2020-2021

Otis College of Art & Design
Student Health Insurance Plan

www.anthem.com/studentadvantageca

Anthem Student Advantage
Keeping you at your personal best

A00337CAMENABC 09/20

Anthem | STUDENT ADVANTAGE

Important notice

This is a brief description of your student health plan underwritten by Anthem Blue Cross. If you would like more details about your coverage and costs, you can find the complete terms in the policy or plan document online at www.anthem.com/ca.

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Welcome to Anthem Student Advantage

As your new school year begins, it's important to understand your health care benefits and how they work.

Your Anthem Student Advantage plan can help keep you at your personal best. This book will guide you through your plan benefits, with information about who is eligible, what is covered, how to access the right type of care when you need it, and more.

What you need to know about Anthem Student Advantage

Who is eligible?

- All Otis College students are automatically enrolled in the student health insurance plan (SHIP).
- Students with health insurance coverage that meet the College's requirements may waive out of the plan by completing an online waiver.
- All waivers must be completed online by the waiver deadline.

Coverage is available for dependents too

If you are covered by Anthem Student Advantage through Otis College, you may enroll your lawful spouse, domestic partner or dependent children under the age of 26.

- If you would like to enroll dependents, please utilize the Dependent Enrollment Sheet.
- If you have any questions or need additional assistance, email studenthealth@otis.edu.

Coverage periods and rates

Coverage will become effective at 12:01 a.m., and will end at 11:59 p.m. on the dates shown below.

Costs and dates of coverage

Medical plan

BFA MFA	Fall 8/15/20 through 1/6/2021	Spring 1/7/21 through 8/14/21
Student	$950	$1,330
Student + Spouse	$1,900	$2,660
Student + Child	$1,900	$2,660
Student + Spouse + Child	$2,850	$3,990

MFA Graphic Design	Fall 1 8/15/20 through 1/6/21	Spring 1/7/21 through 6/8/21	Summer 6/9/21 through 8/14/21	Fall 2 8/15/21 through 1/6/22
Student	$570	$760	$950	$570
Student + Spouse	$1,140	$1,520	$1,900	$1,140
Student + Child	$1,140	$1,520	$1,900	$1,140
Student + Spouse + Child	$1,170	$2,280	$2,850	$1,170

*The above rates include premiums for the plan and commissions and administrative fees.
*Rates are pending approval with the state and subject to change.

Keep in touch with your benefits information

Student Health & Wellness Center

9045 Lincoln Blvd
Ahmanson Room 107
Los Angeles, CA 90045

1-310-846-5738

www.otis.edu/shwc

Academic Year Hours:
Monday - Friday, 9:00 AM - 4:30 PM
Summer Hours:
Monday - Friday, 9:00 AM - 4:00 PM
Closed weekends and
all Otis College holidays

Claims and coverage

1-800-888-2108

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 60007
Los Angeles, CA 90060-0007

Eligibility, enrollment, and waiver questions

Academic HealthPlans
otis.myahpcare.com
Otis College of Art & Design

Student Counseling Services

9045 Lincoln Blvd
Ahmanson Room 107
Los Angeles, CA 90045

1-310-846-5738

www.otis.edu/student-health-wellness-center/student-counseling-services

Monday - Friday, 9:00 AM - 4:30 PM

- Individual counseling
- Crisis and triage appointments
- Couples counseling (when both parties are Otis College students)
- Group counseling and workshops
- Consultations for students, parents, faculty/staff
- Referrals to external mental health providers for open-ended therapy or specialized treatment
- Substance abuse screening and counseling
- Psychological assessment for diagnostic and treatment tracking purposes
- Outreach programming / educational events to promote wellness in the Otis College community

Easy access to care

Access the care you need, in the way that works best for you.

Sydney Health app

With the Sydney Health[1] app through Anthem Student Advantage, you have instant access to:

- Your member ID card.
- The Find a Doctor tool.
- More information about your plan benefits.
- Health tips that are tailored to you.
- LiveHealth Online and 24/7 NurseLine.
- Student support specialists (through click-to-chat or by phone).

Access the Sydney Health app

Go to the App Store℠ or Google Play™ and search for the Sydney Health app to download it today.

LiveHealth Online

From your mobile device or computer with a webcam, you can use LiveHealth Online to visit with a board-certified doctor, psychiatrist or licensed therapist through live video.[2] To use, go to your Sydney Health app or www.livehealthonline.com. You can also download the free LiveHealth Online app to sign up.

