



MEBA MOD Classic PPO (500/20/90/60)
PLAN A EFFECTIVE 01/01/2011 - 12/31/2011

PPO Benefits

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits. This proposed benefit summary is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care.

In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. 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.

Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

PPO Providers—PPO negotiated rates. Members are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-PPO Providers—For non-emergency services, the scheduled amount. For emergency services, same as other health care providers

Other Health Care Providers (*includes those not represented in the PPO provider network*)—The customary & reasonable charge for professional services or the reasonable charge for institutional services.

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible for PAR providers	\$500 member/\$750 family
Calendar year deductible for NON-PAR providers	\$1,000 member/\$1,500 family
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	\$250/admission (<i>waived for emergency admission</i>)
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	\$250/admission (<i>waived for emergency admission</i>)
Deductible for emergency room services	\$100/visit (<i>waived if admitted directly from ER</i>)

Annual Out-of-Pocket Maximums

PPO Providers & Other Health Care Providers

\$1,250/member/year; \$2,500/family/year

Non-PPO Providers

\$5,000/member/year; \$10,000/family/year

The following do not apply to out-of-pocket maximums: deductibles listed above; non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for deductibles listed above; for non-PPO providers & other health care providers, costs in excess of the covered expense; amounts related to a transplant unrelated donor search.

Lifetime Maximum	Unlimited	
Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay¹
Hospital Medical Services (<i>subject to utilization review for inpatient services; waived for emergency admissions</i>)		
➤ Semi-private room, meals & special diets, & ancillary services	10%	40%
➤ Outpatient medical care, surgical services & supplies (<i>hospital care other than emergency room care</i>)	10%	40%
Ambulatory Surgical Centers		
➤ Outpatient surgery, services & supplies	10%	40%
Hemodialysis		
➤ Outpatient hemodialysis services & supplies	10%	40%
Skilled Nursing Facility (<i>subject to utilization review</i>)		
➤ Semi-private room, services & supplies (<i>limited to 100 days/calendar year</i>)	10%	40%
Hospice Care		
➤ Inpatient or outpatient services; family bereavement services	20% ²	

¹The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

²These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay ¹
Home Health Care <i>(subject to utilization review)</i>		
➤ Services & supplies from a home health agency <i>(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)</i>	10%	40%
Home Infusion Therapy <i>(subject to utilization review)</i>		
➤ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	40%
Physician Medical Services		
➤ Office & home visits	\$20/visit ² <i>(deductible waived)</i>	40%
➤ Hospital & skilled nursing facility visits	10%	40%
➤ Surgeon & surgical assistant; anesthesiologist or anesthesiologist	10%	40%
Diagnostic X-ray & Lab		
➤ MRI, CT scan, PET scan & nuclear cardiac scan <i>(subject to utilization review)</i>	10%	40%
➤ Other diagnostic x-ray & lab	10%	40%
Preventive Care Services		
<i>Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits</i>		
➤ Routine physical examinations <i>(birth through age six)</i>	No copay/exam <i>(deductible waived)</i>	40%
➤ Immunizations <i>(birth through age six)</i>	No copay <i>(deductible waived)</i>	40%
➤ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam <i>(members 7 years old and older)</i>	No copay/exam <i>(deductible waived)</i>	40%
➤ Adult preventive services <i>(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings)</i>	No copay <i>(deductible waived)</i>	40%
Physical Therapy, Physical Medicine & Occupational Therapy <i>(limited to 90 visits per calendar year for PAR Providers and 10 visits per calendar year for NON-PAR Providers; additional visits may be authorized)</i>	10%	40%
Chiropractic Services <i>(limited to 30 visits/calendar year for PAR Providers)</i>	\$20/visit <i>(deductible waived)</i>	40% <i>(limited to \$250/calendar year)</i>
Speech Therapy		
➤ Outpatient speech therapy following injury or organic disease	10%	40%
Acupuncture		
➤ Services for the treatment of disease, illness or injury <i>(limited to \$25/visit & 12 visits/calendar year)</i>	10% ³	40% ³
Temporomandibular Joint Disorders		
➤ Splint therapy & surgical treatment	10%	40%
Pregnancy & Maternity Care		
➤ Physician office visits	\$20/visit ² <i>(deductible waived)</i>	40%
➤ Prescription drug for elective abortion <i>(mifepristone)</i>	10%	40%
<i>Normal delivery, cesarean section, complications of pregnancy & abortion (newborn routine nursery care covered when natural mother is subscriber or spouse/domestic partner)</i>		
➤ Inpatient physician services	10%	40%
➤ Hospital & ancillary services	10%	40%

