Your summary of benefits

Anthem® Blue Cross

California State University, Fresno

Your Network: Blue Card PPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This policy has exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent or contact us. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.

This benefit summary is not to be distributed without also providing access to the applicable Anthem enrollment brochure.

The deductible and copays will be waived and benefits will be paid at 100% for covered medical expenses incurred when treatment is rendered at the Student Health Center.

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. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	None	$250 student
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.*	$2,500 student	No maximum
Preventive Care / Screening / Immunization *In-Network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services **Primary Care Visit**	$20 copay per visit	$40 copay per visit, 50% coinsurance after deductible is met
Specialist Care Visit	$20 copay per visit	$40 copay per visit, 50% coinsurance after deductible is met
Prenatal and Post-natal Care	No charge	50% coinsurance after deductible is met

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Other Practitioner Visits:		
Retail Health Clinic	$20 copay per visit	$40 copay per visit, 50% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$20 copay per visit	$40 copay per visit, 50% coinsurance after deductible is met
Manipulation Therapy *Initial Coverage is limited to 50 visits per benefit period. Thereafter, Medical Necessity is required.*	No charge	50% coinsurance after deductible is met
Acupuncture	$20 copay per visit	50% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	No charge	50% coinsurance after deductible is met
Chemo/Radiation Therapy - PCP	No charge	50% coinsurance after deductible is met
Dialysis/Hemodialysis	$20 copay per visit	50% coinsurance after deductible is met
Prescription Drugs- *Dispensed in the office*	$20 copay per visit after deductible is met	50% coinsurance after deductible is met

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Diagnostic Services		
Lab:		
Office	No charge	50% coinsurance after deductible is met
Outpatient Hospital	No charge	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after deductible is met
X-Ray:		
Office	No charge	50% coinsurance after deductible is met
Outpatient Hospital	No charge	50% coinsurance after deductible is met
Advanced Diagnostic Imaging		
Office	No charge	50% coinsurance after deductible is met
Freestanding Radiology Center	No charge	50% coinsurance after deductible is met
Outpatient Hospital	No charge	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	$20 copay per visit	$40 copay per visit, 50% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$150 copay per visit after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance *Non-emergency non-network Ambulance Services are limited to $50,000 per occurrence*	10% coinsurance	Covered as In-Network

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Outpatient Mental / Behavioral Health and Substance Abuse		
Doctor Office Visit	No charge	50% coinsurance after deductible is met
Facility visit:	No charge	50% coinsurance after deductible is met
Facility Fees		
Doctor Services	No charge	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	No charge	50% coinsurance after deductible is met
Freestanding Surgical Center	No charge	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	No charge	50% coinsurance after deductible is met
Freestanding Surgical Center	No charge	50% coinsurance after deductible is met
Hospital Stay (Including Maternity, Mental/Behavioral Health, and Substance Abuse)		
Facility fees *Coverage for Inpatient Rehabilitation is limited to 30 days per year.*	No charge	50% coinsurance after deductible is met
Human Organ and Tissue Transplants	No charge	50% coinsurance after deductible is met
Doctor and other services	No charge	50% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Recovery & Rehabilitation **Home Health Care** *Coverage is limited to 100 visits per year combined with home health services.*	No charge	50% coinsurance after deductible is met
Rehabilitation services *Physical therapy and occupational therapy combined is limited to 30 visits per year. Coverage for speech therapy is limited to 20 visits per year.* Office Outpatient Hospital	 No charge No charge	 50% coinsurance after deductible is met 50% coinsurance after deductible is met
Habilitation services Physical therapy and occupational therapy combined is limited to 30 visits per year. Coverage for speech therapy is limited to 20 visits per year. Office Outpatient Hospital	 No charge No charge	 50% coinsurance after deductible is met 50% coinsurance after deductible is met
Cardiac rehabilitation *Cardiac rehabilitation: Limited to 36 visits per benefit period* Office Outpatient Hospital	 No charge No charge	 50% coinsurance after deductible is met 50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage is limited to 150 days combined per benefit period.*	No charge	50% coinsurance after deductible is met
Hospice	No charge	50% coinsurance after deductible is met
Durable Medical Equipment	No charge	50% coinsurance after deductible is met
Prosthetic Devices	No charge	50% coinsurance after deductible is met

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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	Combined with medical	Combined with medical
Prescription Drug Coverage *Pharmacy Network Name* *Traditional Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs. Home delivery is not covered out of network.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy 90 day supply (home delivery).*	50% coinsurance but will be no more than $250 per supply	Covered as In-Network
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	50% coinsurance but will be no more than $250 per supply	Covered as In-Network
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs *30 day supply (retail pharmacy). 90 day supply (home delivery).*	50% coinsurance but will be no more than $250 per supply	Covered as In-Network
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	50% coinsurance but will be no more than $250 per supply	Covered as In-Network

