Certificate of Coverage

(Referred to as “Booklet” in the following pages)

Anthem Student Advantage
Anthem CA SHP Prudent Buyer Plan

Santa Monica College Student Health Plan

08-25-2021

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece en el reverso de su Tarjeta de Identificación.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Member Services at the number on the back of your Identification Card.

Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health)

21215 Burbank Blvd
Woodland Hills, California 91367

NOTE: If you are 65 years or older at the time your Booklet is issued, you may examine your Booklet and, within 30 days, decide to cancel and request a refund of premiums paid.

Federal Patient Protection and Affordable Care Act Notices

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need prior authorization from us or from any other person (including a primary care physician, or PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com.

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

Health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

If the mother or newborn is discharged early, benefits include a post-discharge follow-up visit within 48 hours of the discharge, when prescribed by the treating Provider. This visit shall include, at a minimum, parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal or neonatal physical assessments.

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call us at the number on the back of your Identification Card.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse is required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Policyholder to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren), if children are eligible under the Plan.

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act requires that the financial requirements and treatment limitations imposed on mental health and substance use disorder (MH/SUD) benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits in the same classification or sub-classification.

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance use disorder benefits with day or visit limits on medical and surgical benefits. In general, health plans offering mental health and substance use disorder benefits cannot set day/visit limits on mental health or substance use disorder benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose

day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance use disorder benefits offered under the Plan.

The Mental Health Parity and Addiction Equity Act also provides for parity in the application of nonquantitative treatment limitations (NQTL). An example of a nonquantitative treatment limitation is a precertification requirement.

Medical Necessity criteria and other plan documents showing comparative criteria, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL are available upon request.

See the “Schedule of Benefits” and “What’s Covered” sections for cost share and benefit information.

Notices Required by State Law

Some Hospitals and other Providers do not provide one or more of the following services that may be covered under your Plan Contract and that you or your Dependent might need:

- **Family planning;**
- **Contraceptive services, including Emergency contraception;**
- **Sterilization, including tubal ligation at the time of labor and delivery;**
- **Infertility treatments; or**
- **Abortion.**

You should obtain more information before you enroll. Call your prospective Doctor, Medical Group, independent practice association, or clinic, or call Member Services toll free at the telephone number on the back of your Identification Card to ensure that you can obtain the health care services that you need.

Notice of Non-Discrimination

Anthem Blue Cross Life and Health does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

For information on how to file a complaint, please see “Grievance And External Review Procedures.” To file a discrimination complaint, please see “Getting Help In Your Language” at the end of this Booklet.

COMPLAINT NOTICE

Should you have any complaints or questions regarding your coverage or about your health care provider, including your ability to access needed health care in a timely manner, and this Booklet was delivered by a broker, you may first contact the broker. You may also contact us at:

Anthem Blue Cross Life and Health Life and Health Insurance Company
Member Services
21215 Burbank Blvd.
Woodland Hills, CA 91367

818-234-2700

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

California Department of Insurance
Consumer Services Division, 11th Floor
300 South Spring Street
Los Angeles, California 90013

1-800-927-HELP (4357) – In California

1-213-897-8921 – Out of California

1-800-482-4833 – Telecommunication Device for the Deaf

E-mail Inquiry: "Consumer Services" link at
www.insurance.ca.gov

Timely Access to Care

Anthem has contracted with health care service Providers to provide Covered Services in a manner appropriate for your condition, consistent with good professional practice. Anthem ensures that its contracted Provider networks have the capacity and availability to offer appointments within the following timeframes:

For Medical care:

- **Urgent Care appointments for services that do not require prior authorization:** within forty-eight (48) hours of the request for an appointment;
- **Urgent Care appointments for services that require prior authorization:** within ninety-six (96) hours of the request for an appointment;
- **Non-Urgent appointments for primary care:** within ten (10) business days of the request for an appointment;
- **Non-Urgent appointments with Specialists:** within fifteen (15) business days of the request for an appointment;
- **Appointments for ancillary services (diagnosis or treatment of an injury, illness or other health condition) that are not urgent care:** within fifteen (15) business days of the request for an appointment.

