Your summary of benefits

Anthem® STUDENT ADVANTAGE

Anthem® Blue Cross Life and Health Insurance Company

Your Plan: CUSTOM ANTHEM STUDENT ADVANTAGE

Your School: University of California Extension

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$100 per person	$200 per person
Out-of-Pocket Limit	$6,350 person / $12,700 family	
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum. All medical and prescription drugs deductibles, copayments and coinsurance apply toward the out-of-pocket maximum. In-network and out-of-network deductibles amounts are separate and do not accumulate toward each. In-network and out-of-network out-of-pocket maximum amounts are combined and do accumulate toward each other		
Preventive Care / Screening / Immunization *In-network preventive care is not subject to deductible*	No charge	50% coinsurance after medical deductible is met
Virtual Care (Telemedicine / Telehealth Visits)		
Virtual Visits with Doctors who also provide services in person		
Primary Care (PCP) *Deductible does not apply to In-Network providers*	No charge	50% coinsurance after medical deductible is met
Mental Health and Substance Abuse Care *Deductible does not apply to In-Network providers*	No charge	50% coinsurance after medical deductible is met
Specialist Care *Deductible does not apply to In-Network providers*	No charge	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *Deductible does not apply to In-Network providers*	No charge	50% coinsurance after medical deductible is met
Specialist Care *Deductible does not apply to In-Network providers*	No charge	50% coinsurance after medical deductible is met
Visits in an Office		
Primary Care (PCP) *Deductible does not apply to In-Network providers*	No charge	50% coinsurance after medical deductible is met
Specialist Care *Deductible does not apply to In-Network providers*	No charge	50% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *In-Network routine prenatal office visits and other preventive prenatal care and screening are covered at 100%.* *Deductible does not apply to In-Network providers*	No charge	50% coinsurance after medical deductible is met
Retail Health Clinic *Deductible does not apply to In-Network providers*	No charge	50% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per year.* *Deductible does not apply to In-Network providers*	No charge	50% coinsurance after medical deductible is met
Acupuncture *Deductible does not apply to In-Network providers*	No charge	50% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Chemo/Radiation Therapy	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Dialysis/Hemodialysis	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prescription Drugs - *Dispensed in the office*	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Surgery	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Lab	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
X-Ray		
Office	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Radiology Center	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Advanced Diagnostic Imaging		
Office	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Radiology Center	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care *Deductible does not apply to In-Network providers*.	No charge	50% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$75 copay per visit then 0% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after medical deductible is met	Covered as In-Network
Emergency Ambulance	0% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit *Deductible does not apply to In-Network providers*.	No charge	Covered as In-Network
Facility Visit		
Facility Fees	0% coinsurance after medical deductible is met	Covered as In-Network
Doctor Services	0% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Surgery		
Facility Fees		
Hospital	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Surgical Center	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor and Other Services		
Hospital	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Surgical Center	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse)		
Facility Fees	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Human Organ and Tissue Transplants *Coverage includes acquisition and transplant procedures, collection and storage.*	0% coinsurance after medical deductible is met	Not Covered
Doctor and other services	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is unlimited visits per year.*	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Rehabilitation services		
Office *Deductible does not apply for In-Network Providers*	No charge	50% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Habilitation services		
Office *Deductible does not apply for In-Network Providers*	No charge	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Cardiac rehabilitation		
Office	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Precertification is required. Coverage for In-Network Providers and Out-of-Network Providers combined has unlimited visits*	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Hospice *Precertification is required. Deductible does not apply to In-Network providers. Respite care-maximum number of respite care limited to 5 consecutive days per admission.*	No charge	50% coinsurance after medical deductible is met
Durable Medical Equipment	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prosthetic Devices	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Impacted Wisdom Teeth Removal	0% coinsurance after medical deductible is met	0% coinsurance after medical deductible is met
Dental Services (All Members/All Ages) *Services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and for transplants, and for the treatment of accidental injuries.*	Benefits are based on the setting in which Covered Services are received.	