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Covered Vision 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 vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for student's choice of eyeglass lenses or contact lenses, but not both. 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 vision services count towards your out of pocket limit.*		
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	$0	$0
Vision exam *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.*	No charge	Covered as In-Network
Frames *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Covered as In-Network
Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Covered as In-Network
Elective contact lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Covered as In-Network
Non-Elective Contact Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Covered as In-Network
Adult Vision (age 19 and older) **Adult Vision Coverage** *Limited to certain vision screenings required by Federal law and covered under the "Preventive Care" benefit.*	See "Preventive Care" benefit	See "Preventive Care" benefit

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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 *Includes filling and simple extractions*	20% coinsurance	20% coinsurance
Major services/Prosthodontic	50% coinsurance	50% coinsurance
Endodontic, Periodontics, Oral Surgery	50% coinsurance	50% coinsurance
Medically Necessary Orthodontia	50% coinsurance	50% coinsurance
Deductible	Not applicable	Not applicable
Adult Dental	Not covered	Not covered

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- 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.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- Network Deductibles Preferred and In-Network commingle towards each other.
- All network covered services cost share for both Preferred and In-Network apply to the In-Network OOP.
- 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.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- Your copays, coinsurance and deductible count toward your out of pocket amount.

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's Not Covered

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.

- **Administrative Charges.**
  - Charges to complete claim forms,
  - Charges to get medical records or reports,
  - 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.
- **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.
- **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.
  - Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body.
  - 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,
  - Holistic medicine,
  - Homeopathic medicine,
  - Hypnosis,
  - Aroma therapy,
  - 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,
  - Reiki therapy,
  - Herbal, vitamin or dietary products or therapies,
  - Naturopathy,
  - Thermography,
  - Orthomolecular therapy,
  - Contact reflex analysis,
  - Bioenergial synchronization technique (BEST),
  - Iridology-study of the iris,
  - Auditory integration therapy (AIT),
  - Colonic irrigation,
  - Magnetic innervation therapy,
  - Electromagnetic therapy,
  - Neurofeedback / Biofeedback.
- **Autopsies.** Autopsies and post-mortem testing.
- **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.
- **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.
- **Charges Not Supported by Medical Records.** Charges for services not described in your medical records.
- **Charges Over the Maximum Allowed Amount.** Charges over the Maximum Allowed Amount for Covered Services.
- **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.
- **Clinically-Equivalent Alternatives.** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

  If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.
- **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.

- **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.
- **Court Ordered Testing.** Court ordered testing or care unless Medically Necessary.
- **Crime.** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if the services are Medically Necessary, your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
- **Custodial Care.** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
- **Delivery Charges.** Charges for delivery of Prescription Drugs.
- **Dental Devices for Snoring.** Oral appliances for snoring.
- **Dental Services**
  - 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).
  - Dental services not listed as covered in this Booklet.
  - 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.
  - Procedures which are not generally accepted standards of dental practice within the organized dental community in California.
  - 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).
  - Dental services completed prior to the date the Member became eligible for coverage or received after the coverage under this Plan has ended.
  - Analgesia, analgesia agents, medicines and Drugs for surgical or non-surgical care.
  - 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).
  - Dental services performed other than by a licensed dentist, licensed Physician, his or her employees.
  - Dental care services you received which you are not legally obligated to pay or dental care services you received that would be no charge to you in the absence of insurance.
  - 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.
  - 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.
  - 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.
  - Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (filling, crown) has not been placed.
  - Athletic mouth guards, enamel microabrasion and odontoplasty.
  - Bacteriologic tests.
  - Cytology sample collection.
  - Separate services billed when they are an inherent component of another Covered Service.
  - Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
  - Additional, elective or enhanced prosthodontic procedures including connector bars, stress breakers and precision attachments.
  - Provisional splinting, temporary procedures or interim stabilization.
  - Adjunctive diagnostic tests.
  - Cone beam images.
  - Anatomical crown exposure.
  - Temporary anchorage devices.
  - Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials, nor the procedures used to prepare and place materials in the canals (tooth roots).
  - Incomplete endodontic treatment and bleaching of discolored teeth.
  - The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
  - Services or supplies that are not Medically Necessary.
- **Dental Treatment.** Excluded treatment includes preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:
  - Removing, restoring, or replacing teeth;
  - Medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet);
  - Services to help dental clinical outcomes.

Dental treatment for injuries that are a result of biting or chewing is also excluded, unless the chewing or biting results from a medical or mental condition.

This Exclusion does not apply to services that we must cover by law.

