This rule applies to any clerical error, regardless of whether it was the fault of the group or the plan.

Providing of Care
We are not responsible for providing any type of pharmacy care, nor are we responsible for the quality of any such care received.

Independent Contractors
Our relationship with providers is that of an independent contractor. Pharmacies and other community agencies are not our agents nor are we, or any of our employees, an employee or agent of any provider of any type.

Non-Regulation of Providers
The benefits of this plan do not regulate the amounts charged by providers of pharmacy services, except to the extent that rates for covered services are regulated with participating pharmacies.

Free Choice of Provider
You may choose any pharmacy facility which provides care covered under this plan, and is properly licensed according to appropriate state and local laws. However, your choice may affect the benefits payable according to this plan.

Discontinuance of Coverage

Anthem may discontinue offering the type of coverage provided under this plan in accordance with applicable state laws. In that event, this group contract will be canceled on the next premium due date following at least 90 days prior written notice. Anthem may also discontinue offering any type of coverage in a particular market to which your group belongs in accordance with applicable state laws and upon proper notice to the appropriate state authority. In that event, this group contract will be canceled on the next premium due date following at least 180 days prior written notice.

Definitions

Some words or phrases in this Certificate have special meaning. If the word or phrase is not explained in the text where it appears, it will be defined in this section.

If you need additional clarification on any of these definitions, please contact Member Services at the number located on the back of your membership card.

Benefit Period – The length of time that we will pay benefits for covered services. The benefit period is listed in the benefits chart. If your coverage ends before this length of time, then the benefit period also ends.

Brand-Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Generic drugs are manufactured and sold by other drug manufacturers and are not available until after the patent on the brand-name drug has expired.

Certificate (also called *Evidence of Coverage*) – The document providing a summary of the terms of your benefits. It is attached to, and is a part of, the group contract. It is also subject to the terms of the group contract.

COBRA – Sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (as amended) that regulate conditions in which an employer must offer continuation of group health insurance coverage to members whose coverage would terminate based upon the terms of the group contract.

Coinsurance – A specific percentage of the maximum allowable amount for covered services that are indicated in the benefits chart, which you must pay.

Copayment – A specific dollar amount of the maximum allowable amount for covered services that are indicated in the benefits chart, which you must pay. Your copayment will be the lesser of the amount shown in the benefits chart or the amount charged by the provider.

Covered Drugs (also called Covered Services) – The term we use to mean all of the outpatient prescription drugs covered by your plan.

Covered Retiree – A retiree of the group who is eligible to receive benefits under the group contract, who has applied for coverage, been approved by the plan and been covered by the required premium payment.

Dependent – A member of the retiree's family who is eligible to be covered under the Certificate, as described in the **"Eligibility and Enrollment"** section.

DESI – Drug Efficacy Study Implementation (DESI) review. Drugs entering the market between 1938 and 1962 that were approved for safety but not effectiveness are referred to as "DESI drugs."

Domestic partner is the retiree's domestic partner under a legally registered and valid domestic partnership.

Effective Date – The date that a member's coverage begins under this Certificate.

Extra Covered Drugs – The term used to describe coverage of drugs which are excluded by law from coverage by Medicare Part D, but are included in some retiree drug plans. If your plan covers drugs under the **"Extra Covered Drug"** benefit, these will be listed in the benefits chart located in the front of this Certificate.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Most of the time generic drugs cost less than brand-name drugs.

Group – The employer or union that has entered into a group contract with the plan.

Group Contract (Group Policy, Contract) – The contract between the plan and the group. It includes the group contract, group application, this Certificate and your application.

Group Medicare Prescription Drug Plan (Group Medicare Part D Plan, Group Part D Plan) – Medicare Prescription Drug plan sold to employers or unions as a retiree benefit plan offered to their Medicare-eligible retirees and the retiree's Medicare-eligible dependents. See also **"Medicare Prescription Drug Plan"** definition.

Maximum Allowable Amount – The maximum allowed amount for covered prescription drugs is the amount determined by us using prescription drug cost information provided by the Pharmacy Benefits Manager (PBM).

Medical Emergency Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities and people with end-stage renal disease (usually those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a Medicare Advantage plan.

Medicare Advantage Plan – A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (hospital) and Part B (medical) benefits. Medicare Advantage plans which also offer Medicare Part D (prescription drug coverage) are called Medicare Advantage Prescription Drug plans.