For Mental Health and Substance Use Disorder care:

- **Urgent Care appointments for services that do not require prior authorization:** within forty-eight (48) hours of the request for an appointment;
- **Urgent Care appointments for services that require prior authorization:** within ninety-six (96) hours of the request for an appointment;
- **Non-Urgent appointments with mental health and substance use disorder providers who are not psychiatrists:** within ten (10) business days of the request for an appointment;
- **Non-Urgent appointments with mental health and substance use disorder providers who are psychiatrists:** within fifteen (15) business days of the request for an appointment. Due to accreditation standards, the date will be ten (10) business days for the initial appointment only.

If a health care Provider determines that the waiting time for an appointment can be extended without a detrimental impact on your health, the Provider may schedule an appointment for a later time than noted above.

Anthem arranges for telephone triage or screening services for you twenty-four (24) hours per day, seven (7) days per week with a waiting time of no more than thirty (30) minutes. If Anthem contracts with a health care service Provider for telephone triage or screening services, the Provider will utilize a telephone answering machine and/or an answering service and/or office staff, during and after business hours, to inform you of the wait time for a return call from the Provider or how the Member may obtain Urgent or Emergency Care or how to contact another Provider who is on-call for telephone triage or screening services.

For Vision care:

- **Urgent Care appointments:** within seventy-two (72) hours of the request for an appointment;
- **Non-Urgent appointments:** within thirty-six (36) business days of the request for an appointment;
- **Preventive vision care appointments:** within forty (40) business days of the request for an appointment;
- **After-hours care (when a vision provider's office is closed):** In-Network Providers are required to have an answering service or a telephone answering machine during non-business hours, which will provide instructions on how you can obtain Urgent or Emergency Care including, when applicable, how to contact another vision provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver Urgent or Emergency Care;
- **Question for Anthem's Member Services by telephone on how to get care or solve a problem:** ten (10) minutes to reach a live person by phone during normal business hours.

For Dental care:
Anthem has contracted with In-Network dentists to provide Covered Services in a manner appropriate for your condition, consistent with good professional practice. Anthem ensures that its network of In-Network dentists has the capacity and availability to offer appointments within the following timeframes:

- **Urgent Care appointments:** within seventy-two (72) hours of the request for an appointment;
- **Non-Urgent appointments for primary care:** within thirty-six (36) business days of the request for an appointment; and
- **Preventive dental care appointments:** within forty (40) business days of the request for an appointment.

If an In-Network dentist determines that the waiting time for an appointment can be extended without a detrimental impact on your health, the In-Network dentist may schedule an appointment for a later time than noted above.

In-Network dentists are required to have an answering service or a telephone answering machine during non-business hours, which will provide instructions on how you can obtain Urgent or Emergency Care including, when applicable, how to contact another dentist who has agreed to be on-call to triage or screen by phone, or if needed, deliver Urgent or Emergency Care.

For Medical, Vision and Dental care:
If you need the services of an interpreter, the services will be coordinated with scheduled appointments and will not result in a delay of an In-Network appointment.

Introduction

Welcome to Anthem!

We are pleased that you have become a Member of our health benefit Plan. We want to make sure that our services are easy to use. We've designed this Booklet to give a clear description of your benefits, as well as our rules and procedures.

The Booklet explains many of the rights and duties between you and us. It also describes how to get health care, what services are covered, and what part of the costs you will need to pay. Many parts of this Booklet are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. You should read the whole Booklet to know the terms of your coverage. **This Booklet constitutes only a summary of the health Plan. The Blanket Contract (Contract) must be consulted to determine the exact terms and conditions of coverage.**

Please read this Booklet completely and carefully. Individuals with special health care needs should carefully read those sections that apply to them. YOU HAVE THE RIGHT TO VIEW THE BOOKLET PRIOR TO ENROLLMENT.

Your University has agreed to be subject to the terms and conditions of Anthem's Provider agreements which may include pre-service review and utilization management requirements, coordination of benefits, timely filing limits, and other requirements to administer the benefits under this Plan.

This Booklet replaces any Booklet issued to you in the past. The coverage described is based upon the terms of the Contract issued to your University, and the Plan that your University chose for you. The Contract, this Booklet, and any endorsements, amendments or riders attached, form the entire legal Contract under which Covered Services are available.