24/7 NurseLine

Call **1-844-545-1429** to speak to a registered nurse who can help you with health issues like fever, allergy relief, cold and flu symptoms and where to go for care. Nurses can also help you enroll in health management programs if you have specific health conditions, remind you about scheduling important screenings and exams, and more.

Provider finder

Use www.anthem.com/ca/find-doctor/ to find the right doctor or facility close to where you are.

Anthem Student Advantage Otis College of Art & Design website

Use www.anthem.com/studentadvantageca to see your health plan information, including providers, benefits, claims, covered drugs and more.

1 Sydney Health is a service mark of CareMarket, Inc.
2 Appointments subject to availability of a therapist. Psychologists or therapists using LiveHealth Online cannot prescribe medications. Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 1-800-784-2433 (National Suicide Prevention Lifeline) or 911 and ask for help. If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.
LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

Your summary of benefits

Anthem Blue Cross

Student health insurance plan:
Otis College of Art & Design

Your network:
Prudent Buyer PPO

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. Plan benefits are pending approval with the state and subject to change.
Student Health Center Benefits: $0 copay for services rendered at the Student Health Center.

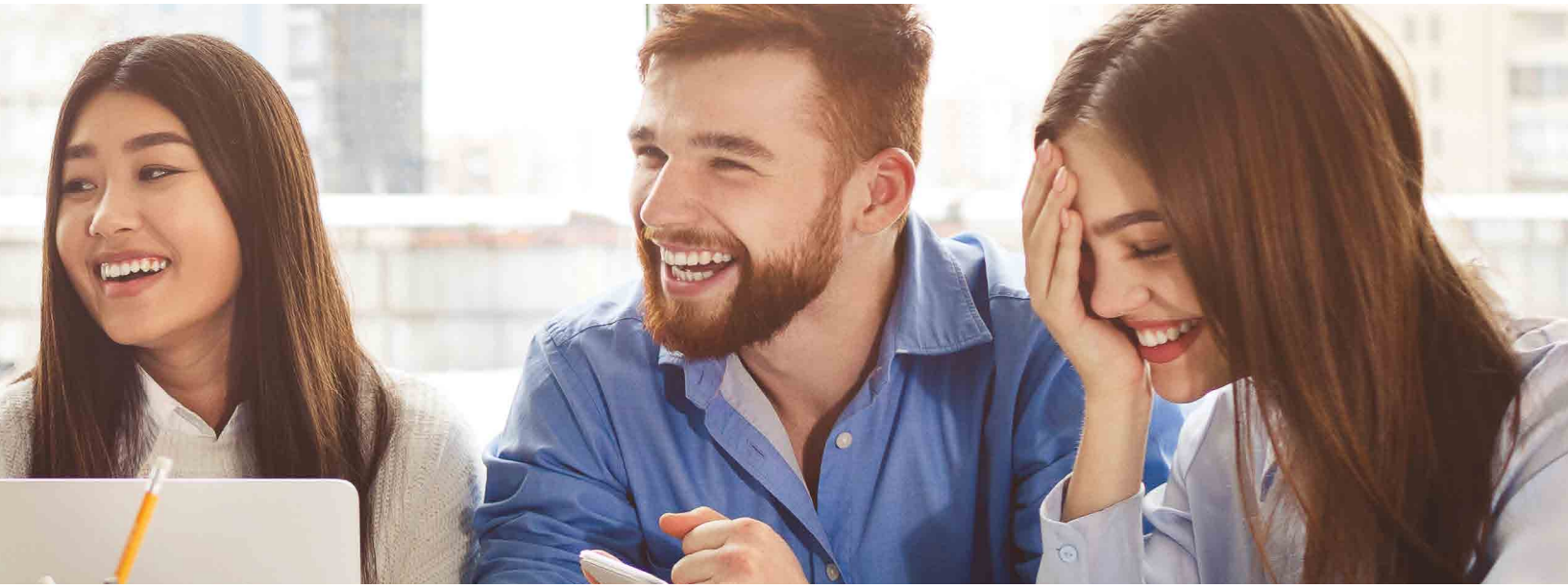
Medical

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible		
See notes section to understand how your deductible works.	250 single / $500 family	$750 single / $1,500 family
Out-of-Pocket Limit		
When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.	$5,900 single / $11,800 family	$12,700 single / $25,400 family
Preventive care/screening/immunization		
In-network preventive care is not subject to deductible, if your plan has a deductible.	No charge	50% coinsurance
Doctor Home and Office Services		
Primary care visit to treat an injury or illness *Deductible does not apply to In-Network providers. $0 copay for services rendered at the Student Health Center.*	$20 copay per visit	50% coinsurance
Specialist care visit *Deductible does not apply to In-Network providers.*	$20 copay per visit	50% coinsurance
Prenatal and Post-natal Care *Deductible does not apply to In-Network providers.*	$20 copay per visit	50% coinsurance
Other practitioner visits:		
Retail health clinic *Deductible does not apply to In-Network providers.*	$20 copay per visit	50% coinsurance
On-line Visit *Includes Mental/Behavioral Health and Substance Abuse. Deductible does not apply to In-Network providers.*	$20 copay per visit	50% coinsurance
Chiropractic Services	20% coinsurance	50% coinsurance
Acupuncture	20% coinsurance	50% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Other services in an office:		
Allergy testing	$0 copay per visit	$20 copay per visit + 50% coinsurance
Chemo/radiation therapy	20% coinsurance	50% coinsurance
Hemodialysis	20% coinsurance	50% coinsurance