- **Drugs Contrary to Approved Medical and Professional Standards.** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- **Drugs Over Quantity or Age Limits.** Drugs which are over any quantity or age limits set by the Plan.
- **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.
- **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, as determined by Anthem.
- **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 over-the-counter Drugs that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a Physician.
- **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.
- **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.
- **Eye Exercises.** Orthoptics and vision therapy.
- **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.
- **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.
- **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.
- **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:
  - Cleaning and soaking the feet.
  - Applying skin creams to care for skin tone.
  - Other services that are given when there is not an illness, injury or symptom involving the foot.
- **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.
- **Foot Surgery.** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- **Gene Therapy.** Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or are related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
- **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. 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.
- **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.
- **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, even if ordered by a Doctor. This Exclusion also applies to health spas.
- **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.

- **Home Care.**
  - 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.
  - 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.
- **Hospital Services Billed Separately.** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.
- **Hyperhidrosis Treatment.** Medical and surgical treatment of excessive sweating (hyperhidrosis).
- **Infertility Treatment.** Testing or treatment related to infertility.
- **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.
- **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.
- **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.

  This Exclusion does not apply to Medically Necessary preventive care services as specified in the "Preventive Care" provision in the section "What's Covered".
- **Lost or Stolen Drugs.** Refills of lost or stolen Drugs.
- **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.
- **Medical Equipment, Devices and Supplies.**
  - Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
  - Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
  - Non-Medically Necessary enhancements to standard equipment and devices.
  - 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.
  - 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.
- **Medicare.** For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for 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.
- **Missed or Cancelled Appointments.** Charges for missed or cancelled appointments.
- **Non-Approved Drugs.** Drugs not approved by the FDA.
- **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.
- **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.
- **Off Label Use.** Off label use, unless we must cover it by law or if we approve it.
- **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.
- **Personal Care, Convenience and Mobile/Wearable Devices.**
  - 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.
  - 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).
  - Home workout or therapy equipment, including treadmills and home gyms.
  - Pools, whirlpools, spas, or hydrotherapy equipment.
  - Hypo-allergenic pillows, mattresses, or waterbeds.

  - Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
  - Consumer wearable / personal mobile devices such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

- **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.
- **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.
- **Prosthetics.** Prosthetics for sports or cosmetic purposes.
- **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:
  - 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.
  - 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.
  - 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.
- **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 Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.
- **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.
- **Services Received Outside of the United States.** Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care and Emergency Ambulance.
- **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.
- **Sexual Dysfunction.** Services or supplies for male or female sexual problems.
- **Sports, Contest, or Competition.** Injury sustained while:
  - Participating in any intercollegiate or professional sport, contest or competition.
  - Traveling to or from such sport, contest or competition as a participant.
  - Participating in any practice or conditioning program for such sport, contest or competition.
- **Stand-By Charges.** Stand-by charges of a Doctor or other Provider.
- **Sterilization.** Services to reverse an elective sterilization.
- **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).
- **Temporomandibular Joint Treatment.** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- **Travel Costs.** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
- **Vein Treatment.** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- **Vision Services.**
  - Vision care for Members age 19 and older, unless covered by the medical benefits of this Plan.
  - Safety glasses and accompanying frames.
  - Two pairs of glasses in lieu of bifocals.
  - Plano lenses (lenses that have no refractive power)

- Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
- Vision services or supplies not specifically listed as covered in this Booklet.
- Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed in this Booklet.
- Blended lenses.
- Oversize lenses.
- Sunglasses.
- 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.
- For Members through age 18, no benefit is available for frames or contact lenses purchased outside of our formulary.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.

- **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.
- **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."
- **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:

- **Administration Charges.** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
- **Charges Not Supported by Medical Records.** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
- **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.
- **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.
- **Contrary to Approved Medical and Professional Standards.** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- **Delivery Charges.** Charges for delivery of Prescription Drugs.
- **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.
- **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.
- **Drugs Over Quantity or Age Limits.** Drugs which are over any quantity or age limits set by the Plan.
- **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.
- **Drugs Prescribed for Cosmetic Purposes.**
- **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, as determined by Anthem.

- **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 over-the-counter Drugs that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a Physician.
- **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.
- **Gene Therapy.** Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
- **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.
- **Hyperhidrosis Treatment.** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
- **Infertility Drugs.** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT).
- **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.
- **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.
- **Lost or Stolen Drugs.** Refills of lost or stolen Drugs.
- **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.
- **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.
- **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.
- **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.
- **Off Label Use.** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.
- **Onychomycosis Drugs.** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
- **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.
- **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.
- **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.
- **Syringes.** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- **Weight Loss Drugs.** Any Drug mainly used for weight loss, except for the Medically Necessary treatment of morbid obesity.

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (844) 241-7085

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 (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (844) 241-7085 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (844) 241-7085:

Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(844) 241-7085。

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (844) 241-7085 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (844) 241-7085.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (844) 241-7085.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (844) 241-7085.

Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、(844) 241-7085 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(844) 241-7085로 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h íłínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (844) 241-7085.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (844) 241-7085.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (844) 241-7085 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (844) 241-7085.

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Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (844) 241-7085.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (844) 241-7085.

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