Many words used in the Booklet have special meanings (e.g., Policyholder, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Blue Cross Life and Health. The words "you" and "your" mean the Member, Student and each covered Dependent if they are eligible under this Plan.

If you have any questions about your Plan, please be sure to call Member Services at the number on the back of your Identification Card. Also be sure to check our website, www.anthem.com for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

Student Health Center (SHC)

The University may offer a separate program which allows you to receive services through a Student Health Center (SHC). Check with your University to learn more. If the University offers such a program, the Student should use the services of the Student Health Center (SHC) first where outpatient/physician treatment will be administered or any required Referral issued.

How to Get Language Assistance

Anthem introduced its Language Assistance Program to provide certain written translation and oral interpretation services to California Members with limited English proficiency.

The Language Assistance Program makes it possible for you to access oral interpretation services and certain written materials vital to understanding your health coverage at no additional cost to you and in a timely manner.

Written materials available for translation include Grievance and appeal letters, consent forms, claim denial letters, and explanations of benefits. These materials are available in the top 15 languages as determined by state law.

Oral interpretation services are also available in these languages.

In addition, appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats are also available, free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity for individuals with disabilities to effectively communicate with us.

Requesting a written or oral translation is easy. Just contact Member Services by calling the phone number on your Identification Card to update your language preference to receive future translated documents or to request interpretation assistance. Anthem also sends/receives TDD/TTY messages at (866) 333-4823 or by using the National Relay Service through 711. A special operator will get in touch with us to help with your needs. For more information about the Language Assistance Program visit www.anthem.com.

Identity Protection Services

Identity protection services are available with our Anthem health plans. To learn more about these services, please visit https://anthemcares.allclearid.com/.

Table of Contents

Schedule of Benefits

A Platinum Plan
Actuarial Value OPT: 87.46%
Actuarial Value: 88.92%

In this section you will find a Schedule of Benefits that sets forth a summary of common benefits available under your Plan. The Schedule of Benefits does not list all benefits available under your Plan or their cost shares, or explain benefits, exclusions, limitations, cost shares, Deductibles or out of pocket limits. For a complete explanation, you should read the whole Booklet to know the terms of your coverage because many parts of this Booklet are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. Please read the "What's Covered" and Prescription Drugs section(s) for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services must be Medically Necessary and are subject to the conditions, exclusions, limitations, and terms of this Booklet including any endorsements, amendments, or riders.

IMPORTANT NOTE: Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. **When you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details.**

Certain services require precertification. In-Network Providers will initiate the review on your behalf. An Out-of-Network Provider may or may not initiate the review for you. In both cases, it is your responsibility to initiate the process and ask your Physician to request prior authorization. You may also call us directly. Please see "Getting Approval for Benefits" for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges. Cost sharing for services with Copayments is the lesser of the Copayment amount or the Maximum Allowed Amount.

If you have a question about your condition or about a plan of treatment which your Physician has recommended, you may receive a second medical opinion from another Physician. This second opinion visit will be provided according to the benefits, limitations, and exclusions of this Plan. If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose an In-Network Provider. You may also ask your Physician to refer you to an In-Network Provider to receive a second opinion.

Benefit Period:	Plan Year
Dependent Age Limit:	To the end of the month in which the child attains age 26. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

Deductible	In-Network	Out-of-Network
Optional Practical Training (OPT) Students only – Per Member	$250	$250
Non-OPT: Per Member	$50	$50

The In-Network and Out-of-Network Deductibles are combined. Amounts you pay toward the In-Network Deductible will apply toward the Out-of-Network Deductible and amounts you pay toward the Out-of-Network Deductible will apply toward the In-Network Deductible.

When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies.

Copayments and Coinsurance are separate from and do not apply to the Deductible.

Coinsurance	In-Network	Out-of-Network
Plan Pays	100%	70%
Member Pays	0%	30%

Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. If you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount.

Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.

Out-of-Pocket Limit	In-Network	Out-of-Network
Per Member	$5,000	None
Per Family – All Members combined	$10,000	None

Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member must contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.