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket Limit	Combined with medical out-of-pocket limit	Combined with medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the Traditional Open drug list appear below. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*		
Home Delivery Pharmacy		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy).*	$10 copay – deductible does not apply	50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy).*	$35 copay – deductible does not apply	50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy).*	$50 copay – deductible does not apply	50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision Essential Health Benefits (up to age 19) **Vision exam** *Limited to 1 exam per benefit period.*	$0 copay	$0 copay plus all charges in excess of the maximum allowed amount
Frames *Limited to 1 unit per benefit period.*	$0 copay, formulary	$0 copay plus all charges in excess of the maximum allowed amount
Lenses *Limited to 1 unit per benefit period*	$0 copay	$0 copay plus all charges in excess of the maximum allowed amount
Elective Contact Lenses *Limited to 1 unit per benefit period.*	$0 copay	$0 copay plus all charges in excess of the maximum allowed amount
Non-Elective Contact Lenses *Limited to 1 unit per benefit period.*	$0 copay, formulary	$0 copay plus all charges in excess of the maximum allowed amount

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your dental coverage. Only children's dental services count towards your out of pocket limit.		
Children's Dental Essential Health Benefits (up to age 19) **Diagnostic and preventive** *Limited to 1 visit per 6 months.*	0% coinsurance	0% coinsurance
Basic services	20% coinsurance	20% coinsurance
Major services	50% coinsurance	50% coinsurance
Medically Necessary Orthodontia services	50% coinsurance	50% coinsurance
Cosmetic Orthodontia services	50% coinsurance	50% coinsurance
Deductible	Not applicable	Not applicable

Adult Dental Benefits	Not covered*

*With the exception of any benefits as stated within medical section

Notes:

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment..
- When using a non-network pharmacy, members are responsible for the stated copay & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

What Is Not Covered – 2023

In this section you will find a review of items that are not covered by your Plan. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

1. **Administrative Charges.**
    a. Charges to complete claim forms,
    b. Charges to get medical records or reports,
    c. Membership, administrative, or access fees charged by Doctors or other Providers. Examples include fees for educational brochures or calling you to give you test results.
2. **Aids for Non-Verbal Communication.** Devices and computers to assist in communication and speech except for speech aid devices and tracheoesophageal voice devices approved by Anthem.
3. **Alternative / Complementary Medicine.** Services or supplies for alternative or complementary medicine. This includes those services listed below. This Exclusion does not apply to Medically Necessary services to treat Mental Health and Substance Use Disorder as required by state law.
    a. Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body, except massage therapy that is Medically Necessary as a physical therapy modality.
    b. Aquatic therapy and other water therapy except for other water therapy services that are part of a physical therapy treatment plan and covered under the “Therapy Services” section of this Booklet,
    c. Holistic medicine,
    d. Homeopathic medicine,
    e. Hypnosis,
    f. Aroma therapy,
    g. Massage and massage therapy, except for other massage therapy services that are part of a physical therapy treatment plan and covered under the “Therapy Services” section of this Booklet,
    h. Reiki therapy,
    i. Herbal, vitamin or dietary products or therapies,
    j. Naturopathy,
    k. Thermography,
    l. Orthomolecular therapy,
    m. Contact reflex analysis,
    n. Bioenergial synchronization technique (BEST),
    o. Iridology-study of the iris,
    p. Auditory integration therapy (AIT),
    q. Colonic irrigation,
    r. Magnetic innervation therapy,
    s. Electromagnetic therapy,
    t. Neurofeedback / Biofeedback.