Prescription Drugs *For the drug itself dispensed in the office through infusion/injection.*	20% coinsurance	50% coinsurance
Diagnostic Services		
Lab: *Deductible does not apply to In-Network providers.*		
Office	20% coinsurance	50% coinsurance
Freestanding Lab	20% coinsurance	50% coinsurance
Outpatient Hospital	20% coinsurance	50% coinsurance
X-ray: *Deductible does not apply to In-Network providers.*		
Office	20% coinsurance	50% coinsurance
Freestanding Radiology Center	20% coinsurance	50% coinsurance
Outpatient Hospital	20% coinsurance	50% coinsurance
Advanced diagnostic imaging (for example, MRI/PET/CAT scans): *Deductible does not apply to In-Network providers.*		
Office	20% coinsurance	50% coinsurance
Freestanding Radiology Center	20% coinsurance	50% coinsurance
Outpatient Hospital	20% coinsurance	50% coinsurance
Emergency and Urgent Care		
Emergency room facility services *Copay waived if admitted. This is for the hospital/facility charge only. The ER physician charge may be separate.*	$150 copay per visit and then 20% coinsurance	Covered as In-Network
Emergency room doctor and other services	20% coinsurance	Covered as In-Network
Ambulance (air and ground)	20% coinsurance	Covered as In-Network
Urgent Care (office setting) *Deductible does not apply to In-Network providers.*	$20 copay per visit	50% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit *Deductible does not apply to In-Network providers.*	No charge for first 15 visits and then $20 copay per visit	50% coinsurance
Facility visit:		
Facility Fees	No charge	50% coinsurance
Outpatient Surgery		
Facility fees:		
Hospital	20% coinsurance	50% coinsurance
Freestanding Surgical Center	20% coinsurance	50% coinsurance
Doctor and other services:	20% coinsurance	50% coinsurance
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board)	20% coinsurance	50% coinsurance
Doctor and other services	20% coinsurance	50% coinsurance
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 visit limit per benefit period.*	20% coinsurance	50% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Rehabilitation and Habilitation services (for example, physical/speech/occupational therapy):		
Office *Deductible does not apply to In-Network providers.* *Costs may vary by site of service.*	$20 copay per visit then 20% coinsurance	$20 copay per visit + 50% coinsurance
Outpatient hospital *Deductible does not apply to In-Network providers.*	$20 copay per visit then 20% coinsurance	$20 copay per visit + 50% coinsurance
Cardiac rehabilitation		
Office *Deductible does not apply to In-Network providers.*	$20 copay per visit then 20% coinsurance	$20 copay per visit + 50% coinsurance
Outpatient hospital *Deductible does not apply to In-Network providers.*	$20 copay per visit then 20% coinsurance	$20 copay per visit + 50% coinsurance
Skilled nursing care (in a facility)		
Precertification is required. Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 day limit per benefit period.	20% coinsurance	50% coinsurance
Hospice		
Precertification is required.	20% coinsurance	50% coinsurance
Durable Medical Equipment		
	20% coinsurance	50% coinsurance
Prosthetic Devices		
	20% coinsurance	50% coinsurance