The Out-of-Pocket Limit includes all Deductibles, Coinsurance and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include amounts you pay for the following which are always your responsibility:

- Expense which is in excess of the Maximum Allowed Amount for all covered services.
- Amounts you pay for non-covered services.

Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance or Copayments for the rest of the Benefit Period, except for the charges listed above.

The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.

Important Notice about Your Cost Shares

In certain cases, if we pay a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

When you receive Emergency services (except certain ambulance services) from an Out-of-Network Provider within California, you will not be responsible for amounts in excess of the Maximum Allowed Amount.

The tables below outline common Covered Services and the cost shares you must pay. The table does not list all Covered Services available under your Plan, nor does it list within each Covered Service all settings where that service may be received. If a benefit is available in another setting you may determine the applicable cost shares you must pay by referring to that setting. For example, you might get physical therapy in a Doctor's office, an outpatient Hospital Facility, or during an inpatient Hospital stay. For services in the office, look up "Office Visits." For services in the outpatient department of a Hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services." For services involving mental health, substance use disorder, or behavioral health treatment for autism spectrum disorders, look up "Mental Health and Substance Use Disorder (Chemical Dependency) Services."

Benefits	**In-Network**	**Out-of-Network**
Acupuncture	See "Therapy Services" in the "Office Visits" and "Outpatient Facility Services" provisions for details.	
Ambulance Services (Ground, Air and Water) in an Emergency	0% Coinsurance after Deductible	
Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount; however, Out-of-Network air ambulance Providers may not bill you for any charges over the Plan's Maximum Allowed Amount.		
Ambulance Services (Ground and Water only) in a non-Emergency	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Important Notes: • All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through Precertification. Please see "Getting Approval for Benefits" for details. • Out-of-Network Providers may bill you for any charges over the Plan's Maximum Allowed Amount.		
Ambulance Services (Air only) in a non-Emergency	0% Coinsurance after Deductible	
Important Notes: • When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select no benefits will be available. • Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through Precertification. Please see "Getting Approval for Benefits" for details. • Out-of-Network air ambulance Providers may not bill you for any charges over the Plan's Maximum Allowed Amount.		

Benefits	In-Network	Out-of-Network
Autism Spectrum Disorders Services	Benefits are based on the setting in which Covered Services are received. Please see the section titled "Mental Health and Substance Use Disorder (Chemical Dependency) Services" to determine your cost share.	
Bariatric surgery is covered only when performed at a designated Hospital Precertification required. Please see "Getting Approval for Benefits" for more details.		
• Inpatient Services (designated Hospital)	$75 Copayment per admission plus No Deductible	Not covered
• Outpatient Facility Services (designated Hospital)	0% Coinsurance after Deductible	Not covered
• Travel expense For an approved, specified bariatric surgery, performed at a designated Hospital that is fifty (50) miles or more from the Member's place of residence, the following travel expenses incurred by the Member and/or one companion are covered: – Transportation for the Member and/or one companion to and from the designated Hospital. – Lodging, limited to one room, double occupancy. – Other reasonable expenses. Meals, tobacco, alcohol and drug expenses are excluded from coverage.	No Deductible, Copayment, or Coinsurance Covered as approved by us, up to $3,000 per surgery	
Clinical Trails	Benefits are based on the setting in which Covered Services are received.	
Dental Services For Members Up to Age 19 **Note**: Pediatric dental services are covered for members until the end of the month in which they turn 19. To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at the number on the back of your ID card. **Note**: Pediatric dental services are not subject to any Deductible amounts shown in the "Deductible" section at the beginning of this "Schedule of Benefits." Out-of-network providers may bill you for any charges that exceed the plan's Maximum Allowed Amount.		
• Diagnostic and Preventive Services	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance

Benefits	In-Network	Out-of-Network
• Basic Restorative Services	20% Coinsurance	20% Coinsurance
• Endodontic Services	50% Coinsurance	50% Coinsurance
• Periodontal Services	50% Coinsurance	50% Coinsurance
• Oral Surgery Services	50% Coinsurance	50% Coinsurance
• Major Restorative Services	50% Coinsurance	50% Coinsurance
• Prosthodontic Services	50% Coinsurance	50% Coinsurance
• Dentally Necessary Orthodontic Care	50% Coinsurance	50% Coinsurance
Dental Services (All Members/All Ages) Services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and for transplants, and for the treatment of accidental injuries.	Benefits are based on the setting in which Covered Services are received.	
Diabetes Equipment, Education, and Supplies Screenings for gestational diabetes, Type 2 Diabetes Mellitus, and Diabetes Mellitus after pregnancy for those with a history of gestational Diabetes Mellitus, are covered under "Preventive Care."	Benefits are based on the setting in which Covered Services are received.	
Diagnostic Services Services include diagnostic x-ray and lab services, EKGs, advanced imaging. Precertification required. Please see "Getting Approval for Benefits" for more details.	Benefits are based on the setting in which Covered Services are received.	
Durable Medical Equipment (DME), Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies (Received from a Supplier)		
• Durable Medical Equipment (DME), Medical Devices, Medical and Surgical Supplies	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Prosthetics	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Orthotics	0% Coinsurance after Deductible	30% Coinsurance after Deductible
The cost shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received.		