4. **Autopsies.** Autopsies and post-mortem testing.
5. **Before Effective Date or After Termination Date.** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
6. **Certain Providers.** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers, except for massage therapy that is Medically Necessary as a physical therapy modality. This Exclusion does not apply to Medically Necessary services to treat Mental Health and Substance Use Disorder as required by state law.
7. **Charges Not Supported by Medical Records.** Charges for services not described in your medical records.
8. **Charges Over the Maximum Allowed Amount.** Charges over the Maximum Allowed Amount for Covered Services, except for Surprise Billing Claims as outlined in the "Consolidated Appropriations Act of 2021 Notice" in the front of this Booklet.
9. **Clinical Trial Non-Covered Services.** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
10. **Compound Drugs.** Compound Drugs unless all of the ingredients are FDA-approved in the form in which they are used in the Compound Drug, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
11. **Cosmetic Services.** Treatments, services, Prescription Drugs, equipment, or supplies given for Cosmetic Services. Cosmetic Services are meant to preserve, change**,** or improve how you look. This exclusion does not apply to any services and supplies that are covered as part of Reconstructive Surgery for breast symmetry after a mastectomy, surgery to correct birth defects and birth abnormalities, services provided for the treatment of Gender Dysphoria, or any surgery to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomology or creating a normal appearance.
12. **Court Ordered Testing.** Court ordered testing or care unless Medically Necessary.
13. **Custodial Care.** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
14. **Delivery Charges.** Charges for delivery of Prescription Drugs.
15. **Dental Devices for Snoring.** Oral appliances for snoring.
16. **Dental Services**
    a. Dental care for Members age 19 and older, except for what is provided for in the "What's Covered" section under Dental Services (All Members/All Ages).
    b. Dental services not listed as covered in this Booklet.
    c. Dental services which a Member would be entitled to receive for a nominal charge or without charge if this coverage were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Member receives a bill or direct charge for dental services under any governmental program, then this Exclusion shall not apply. Benefits under this Plan will not be reduced or denied because dental services are rendered to a Student or Dependent who is eligible for or receiving medical assistance.
    d. Procedures which are not generally accepted standards of dental practice within the organized dental community in California.

e. Dental services or health care services not specifically listed in the “What’s Covered” section of this EOC (including any Hospital charges or Prescription Drug charges and dental services or supplies that do not have an American Dental Association Procedure Code, unless covered by the medical benefits of this Plan).

f. Dental services completed prior to the date the Member became eligible for coverage or received after the coverage under this Plan has ended.

g. Analgesia, analgesia agents, medicines and Drugs for surgical or non-surgical care.

h. Local anesthetic when billed separately from a Covered Service, as this is a part of the final service, such as for restoration services (fillings, crowns).

i. Dental services performed other than by a licensed dentist, licensed Physician, his or her employees.

j. Dental care services you received for which you are not legally obligated to pay or dental care services you received for which there would be no charge to you in the absence of insurance.

k. Covered Services received from a person who lives in the Member’s home or who is related to the Member by blood, marriage or adoption.

l. Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

m. Dental services provided by dentists solely for the purpose of improving the appearance of the tooth when the tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist. This includes tooth whitening agents, bonding and veneers or restorations (such as fillings) placed for preventive purposes.

n. Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (filling, crown) has not been placed.

o. Athletic mouth guards, enamel microabrasion and odontoplasty.

p. Bacteriologic tests.

q. Cytology sample collection.

r. Separate services billed when they are an inherent component of another Covered Service.

s. Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.

t. Additional, elective or enhanced prosthodontic procedures including connector bars, stress breakers and precision attachments.

u. Provisional splinting, temporary procedures or interim stabilization.

v. Adjunctive diagnostic tests.

w. Cone beam images.

x. Anatomical crown exposure.

y. Temporary anchorage devices.

z. Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials, and the procedures used to prepare and place materials in the canals (tooth roots).

aa. Incomplete endodontic treatment and bleaching of discolored teeth.

bb. The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.

cc. Hemisection of deciduous teeth.

dd. Crowns are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

ee. Inlays.

ff. Services or supplies that are not Medically Necessary.

17. **Drugs Contrary to Generally Accepted Medical and Professional Standards.** Drugs given to you or prescribed in a way that is against generally accepted standards of medical practice or inconsistent with FDA approvals (except covered off-label use).

18. **Drugs Over Quantity or Age Limits.** Drugs which are over any quantity or age limits set by the Plan unless Medically necessary and approved through an exception request (please see the "Prior Authorization" provision in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy).

19. **Drugs Over the Quantity Prescribed or Refills After One Year.** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.

20. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications.** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications.

21. **Drugs That Do Not Need a Prescription.** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to drugs and other products that are available over-the-counter and do not legally require a Prescription, but are recommended by the USPSTF or the Health Resources and Services Administration for certain individuals as preventive care services, when prescribed by a licensed Provider (please see APPENDIX I for more information).