Pediatric Vision

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Children's Vision Essential Health Benefits *Limited to covered persons under the age of 19.*		
Vision exam *Includes one exam/fitting per year*	No charge	$0 copay plus all charges in excess of the maximum allowed amount
Frames *Includes one per year*	No charge	$0 copay plus all charges in excess of the maximum allowed amount
Lenses *Includes one per year*	No charge	$0 copay plus all charges in excess of the maximum allowed amount
Elective contact lenses *Includes one per year*	No charge	$0 copay plus all charges in excess of the maximum allowed amount

Standalone Vision

Blue View Vision plan benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Routine Eye Exam		
A comprehensive eye examination once every plan year	$10 copay	Up to $42 reimbursement
Eyeglass Frames		
One pair of eyeglass frames once every two plan years	$130 allowance, then 20% off any balance	Up to $45 reimbursement
Eyeglass Lenses *(instead of contact lenses)*		
One pair of standard plastic prescription lenses:		
Single vision lenses once every plan year	$10 copay	Up to $40 reimbursement
Bifocal lenses once every plan year	$10 copay	Up to $60 reimbursement
Trifocal lenses once every plan year	$10 copay	Up to $80 reimbursement
Eyeglass Lens Enhancements[1]		
Transitions Lenses (for a child under age 19) same as covered eyeglass lenses	$0 copay	No allowance when obtained out-of-network
Standard polycarbonate (for a child under age 19) same as covered eyeglass lenses	$0 copay	No allowance when obtained out-of-network
Factory scratch coating same as covered eyeglass lenses	$0 copay	No allowance when obtained out-of-network
Contact Lenses[2] *(instead of eyeglass lenses)*		
Elective conventional (non-disposable); OR once every plan year	$130 allowance, then 15% off any balance	Up to $105 reimbursement
Elective disposable; OR once every plan year	$130 allowance *(no additional discount)*	Up to $105 reimbursement
Non-elective (medically necessary) Once every plan year	Covered in full	Up to $210 reimbursement

1 When obtaining covered eyewear from a Blue View Vision provider, members may choose to add any of the listed lens enhancements at no extra cost.
2 Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.

Additional savings available from in-network providers

Description	Member cost
When obtaining covered eyewear from a Blue View Vision provider, members may choose to upgrade their new eyeglass lenses at a discounted cost. Costs shown are after any applicable eyeglass lens copayment.	
Progressive Lenses	
Standard	$55
Premium Tier 1	$85
Premium Tier 2	$95
Premium Tier 3	$110
Premium Tier 4	$175
Anti-Reflective Coating	
Standard	$45
Premium Tier 1	$57
Premium Tier 2	$68
Premium Tier 3	$85
Transitions lenses (Adults)	$75
Standard Polycarbonate lenses (Adults)	$40
UV Coating	$15
Tint (Solid and Gradient)	$15
Other lens upgrades and add-ons	20% off retail price
Retinal Imaging (obtained at same time as covered eye exam)	Up to $39
Standard contact lens fitting and follow-up after comprehensive eye exam	Up to $55
Premium contact lens fitting and follow-up after comprehensive eye exam	10% off retail price
Additional supplies of conventional contact lenses after benefits have been used	15% off retail price
Additional complete pairs of eyeglasses	40% off retail price
Eyeglass materials purchased separately	20% off retail price
Other items including most non-prescription sunglasses, eyewear accessories such as lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price

Other discount offers on LASIK surgery and much more are available through our SpecialOffers program.

Pediatric Dental

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's dental services count towards your out of pocket limit.		
Children's Dental Essential Health Benefits		
Diagnostic and preventive *Includes cleanings, exams, x-rays, sealants, fluoride.*	No charge	No charge
Basic services	20% coinsurance	20% coinsurance
Major services	50% coinsurance	50% coinsurance
Endodontic, Periodontics, Oral Surgery	50% coinsurance	50% coinsurance
Medically Necessary Orthodontia	50% coinsurance	50% coinsurance
Deductible	Not applicable	Not applicable

Standalone Dental

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Annual Benefit Maximum Plan Year		
Per insured person	$1,500	$1,500
Annual Deductible Plan Year		
Per insured person/Family maximum	$50/3X Individual	$50/3X Individual
Deductible Waived for Diagnostic/Preventive Services	Yes	Yes