¹ The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

² The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

³ Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay ¹
Family Planning		
➤ Tubal ligation	10%	40%
➤ Vasectomy	10%	40%
➤ Counseling & Consultation	10%	40%
Organ & Tissue Transplants <i>(subject to utilization review; specified organ transplants covered only when performed at Centers of Medical Excellence [CME])</i>		
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants		10%
➤ Physician office visits		\$20/visit (deductible waived)
➤ Transplant travel expense for an authorized, specified transplant at a CME		No copay (deductible waived)
Bariatric Surgery <i>(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at Centers of Medical Excellence [CME])</i>		
➤ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity		10%
➤ Physician office visits		\$20/visit (deductible waived)
➤ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric CME (member's transportation to & from CME limited to \$130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from CME limited to \$130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & \$100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & \$100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to \$25/day/person for 4 days/trip)		No copay (deductible waived)
Diabetes Education Programs <i>(requires physician supervision)</i>		
➤ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	\$20/visit (deductible waived)	40%
Prosthetic Devices		
➤ Coverage for breast prostheses; 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	10%	40%
Durable Medical Equipment		
➤ Rental or purchase of DME including hearing aids, dialysis equipment & supplies (hearing aids benefit available for one hearing aid per ear every three years)	10%	40%
Related Outpatient Medical Services & Supplies		
➤ Ground or air ambulance transportation, services & disposable supplies		20% ²
➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products		20% ²
➤ Autologous blood (self-donated blood collection, testing, processing & storage for planned surgery)		20% ²

¹ The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

² These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay ¹
Emergency Care		
➤ Emergency room services & supplies <i>(\$100 deductible waived if admitted)</i>	10%	10%
➤ Inpatient hospital services & supplies	10%	10%
➤ Physician services	10%	10%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➤ Facility-based care <i>(subject to utilization review; waived for emergency admissions)</i>	10%	40%
➤ Inpatient physician visits	10%	40%
Outpatient Care		
➤ Facility-based care <i>(subject to utilization review; waived for emergency admissions)</i>	10%	40%
➤ Outpatient physician visits <i>(pre-service review required after the 12th visit)</i>	\$20/visit ³ <i>(deductible waived)</i>	40%

¹ The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

² 10% copay if member or non-PPO physician obtains drug from Specialty Pharmacy Program; otherwise, not covered.

³ The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Classic PPO Exclusions and Limitations

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

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).

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

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.

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.

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

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.

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.

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.

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.

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

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.

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.

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.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

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.

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

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.

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.

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

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).

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

Sterilization Reversal.

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).

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 foot complications as specified as covered in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

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.

Chronic Pain. Treatment of chronic pain, except as specified as covered in the EOC.

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.

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

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 require either a written prescription or dispensing by a licensed pharmacist.

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

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.

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.

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.

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.

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.

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.

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

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

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

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.

Wigs.

Pre-Existing Condition Exclusion — No payment will be made for services or supplies for the treatment of a pre-existing condition during a period of six months following either: (a) the member's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. However, this limitation does not apply to a child born to or newly adopted by an enrolled subscriber or spouse/domestic partner, or to conditions of pregnancy. Also if a member was covered under creditable coverage, as outlined in the member's EOC, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six-month period.

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

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.

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Your 2011 Prescription Drug Benefit Chart

Premier 10/20/40 Plan

MEBA – High Option PPO

Effective January 1, 2011 through 12/31/2011

Formulary	Premier 3 Tier – Open
Mandatory Generic	No
Deductible	\$0
Covered Services	What you pay

Initial Coverage

Below is your payment responsibility from the time you meet your deductible, until the cost paid by you for your prescriptions reaches your True Out of Pocket costs of \$3,600.

Retail Pharmacy	per 30-day supply
<ul style="list-style-type: none"> • Generics, including Specialty Drugs • Select Generics 	\$10 copay
	\$0 copay for Select Generics
<ul style="list-style-type: none"> • Preferred Brands, including Specialty Drugs and Vaccines 	\$20 copay
<ul style="list-style-type: none"> • Non-Preferred Brands and Non-Formulary Drugs 	\$40 copay
<ul style="list-style-type: none"> • Diabetic Supplies – insulin syringes and alcohol swabs 	\$10 copay (up to a 90-day supply)

Typically retail pharmacies dispense a 30-day supply of medication. Some of our retail pharmacies can dispense up to a 90-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. For example, if you order a 90-day supply, you will need to pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will need to pay two 30-day copays.