22. **Educational Services.** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based. This Exclusion does not apply to Medically Necessary services to treat Mental Health and Substance Use Disorder as required by state law, or to educational and counseling services related to screening for or the treatment of asthma, diabetes, HIV, tobacco use prevention and cessation, family planning and contraceptive management, breastfeeding, nutritional counseling, or educational services in the treatment of mental health or substance use disorder.

23. **Experimental or Investigational Services.** Services or supplies that we find are Experimental / Investigational, except as specifically stated under Clinical Trials in the section "What's Covered." This Exclusion applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

    The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational.

    If a Member has a life-threatening or seriously debilitating condition and Anthem determines that requested treatment is not a Covered Service because it is Experimental or Investigational, the Member may request an Independent Medical Review. See the "Grievance and External Review Procedures" section for further details.

24. **Eye Exercises.** Orthoptics and vision therapy.

25. **Eye Surgery.** Eye surgery to fix errors of refraction, such as near-sightedness. This includes LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

26. **Eyeglasses and Contact Lenses.** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.
27. **Family Members.** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
28. **Foot Care.** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including:
    a. Cleaning and soaking the feet.
    b. Applying skin creams to care for skin tone.
    c. Other services that are given when there is not an illness, injury or symptom involving the foot.
29. **Foot Orthotics.** Foot orthotics, orthopedic shoes or footwear or support items except as covered under Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical Surgical Supplies or used for a systemic illness affecting the lower limbs, such as severe diabetes.
30. **Foot Surgery.** Surgical treatment of flat feet; subluxation of the foot; tarsalgia; metatarsalgia; hyperkeratoses. This Exclusion does not apply to Medically Necessary reconstructive surgery to correct congenital defects, developmental abnormalities, trauma, infection, tumors, or other disease as stated in the "Surgery" provision in the section "What's Covered".
31. **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
32. **Government Treatment.** Any services you actually received that were provided by a local, state, or federal government agency, or by a public school system or school district, except when payment under this Plan is expressly required by federal or state law. This Exclusion does not apply to Medically Necessary services you receive from the Student Health Center, if such services are otherwise covered by this Plan. We will not cover payment for these services if you are not required to pay for them or they are given to you for free. You are not required to seek any such services prior to receiving Medically Necessary health care services that are covered by this Plan.
33. **Growth Hormone Treatment.** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth. This Exclusion does not apply to Medically Necessary hormone therapy for the treatment of Gender Dysphoria.
34. **Health Club Memberships and Fitness Services.** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, such as a gym, even if ordered by a Doctor. This Exclusion also applies to health spas. This Exclusion does not apply to Medically Necessary therapy services as specified under the "Therapy Services" provision in the section "What's Covered" when rendered by a licensed health care Provider.
35. **Hearing Aids.** Hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.
36. **Home Care.**
    a. Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
    b. Food, housing, homemaker services and home delivered meals.

This Exclusion does not apply to Medically Necessary services to treat Mental Health and Substance Use Disorder as required by state law, or to “Hospice Care” as specified in the section “What’s Covered".

37. **Hospital Services Billed Separately.** Services rendered by Hospital resident Doctors or interns that are billed separately by the Doctor or intern, that are also billed by the Hospital. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions that are normally billed by that institution, and charges included in other duplicate billings.
38. **Illegal Occupation.** Any claim to which a contributing cause was your commission of or attempt to commit a felony or to which a contributing cause was your being engaged in an illegal occupation.
39. **Infertility Treatment.** Testing or treatment related to infertility. This does not apply to medically necessary fertility preservation services to prevent iatrogenic infertility as specified in the section “What’s Covered”.
40. **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.
41. **In-vitro Fertilization.** Services or supplies for in-vitro fertilization (IVF) for purposes of pre-implant genetic diagnosis (PGD) of embryos, regardless of whether they are provided in connection with infertility treatment.
42. **Lifestyle Programs.** Programs to alter one’s lifestyle which may include diet, exercise, imagery or nutrition that are not Medically Necessary for the diagnosis and treatment of a covered illness or injury. This Exclusion does not apply to Medically Necessary preventive care services as specified in the “Preventive Care” provision in the section “What’s Covered" and in APPENDIX I (“Preventive Care Services Covered by this Plan”).
43. **Lost or Stolen Drugs.** Refills of lost or stolen Drugs.
44. **Maintenance Therapy.** Rehabilitative treatment or care that is provided when no further gains or improvements in your current level of function are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to habilitative services.
45. **Medical Equipment, Devices and Supplies.**
    a. Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
    b. Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
    c. Non-Medically Necessary enhancements to standard equipment and devices.
    d. Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is your responsibility.
    e. Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the “What's Covered” section.
    f. Continuous glucose monitoring systems. These are covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.