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Diagnostic and Preventive Services		
Periodic oral exam 2 per 12 months	0% Coinsurance	0% Coinsurance
Teeth cleaning (prophylaxis) 2 per 12 months; w/periodontal maintenance	0% Coinsurance	0% Coinsurance
Bitewing X-rays: 1 set per 12 months	0% Coinsurance	0% Coinsurance
Full-mouth or Panoramic X-rays: 1 per 60 months	0% Coinsurance	0% Coinsurance
Fluoride application: 1 per 12 months through age 18	0% Coinsurance	0% Coinsurance
Sealants 1 per 60 months; through age 18	0% Coinsurance	0% Coinsurance
Basic Services		
Consultation (second opinion) 1 per 12 months	20% Coinsurance	20% Coinsurance
Amalgam (silver-colored) Filling 1 per tooth per 24 months	20% Coinsurance	20% Coinsurance
Composite (tooth-colored) Filling posterior (back) fillings covered as composites 1 per tooth per 24 months	20% Coinsurance	20% Coinsurance
Brush Biopsy (cancer test) Covered, 1 per 12 months; all ages	20% Coinsurance	20% Coinsurance
Space Maintainers 1 per lifetime through age 18; posterior teeth	20% Coinsurance	20% Coinsurance
Endodontics (Non-Surgical)		
Root Canal and retreatments 1 per tooth per lifetime	50% Coinsurance	50% Coinsurance
Endodontics (Surgical)		
Apicoectomy and apexification 1 per tooth per lifetime	50% Coinsurance	50% Coinsurance
Periodontics (Non-Surgical)		
Periodontal Maintenance 2 per 12 months; w/teeth cleaning	20% Coinsurance	20% Coinsurance
Scaling and root planing 1 per quadrant per 24 months	20% Coinsurance	20% Coinsurance
Periodontics (Surgical)		
Periodontal Surgery (osseous, gingivectomy, graft procedures) 1 per quadrant per 36 months	50% Coinsurance	50% Coinsurance
Oral Surgery (Simple)		
Simple Extractions 1 per tooth per lifetime	50% Coinsurance	50% Coinsurance

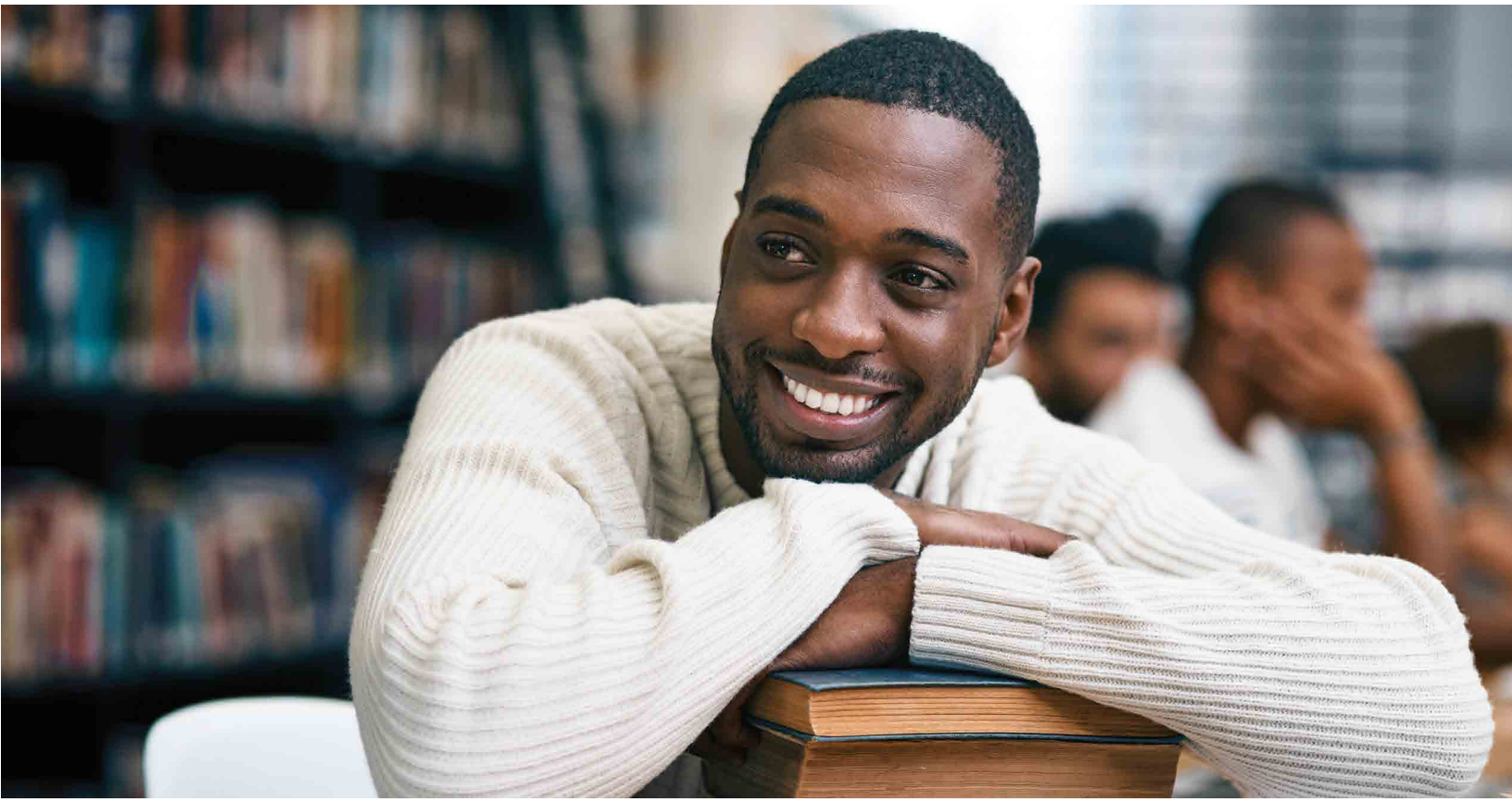
Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Oral Surgery (Complex)		
Surgical Extractions 1 per tooth per lifetime	50% Coinsurance	50% Coinsurance
Major (Restorative) Services		
Crowns, onlays, veneers 1 per tooth per 84 months	50% Coinsurance	50% Coinsurance
Prosthodontics		
Dentures and bridges 1 per tooth per 84 months	50% Coinsurance	50% Coinsurance
Dental Implants Covered, 1 per tooth per 84 month	50% Coinsurance	50% Coinsurance
Prosthodontic Repairs/Adjustments		
Crown, denture, bridge repairs 1 per 12 months; 6 months after placement	50% Coinsurance	50% Coinsurance
Denture and bridge adjustments: 2 per 12 months; 6 months after placement	50% Coinsurance	50% Coinsurance
Orthodontic Services		
None	Not Covered	Not Covered