Benefits	In-Network	Out-of-Network
Emergency Room Services		
Emergency Room		
• Emergency Room Facility Charge	$50 Copayment per visit then 0% Coinsurance after Deductible Copayment waived if admitted	
• Emergency Room Doctor Charge (ER Physician, Radiologist, Anesthesiologist, Surgeon, etc.)	0% Coinsurance after Deductible	
• Emergency Room Doctor Charge (Mental Health / Substance Use Disorder)	0% Coinsurance after Deductible	
• Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	0% Coinsurance after Deductible	
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	0% Coinsurance after Deductible	
Out-of-Network Providers may bill you for any charges over the Plan's Maximum Allowed Amount.		
Gene Therapy Services Precertification required. Please see "Getting Approval for Benefits" for more details.	Benefits are based on the setting in which Covered Services are received.	
Habilitative Services	Benefits are based on the setting in which Covered Services are received. See "Office Visits" and "Outpatient Facility Services" for details.	
Home Care Precertification required. Please see "Getting Approval for Benefits" for more details.		
• Home Care Visits	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Home Care Benefit Maximum	Coverage is limited to 100 visits per Benefit Period. This limit applies separately to rehabilitative services and habilitative services. A visit of four hours or less by a home health aide shall be considered as one home health visit. The limit does not apply to Home Infusion Therapy or Home Dialysis.	
• Home Dialysis	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Home Infusion Therapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Specialty Prescription Drugs	0% Coinsurance after Deductible	30% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Other Home Care Services / Supplies	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Hospice Care Precertification required. Please see "Getting Approval for Benefits" for more details.		
• Home Hospice Care	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Bereavement	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Inpatient Hospice	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Outpatient Hospice	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Respite Care	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount.		
This Plan's Hospice benefit will meet or exceed Medicare's Hospice benefit.		
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	
Inpatient Services Precertification is required, except for Emergency admissions and inpatient Hospital stays for the delivery of a child or mastectomy surgery, including the length of Hospital stays associated with mastectomy and/or breast reconstruction surgery for breast cancer. Please see "Getting Approval for Benefits" for more details.		
Facility Room & Board Charge:		
• Hospital / Acute Care Facility	$75 Copayment per admission No Deductible	$75 Copayment per admission plus 30% Coinsurance after Deductible
• Rehabilitation	$75 Copayment per admission No Deductible	$75 Copayment per admission plus 30% Coinsurance after Deductible
• Ancillary Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Skilled Nursing Facility	$25 Copayment per admission plus 0% Coinsurance after Deductible	30% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Skilled Nursing Facility Benefit Maximum	150 days per Benefit Period In and Out-of-Network combined	
Hospital Transfers: If you are transferred between Facilities, only one Copayment will apply. You will not have to pay separate Copayments per Facility.		
Hospital Readmissions: If you are readmitted to the Hospital within 72 hours of your discharge for the same medical diagnosis, you will not have to pay an additional Copayment upon readmission.		
Doctor Services when billed separately from the Facility:		
• General Medical Care / Evaluation and Management (E&M)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Surgery	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Maternity	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Maternity and Reproductive Health Services (includes maternity and abortion services)		
• Global fee for the OB-Gyn's services, including the delivery	Benefits are based on the setting in which Covered Services are received.	
• Routine Prenatal and Postpartum Office Visits For services other than routine Prenatal and Postpartum Office Visits, please see that setting for your Copayment / Coinsurance.	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible
• Inpatient Services (Delivery)	See "Inpatient Services"	
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Mental Health and Substance Use Disorder (Chemical Dependency) Services (includes Transgender Services, and behavioral health treatment for autism spectrum disorders) Precertification required for Inpatient Services. Please see "Getting Approval for Benefits" for more details.		
Inpatient Mental Health / Substance Use Disorder Services:		
• Inpatient psychiatric hospitalization	$75 Copayment per admission No Deductible	$75 Copayment per admission plus 30% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Psychiatric observation for a psychiatric crisis	$75 Copayment per admission No Deductible	$75 Copayment per admission plus 30% Coinsurance after Deductible
• Detoxification	$75 Copayment per admission No Deductible	$75 Copayment per admission plus 30% Coinsurance after Deductible
• Residential Treatment Center	$75 Copayment per admission No Deductible	$75 Copayment per admission plus 30% Coinsurance after Deductible
• Transitional residential recovery services	$75 Copayment per admission No Deductible	$75 Copayment per admission plus 30% Coinsurance after Deductible
• Inpatient Mental Health / Substance Use Disorder Provider Services (e.g., Doctor and other professional Providers)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Inpatient facility services for transgender services	$75 Copayment per admission No Deductible	$75 Copayment per admission plus 30% Coinsurance after Deductible
Hospital Transfers: If you are transferred between Facilities, only one Copayment will apply. You will not have to pay separate Copayments per Facility.		
Hospital Readmissions: If you are readmitted to the Hospital within 72 hours of your discharge for the same medical diagnosis, you will not have to pay an additional Copayment upon readmission.		
Other Outpatient Mental Health / Substance Use Disorder Items and Services:		
• Partial Hospitalization Program (PHP) / Intensive Outpatient Program (IOP) (Facility)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Partial Hospitalization Program (PHP) / Intensive Outpatient Program (IOP) (professional)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Behavioral health treatment for autism spectrum disorders delivered in the home	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Durable Medical Equipment	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Outpatient psychological testing	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Outpatient substance use disorder day treatment programs	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Multidisciplinary treatment in an intensive outpatient psychiatric treatment program	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Electroconvulsive therapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Transcranial magnetic stimulation and esketamine for treatment-resistant depression	0% Coinsurance after Deductible	30% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Facility surgery for transgender services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Other Facility surgery charges for transgender services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Doctor surgery services for transgender services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Hormone therapy for transgender services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Speech therapy for transgender services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Mental Health / Substance Use Disorder Office Visits	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Individual / group mental health evaluation and treatment • Individual / group chemical dependency counseling • Services to monitor drug therapy • Medical treatment for withdrawal symptoms • Intensive In-Home Behavioral Health Programs • Methadone maintenance treatment • Behavioral health treatment for autism spectrum disorders delivered in an office setting • Nutritional Counseling for Eating Disorders • Office visits for transgender services • Hormone therapy for transgender services • Speech therapy for transgender services		
Travel expense for Transgender Services	No Deductible, Copayment, or Coinsurance Covered as approved by us, up to $10,000 per surgery or series of surgeries	
For an approved transgender surgery, the following travel expenses incurred by the Member and/or one companion are covered:	– Ground transportation for the Member and/or one companion to and from the Hospital when it is 75 miles or more from the Member's place of residence. – Coach airfare to and from the Hospital when it is 300 miles or more from the Member's place of residence. – Lodging, limited to one room, double occupancy. – Other reasonable expenses. Meals, tobacco, alcohol and drug expenses are excluded from coverage.	

Please see the following sections under the What's Covered section for a listing of covered services:

- "Autism Spectrum Disorder Services";
- "Mental Health and Substance Use Disorder (Chemical Dependency) Services";
- "Transgender Services".

Mental Health and Substance Use Disorder Services / chemical dependency will be covered as required by state and federal law. Please see "Mental Health Parity and Addiction Equity Act" in the "Additional Federal Notices" section for details.