46. **Medicare.** For which benefits are paid under Medicare Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in "General Provisions." If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when you should enroll and when you are allowed to delay enrollment without penalties.
47. **Missed or Cancelled Appointments.** Charges for missed or cancelled appointments.
48. **Non-Approved Drugs.** Drugs not approved by the FDA.
49. **Non-Medically Necessary Services.** Any services or supplies that are not Medically Necessary as defined. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
50. **Nutritional or Dietary Supplements.** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes *nutritional formulas and dietary supplements that you can buy over the counter* and those you can get without a written Prescription or from a licensed pharmacist. This Exclusion does not apply to Medically Necessary services to treat Mental Health and Substance Use Disorder as required by state law.
51. **Off Label Use.** Off label use, unless we must cover it by law or if we approve it.
52. **Oral Surgery.** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.
53. **Personal Care, Convenience and Mobile/Wearable Devices.**
    a. Items for personal comfort, convenience, protection, cleanliness or beautification such as air conditioners, humidifiers, air or water purifiers, sports helmets, raised toilet seats, and shower chairs.
    b. First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads, disposable sheaths and supplies).
    c. Home workout or therapy equipment, including treadmills and home gyms.
    d. Pools, whirlpools, spas, or hydrotherapy equipment.
    e. Hypoallergenic pillows, mattresses, or waterbeds.
    f. Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
    g. Consumer wearable / personal mobile devices such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.
54. **Private Contracts.** Services or supplies provided pursuant to a private contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.
55. **Private Duty Nursing.** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the "Home Health Care Services" benefit.
56. **Prosthetics.** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics.
57. **Residential Accommodations.** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:
    a) Domiciliary care provided in a residential institution, treatment center, halfway house, or

school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

b) Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

c) Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward-bound programs, even if psychotherapy is included.

This Exclusion does not apply to Medically Necessary services to treat Mental Health and Substance Use Disorder as required by state law.

58. **Routine Physicals and Immunizations.** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit. This Exclusion does not apply to Medically Necessary services to treat Mental Health and Substance Use Disorder as required by state law, or to immunizations required or recommended for travel to countries outside the United States.

59. **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits** Services that require in-person contact and/or equipment that cannot be provided remotely.

60. **Services You Receive for Which You Have No Legal Obligation to Pay.** Services you actually receive for which you have no legal obligation to pay or for which no charge would be made if you did not have health plan or insurance coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines: a) it must be internationally known as being devoted mainly to medical research, and b) at least ten percent of its yearly budget must be spent on research not directly related to patient care, and c) at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care, and d) it must accept patients who are unable to pay, and e) two-thirds of its patients must have conditions directly related to the Hospital research.

61. **Stand-By Charges.** Stand-by charges of a Doctor or other Provider.

62. **Surrogate Mother Services.** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including the bearing of a child by another woman for an infertile couple).

63. **Temporomandibular Joint Treatment.** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

64. **Travel Costs.** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.

65. **Vein Treatment.** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

66. **Vision Services.**

    a. Vision care for Members age 19 and older, unless covered by the medical benefits of this Plan.

    b. Safety glasses and accompanying frames.

    c. Two pairs of glasses in lieu of bifocals.

    d. Plano lenses (lenses that have no refractive power)

    e. Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.

    f. Vision services or supplies not specifically listed as covered in this Booklet.

g. Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed in this Booklet.

h. Blended or oversize lenses or sunglasses, unless specifically listed in this Booklet.

i. Services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.

j. For Members through age 18, no benefit is available for frames or contact lenses purchased outside of our formulary.

k. Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.