Additional Limitations & Exclusions. Below is a partial listing of non-covered services under your dental plan. Please see your policy for a full list.

Services provided before or after the term of this coverage - Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate
Orthodontics (unless included as part of your dental plan benefits) including orthodontic braces, appliances and all related services
Cosmetic dentistry (unless included as part of your dental plan benefits) provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist
Drugs and medications including intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care
Analgesia, analgesic agents, and anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.
Waiting periods for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan.
There is a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

Pharmacy

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Pharmacy Deductible	$0	$0
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage *This plan uses a Traditional Drug List. Drugs not on the list are not covered. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days.*		
Tier 1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).*	$15 copay per prescription (retail) and $45 copay per prescription (home delivery).	N/A
Tier 2 - Typically Preferred / Brand *Covers up to a 30 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).*	$30 copay per prescription (retail) and $90 copay per prescription (home delivery).	N/A
Tier 3 - Typically Non-Preferred / Specialty Drugs *Covers up to a 30 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).*	$70 copay per prescription (retail) and $210 copay per prescription (home delivery).	N/A
Tier 4 - Typically Specialty Drugs *Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program. Covers up to a 30 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).*	$200 copay per prescription (retail) and $600 copay per prescription (home delivery).	N/A



Benefits that go with you

You are covered for emergency health situations when travelling abroad. With our 24/7 help center and international network of doctor advisors, you have the right support and services when you need them through GeoBlue®.

In a medical emergency:

1. Go immediately to the nearest doctor or hospital.

2. Call us at **1-833-511-4763**. The GeoBlue Global Health & Safety Team will contact the doctor treating you and closely monitor your situation to decide whether a medical evacuation is needed. When you call, have this information ready:

   - Your name
   - Details of the emergency
   - The name and contact information of the doctor and/or the hospital treating you
   - The ID number on the front of your member ID card
   - The name of your health coverage program: **Anthem Student Advantage**
   - Your specific location, using GPS if it is available