Benefits	In-Network	Out-of-Network
Office Visits		
Important Note on Office Visits at an Outpatient Facility: If you have an office visit with your PCP or SCP at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under the "Outpatient Facility Services" section later in this Schedule. Please refer to that section for details on the cost shares (e.g., Deductibles, Copayments, Coinsurance) that will apply.		
• Primary Care Physician / Provider (PCP) (Includes non-routine OB-Gyn)	$25 Copayment per visit No Deductible	30% Coinsurance after Deductible
• Specialty Care Physician / Provider (SCP) (Including SCP Online Visits)	$25 Copayment per visit No Deductible	30% Coinsurance after Deductible
• Retail Health Clinic Visit	$25 Copayment per visit No Deductible	30% Coinsurance after Deductible
• Virtual Visits from our Online Provider LiveHealth Online (whether accessed directly or through our mobile app) – Includes Mental Health & Substance Use Disorder Virtual Visits	$25 Copayment per visit No Deductible	Not covered
• Other Online Visits (Including Primary Care and Mental Health & Substance Use Disorder Services)	$25 Copayment per visit No Deductible	30% Coinsurance after Deductible
Additional Services in an Office Setting In addition to the applicable Office Visit Copayment listed above, if you receive any services listed below that have a Coinsurance cost share, the cost share for those services will also apply.		
• Counseling – Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders)	$25 Copayment per visit No Deductible	30% Coinsurance after Deductible
• Allergy Testing	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Diagnostic Labs (other than reference labs)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Diagnostic X-ray	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Other Diagnostic Tests (including hearing and EKG)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Office Surgery (including anesthesia)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Therapy Services:		
– Chiropractic / Osteopathic / Manipulative Therapy	$25 Copayment per visit No Deductible	30% Coinsurance after Deductible
– Chiropractic / Osteopathic / Manipulative Therapy Benefit Maximum	Benefit maximum of 26 visits per Benefit Period, office and outpatient facility visits combined	

Benefits	In-Network	Out-of-Network
– Acupuncture	$25 Copayment per visit No Deductible	30% Coinsurance after Deductible
– Physical Therapy	$25 Copayment per visit after Deductible	30% Coinsurance after Deductible
– Speech Therapy	$25 Copayment per visit after Deductible	30% Coinsurance after Deductible
– Occupational Therapy	$25 Copayment per visit after Deductible	30% Coinsurance after Deductible
– Cardiac Rehabilitation	$25 Copayment per visit after Deductible	30% Coinsurance after Deductible
– Pulmonary Therapy	$25 Copayment per visit after Deductible	30% Coinsurance after Deductible
– Dialysis	$25 Copayment per visit after Deductible	30% Coinsurance after Deductible
– Radiation / Chemotherapy / Respiratory Therapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Prescription Drugs Administered in the Office (includes allergy serum)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Orthotics	See “Durable Medical Equipment (DME), Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies”.	
Other Eligible Providers	Not applicable	20% Coinsurance after Deductible plus all charges in excess of the Maximum Allowed Amount
Nurse anesthetists and blood banks do not enter into participating agreements with us. These Providers must be licensed according to state and local laws to provide covered medical services.		
Outpatient Facility Services Precertification required. Please see “Getting Approval for Benefits” for more details.		
• Facility Surgery Charges	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Facility Surgery Lab	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Facility Surgery X-ray	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Ancillary Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Doctor Surgery Charges	0% Coinsurance after Deductible	30% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Other Facility Charges (for procedure rooms)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Additional Services in an Outpatient Facility Setting If you receive only one or more of the services listed below, you will be responsible only for the cost shares for those services. You will not in addition have to pay the Facility charge.		
• Diagnostic Lab (non-preventive)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Diagnostic X-ray (non-preventive)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Other Diagnostic Tests (EKG, EEG, etc.)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Therapy Services:		
– Chiropractic / Osteopathic / Manipulative Therapy	$25 Copayment per visit No Deductible	30% Coinsurance after Deductible
– Chiropractic / Osteopathic / Manipulative Therapy Benefit Maximum	Benefit maximum of 26 visits per Benefit Period, office and outpatient facility visits combined	
– Acupuncture	$25 Copayment per visit No Deductible	30% Coinsurance after Deductible
– Physical Therapy	$25 Copayment per visit after Deductible	30% Coinsurance after Deductible
– Speech Therapy	$25 Copayment per visit after Deductible	30% Coinsurance after Deductible
– Occupational Therapy	$25 Copayment per visit after Deductible	30% Coinsurance after Deductible
– Cardiac Rehabilitation	$25 Copayment per visit after Deductible	30% Coinsurance after Deductible
– Pulmonary Therapy	$25 Copayment per visit after Deductible	30% Coinsurance after Deductible
– Dialysis	$25 Copayment per visit after Deductible	30% Coinsurance after Deductible
– Radiation / Chemotherapy / Respiratory Therapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Prescription Drugs Administered in an Outpatient Facility	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Preventive Care	No Copayment, Deductible, or Coinsurance	30% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Prosthetics	See “Prosthetics” under “Durable Medical Equipment (DME), Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies.”	
Rehabilitative Services	Benefits are based on the setting in which Covered Services are received. See “Office Visits” and “Outpatient Facility Services” for details.	
Skilled Nursing Facility	See “Inpatient Services”	
Sterilization Procedures for Men	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Surgery	Benefits are based on the setting in which Covered Services are received.	
Telehealth	$25 Copayment per visit No Deductible	30% Coinsurance after Deductible
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Transplant	See “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services” later in this section.	
Urgent Care Services (Office Visits)	$25 Copayment per visit plus 0% Coinsurance after Deductible	$25 Copayment per visit plus 30% Coinsurance after Deductible
If you get urgent care at a Hospital or other outpatient Facility, please refer to “Outpatient Facility Services” for details on what you will pay.		