Mail Order Pharmacy	per 90-day supply
<ul style="list-style-type: none"> • Generics, including Specialty Drugs • Select Generics 	\$20 copay
	\$0 copay for Select Generics
<ul style="list-style-type: none"> • Preferred Brands, including Specialty Drugs and Vaccines 	\$40 copay
<ul style="list-style-type: none"> • Non-Preferred Brands and Non-Formulary Drugs 	\$80 copay
<ul style="list-style-type: none"> • Diabetic Supplies – insulin syringes and alcohol swabs 	\$20 copay

If you purchase drugs at Retail or Mail Order Pharmacies that are not listed in our participating pharmacy directory, you will be responsible for all amounts over our negotiated cost. If you need an emergency supply of drugs and you are not near a Retail Pharmacy in our participating pharmacy directory, you will not be responsible for amounts over our negotiated costs.

A stand alone prescription drug plan with a Medicare contract.

Y0071_11_10506 08/23/2010

2011 Custom Premier 10/20/40 Plan MEBA – High Option PPO Full Gap

P3TARO (10R)

09/08/2010

Covered Services	What you pay
Vaccine Coverage	
<p>The up front costs for vaccines will vary based upon where the vaccine is purchased and administered. Some vaccines, such as Flu Vaccines, are paid under your Medicare Part B coverage. Vaccines that are covered by Medicare Part B are not covered by your Part D plan. Please see your Evidence of Coverage booklet for a complete explanation of your vaccine coverage.</p>	
Catastrophic Coverage	
<p>Your payment responsibility changes after the cost you have paid for prescription drugs reaches your True Out of Pocket cost of \$3,600.</p>	
<ul style="list-style-type: none"> Generics, including Specialty Drugs 	\$0 copay
<ul style="list-style-type: none"> Select Generics 	\$0 copay for Select Generics
<ul style="list-style-type: none"> Preferred and Non-Preferred Brands including Specialty Drugs, Vaccines, and Non-Formulary Drugs 	\$0 copay
Extra Covered Drug Group	
<p>These are drugs that are covered by your plan that are often excluded from Part D Prescription Drug Plans. These drugs do not count towards your True Out of Pocket expenses. They do not qualify for lower Catastrophic copays.</p>	
<p>Benzodiazepines and Barbiturates Cosmetics Cough and Cold DESI Over the Counter Vitamins and Minerals Erectile Dysfunction</p>	See Formulary for complete list of drugs covered
<ul style="list-style-type: none"> Generics 	You pay your retail or mail order generic copay
<ul style="list-style-type: none"> Brands 	You pay your retail or mail order brand copay
Non Part D Diabetic Supplies	
<ul style="list-style-type: none"> Generics 	<p>Lancets Urine Test Strips Blood Sugar Diagnostics</p> <p>\$10 copay for Retail Pharmacy (up to a 90-day supply)</p> <p>\$20 copay for Mail Order Pharmacy</p>
<ul style="list-style-type: none"> Brands 	<p>\$10 copay for Retail Pharmacy (up to a 90-day supply)</p> <p>\$20 copay for Mail Order Pharmacy</p>
<ul style="list-style-type: none"> Urine Test Strips and Blood Sugar Diagnostics – manufactured by Lifescan or Roche 	\$0 copay for Retail Pharmacy and Mail Order Pharmacy
Non Part D Diabetic Supplies	
Glucometers	
<ul style="list-style-type: none"> Generics 	You pay your retail or mail order generic copay
<ul style="list-style-type: none"> Brands 	You pay your retail or mail order brand copay

- When a member's physician has specified "dispense as written" (DAW) for non-preferred brand name drugs or non-formulary drugs, the copay for preferred brand name formulary drugs will apply.
When a member's physician has not specified DAW for non-preferred brand name drugs or non-formulary drugs, the Tier 3 copay will apply.
- Beginning in 2011, when the cost of Part D qualified drugs paid by you and this plan is more than \$2840, you will receive help paying your share of the cost of most covered brand drugs from Drug Manufacturers. This help will continue until the cost of Part D qualified drugs paid by you and the Drug Manufacturer Discount reaches the True Out of Pocket amount shown on this Benefit Chart. Drug Manufacturers have agreed to provide a discount on brand drugs which Medicare considers Part D qualified drugs. Your plan covers some brand drugs beyond those covered by Medicare. The discount will not apply to benefits described in the "Extra Covered Drugs" section of this Benefit Chart.