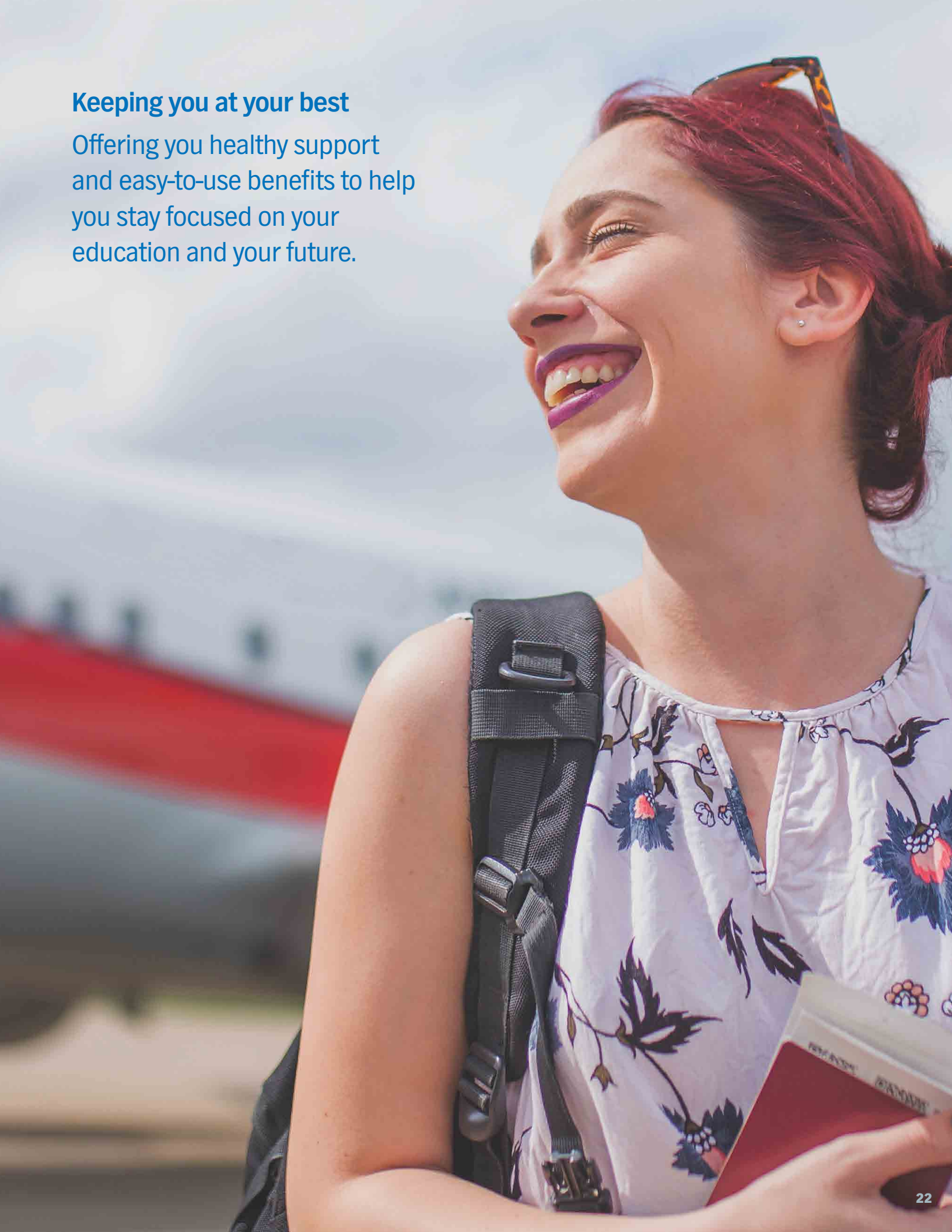
Your GeoBlue benefits	
Emergency medical evacuation	Unlimited
Repatriation of remains	Unlimited
Emergency family travel arrangements	Maximum benefit up to $5,000 per coverage year
Political emergency and natural disaster evacuation *(Available only when traveling outside the U.S.)*	Covered 100% up to $100,000 per person. Subject to a combined $5,000,000 limit per any one covered event for all people covered under the plan.
Accidental death and dismemberment	Maximum benefit up to $10,000 per coverage year

Use of benefits must be coordinated and approved by GeoBlue.

GeoBlue®

Keeping you at your best

Offering you healthy support and easy-to-use benefits to help you stay focused on your education and your future.



Notes

- 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 Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual Out-of-Pocket Maximums includes deductible, copays, coinsurance and prescription drug.
- In network and out of network deductible and out of pocket maximum are exclusive of each other.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration. This is not an inclusive list of services. Please refer to your evidence of coverage.
- For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- If your plan includes out of network benefits and you use a non-network provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.
- Bariatric Surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 consecutive days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- 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 coverage do not exceed 100% of the covered expense.
- Supply limits for certain drugs may be different, go to Anthem website or call customer service.