67. **Waived Cost-Shares Out-of-Network.** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.

68. **Weight Loss Programs.** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

    This Exclusion includes 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 stated in the "Bariatric Surgery" provision of "What's Covered."

69. **Wilderness or other outdoor camps and/or programs**. This Exclusion does not apply to Medically Necessary services to treat Mental Health and Substance Use Disorder as required by state law.

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

70. **Administration Charges.** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.

71. **Charges Not Supported by Medical Records.** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.

72. **Clinical Trial Non-Covered Services.** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.

73. **Compound Drugs.** Compound Drugs unless all of the ingredients are FDA-approved in the form in which they are used in the Compound Drug, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

74. **Contrary to Approved Medical and Professional Standards.** Drugs given to you or prescribed in a way that is against generally accepted standards of medical practice or inconsistent with FDA approvals (except covered off-label use).

75. **Delivery Charges.** Charges for delivery of Prescription Drugs.

76. **Drugs Given at the Provider's Office / Facility.** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
77. **Drugs Not on the Prescription Drug List (a formulary).** Drugs not on the Prescription Drug List except if authorized through prior authorization. If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to the "Prescription Drug List" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception. You can get a copy of the list by calling us or visiting our website at www.anthem.com.
78. **Drugs Over Quantity or Age Limits.** Drugs which are over any quantity or age limits set by the Plan unless Medically necessary and approved through an exception request (please see the "Prior Authorization" provision in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy).
79. **Drugs Over the Quantity Prescribed or Refills After One Year.** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
80. **Drugs Prescribed for Cosmetic Purposes.**
81. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications.** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications.
82. **Drugs that Do Not Need a Prescription.** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to drugs and other products that are available over-the-counter and do not legally require a Prescription, but are recommended by the USPSTF or the Health Resources and Services Administration for certain individuals as preventive care services, when prescribed by a licensed Provider (please see APPENDIX I for more information).
83. **Family Members.** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
84. **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
85. **Growth Hormone Treatment.** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth. This Exclusion does not apply to Medically Necessary hormone therapy for the treatment of Gender Dysphoria.
86. **Infertility Drugs.** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT).
87. **Items Covered as Durable Medical Equipment (DME).** Therapeutic DME, devices and supplies except as described in this Booklet or that we must cover by law, including peak flow meters, spacers, and glucose monitors, and other diabetes supplies. See the "Diabetes Equipment, Education, and Supplies" section for more information. Items not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.
88. **Items Covered Under the "Allergy Services" Benefit.** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home

Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.

89. **Lost or Stolen Drugs.** Refills of lost or stolen Drugs.
90. **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider.** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
91. **Non-Approved Drugs.** Drugs not approved by the FDA. If Anthem determines that the requested drug is not covered because it is Investigational or prescribed for Experimental indications, the Member may request an Independent Medical Review. See the "Grievance and External Review Procedures" section for further details.
92. **Non-Medically Necessary Services.** Any services or supplies that are not Medically Necessary as defined. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
93. **Nutritional or Dietary Supplements.** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist. This Exclusion does not apply to Medically Necessary services to treat Mental Health and Substance Use Disorder as required by state law.
94. **Off Label Use.** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.
95. **Out-of-Network Prescription Drugs** Prescription Drugs purchased from an Out-of-Network Pharmacy inside or outside the state of California. You will be responsible for payment in full for any Prescription purchased at an Out-of-Network Pharmacy.
96. **Over-the-Counter Items.** Drugs, devices and products, or Prescription Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product may not be covered, even if written as a Prescription. This includes Prescription Drugs when any version or strength becomes available over the counter.

    This Exclusion does not apply to over-the-counter products that we must cover as a "Preventive Care" benefit under state law or federal law with a Prescription.
97. **Sanctioned or Excluded Providers.** Any Drug, Drug regimen, treatment, or supply, furnished, ordered, or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies.
98. **Syringes.** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
99. **Weight Loss Drugs.** Any Drug mainly used for weight loss, except for the Medically Necessary treatment of morbid obesity.