Medicare Part D-eligible (referred to as "Medicare-eligible" in this Certificate) – An individual is eligible to enroll in a Medicare Part D plan if the individual is entitled to Medicare Part A and/or enrolled in Medicare Part B.

Medicare Part D-eligible Drug – Subject to certain exclusions, a Medicare Part D-eligible drug is a drug dispensed only upon a prescription, used for a medically-accepted indication, approved by the Food and Drug Administration (FDA), and used and sold in the United States. Medicare Part D-eligible drugs include outpatient prescription drugs, biological products, insulin, medical supplies associated with the injection of insulin and certain vaccines.

Medicare Prescription Drug Plan (Medicare Part D Plan, Part D Plan) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals and some supplies not covered by Medicare Part A or Part B. Medicare Prescription Drug plans are available as stand-alone plans or coupled with the Medicare Advantage medical plans.

Member – A covered retiree or dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the plan and been covered by the required premium payment. Members are sometimes called "you" or "your" in this Certificate.

Membership Card (also called Identification Card/ID Card) – A card issued by the plan, showing the member's name and membership number which is used to access benefits for covered services.

Multi-source Drug – A prescription drug that is manufactured and sold by more than one pharmaceutical company. Multi source drugs include both brand and generic drug options.

Open Enrollment – A period of enrollment designated by the retiree's former employer and the plan in which eligible retirees or their eligible dependents can enroll without penalty after the initial enrollment. See **"Eligibility and Enrollment"** section for more information.

Participating Pharmacy (Network Pharmacy) – A pharmacy which has contracted with us to provide outpatient prescription drugs to our members at negotiated costs.

Pharmacy – An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a physician's order.

Pharmacy Benefits Manager (PBM) – The entity with which Anthem has contracted with to administer its prescription drug benefits. The PBM is an independent contractor and not affiliated with Anthem.

Pharmacy and Therapeutics (P&T) Committee – A committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Preferred Retail Pharmacy – A retail pharmacy which has contracted with us to provide outpatient prescription drugs to our members at reduced negotiated costs. Members pay a lower copay when they use one of these pharmacies. Please check the benefits chart in the front of this Certificate to see if your plan includes this coverage.

Premium – The charges that must be paid by the covered retiree or the group to maintain coverage.

Prescription Legend Drug (Prescription Drug or Drug) – A medicinal substance that is produced to treat illness or injury and is dispensed to outpatients. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that states, "Caution: Federal law prohibits dispensing without a prescription." Compounded (combination) medications, which contain at least one such medicinal substance, are considered to be prescription legend drugs. Insulin is considered a prescription legend drug under this Certificate.

Prior Authorization – Approval in advance to get certain drugs that may or may not be on our *Formulary*. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Prescription drugs and their criteria for coverage are defined by the P&T Committee.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Recovery – A Recovery is money you receive from another, their insurer or from any uninsured motorist, underinsured motorist, medical payments, no-fault or personal injury protection or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Recovery provisions of this plan.

Retiree – Former employee of the employer or member of a union who is entitled to participate in the retiree benefit plan arranged by the employer or union and who is enrolled in or enrolling in Medicare.

Select Generics – A specific list of generic drugs that have been on the market long enough to have a proven track record for effectiveness and value. A complete list of these drugs is included in your Group Part D and Senior Rx Plus *Drug List* (*Formulary*). You can access your *Drug List* by visiting www.anthem.com/ca/pharmacyinformation/groupmedicare.html. Please refer to the benefits chart in your Group Part D *Evidence of Coverage* to obtain the *Drug List* name. You can also call Member Services at the number on the back of your membership card if you have any questions about your drug coverage. Some plans have reduced copayments for Select Generics. If your plan includes a reduced copayment, you can find this information listed on the benefits chart located in the front of this Certificate.

Service Area – The geographical area where we can provide convenient access to participating pharmacies, which includes the 50 United States, District of Columbia (DC) and all US Territories.

Single Source Drug – A prescription brand drug that is manufactured and sold only by the pharmaceutical company that originally researched and developed the drug. Single source drugs are always brand drugs.

Special Enrollment – A period of enrollment in which certain eligible retirees or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, adoption, etc.

Specialty Drugs – The Centers for Medicare & Medicaid Services (CMS) defines specialty drugs as any drug that costs $830 or more per unit.

Spouse is the retiree's spouse as recognized under state or federal law. This includes same sex spouses when legally married in a state that recognizes same-sex marriages.

Tier – Every covered drug is in a specific cost-sharing tier. Most of the time, the higher the cost sharing tier, the higher your cost for the drug.

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