- Certain drugs require pre-authorization approval to obtain coverage.
- This plan includes custom benefits that may supersede some of the information included in the Limitations and Exclusions list provided here. Please see your EOC for full details on your covered benefits.

Exclusions

In this section you will find a review of items that are not covered by your Medical 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.

Exclusions are pending approval with the state and subject to change.

What Is Not Covered – 2020/2021

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 the following. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child 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
   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. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child 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.
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 and as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, 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 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 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 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) Services or supplies that are not Medically Necessary.

16. **Drugs 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).

17. **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).

18. **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.

19. **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.

20. **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.

21. **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 Severe Mental Illness or Serious Emotional Disturbances of a Child 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 abuse.

22. **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.

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

24. **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.

25. **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.

26. **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.

27. **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.

28. **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.

29. **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".

30. **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.

31. **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.

32. **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.

33. **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.

34. **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 Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law, or to "Hospice Care" as specified in the section "What's Covered".

35. **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.

36. **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.

37. **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".

38. **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.

39. **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.

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

41. **Lost or Stolen Drugs.**
Refills of lost or stolen Drugs.

42. **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.

43. **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 Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable 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.

44. **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.

45. **Missed or Cancelled Appointments.**
Charges for missed or cancelled appointments.

46. **Non-Approved Drugs.**
Drugs not approved by the FDA.

47. **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.

48. **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 Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

49. **Off Label Use.**
Off label use, unless we must cover it by law or if we approve it.

50. **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.

51. **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) Hypo-allergenic 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.

52. **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.

53. **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 Care Services" benefit.

54. **Prosthetics.**
Prosthetics for sports or cosmetic purposes.

55. **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 Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

56. **Routine Physicals and Immunizations.**
Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, 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 Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law, or to immunizations required or recommended for travel to countries outside the United States.

57. **Sanctioned or Excluded Providers.**
Any service, 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. This exclusion does not apply to Emergency Care.

58. **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.

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

60. **Sterilization.**
Services to reverse an elective sterilization.

61. **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).

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

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

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

65. **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.

66. **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.

67. **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."

68. **Wilderness or other outdoor camps and/or programs.**
This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child 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:

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

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

3. **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.

4. **Compound Drugs.**
Compound Drugs unless all of the ingredients are FDA-approved in the form in which they are used in the Compound Drug and as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, 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.

5. **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).

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

7. **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.

8. **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/ca.

9. **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).

10. **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.

11. **Drugs Prescribed for Cosmetic Purposes.**

12. **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.

13. **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.

14. **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.

15. **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.

16. **Infertility Drugs.**
Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT).

17. **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 blood 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.

18. **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.

19. **Lost or Stolen Drugs.**
Refills of lost or stolen Drugs.

20. **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.

21. **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.

22. **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.

23. **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 Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

24. **Off Label Use.**
Off label use, unless we must cover the use by law or if we, or the PBM, approve it.

25. **Over-the-Counter Items.**
Drugs, devices and products, or Prescription Legend 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 Legend 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.

26. **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.

27. **Sexual Dysfunction Drugs.**
Drugs to treat sexual or erectile problems unless Medically Necessary or as stated in this Plan. Documentation of a confirmed diagnosis of erectile dysfunction must be submitted to us for review.

28. **Syringes.**
Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.

29. **Weight Loss Drugs.**
Any Drug mainly used for weight loss, except for the Medically Necessary treatment of morbid obesity.

Access help in your language

If you have any questions about this document, you have the right to help and information in your language at no cost. To talk to an interpreter, call **1-800-888-2108**.

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card. (TTY/TDD: 711)

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجاناً. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف (TTY/TDD: 711) الخاصة بك للمساعدة

Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Navajo

Bee n1 ahoot'i' t'11 ni nizaad k'ehj7 n7k1 a'doowo[t'11 j77k'e. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. (TTY/TDD: 711)

Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Tagalog

May karapatan kayong makakuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

It is important we treat you fairly

That is why we follow federal civil rights laws in our health programs and activities. We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language is not English, we offer free language assistance services through interpreters and other written languages. If you are interested in these services, call the Customer Service number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you have questions, call 1-800-888-2108 or visit us at www.anthem.com/studentadvantageca.

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