Benefits	In-Network	Out-of-Network
Vision Services For Members Up to Age 19		
Note: Pediatric vision services are covered for members until the end of the month in which they turn age 19. To receive the In-Network benefit, you must use a Blue View Vision provider. Visit our website or call the number on your ID card for help with finding a Blue View Vision provider.		
Note: Pediatric vision services are not subject to any Deductible amounts shown in the "Deductible" section at the beginning of this "Schedule of Benefits." Out-of-network providers may bill you for any charges that exceed the plan's Maximum Allowed Amount.		
• Routine Eye Exam Limited to one exam per Benefit Period per Member	$0 Copayment	$0 Copayment
• Standard Plastic or Glass Lenses Limited to one set of lenses per Benefit Period per Member		
Single Vision	$0 Copayment	$0 Copayment
Bifocal	$0 Copayment	$0 Copayment
Trifocal	$0 Copayment	$0 Copayment
Standard Progressive	$0 Copayment	$0 Copayment
Lenticular	$0 Copayment	$0 Copayment
Additional Lens Options: Covered lenses include factory scratch coating, UV coating, standard polycarbonate and standard photochromic at no additional cost when received from In-Network providers.		
• Frames Limited to one frame from the Anthem Formulary per Benefit Period per Member	$0 Copayment	$0 Copayment
• Contact Lenses Elective or non-elective contact lenses from the Anthem formulary are covered once per Benefit Period per Member		
Elective Contact Lenses (Conventional or Disposable)	$0 Copayment	$0 Copayment
Non-Elective Contact Lenses	$0 Copayment	$0 Copayment
Important Note: Benefits for contact lenses are in lieu of your eyeglass lens benefit. If you receive contact lenses, no benefit will be available for eyeglass lenses until the next Benefit Period.		

Benefits	In-Network	Out-of-Network
• Comprehensive low vision exam Limited to one every five Benefit Periods	$0 Copayment	Not covered
• Low vision follow-up visits Limited to up to four visits in any five Benefit Periods	$0 Copayment	Not covered
• Optical/non-optical aids Limited to one occurrence per Benefit Period.	$0 Copayment	Not covered
• Supplemental testing Limited to one occurrence per Benefit Period.	$0 Copayment	Not covered
Vision Services (for medical and surgical treatment of injuries and/or diseases of the eye). Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.	Benefits are based on the setting in which Covered Services are received.	

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Please call our Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from an In-Network Transplant Provider. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

The requirements described below do not apply to the following:

- Cornea transplants, which are covered as any other surgery; and
- Any Covered Services related to a Covered Transplant Procedure that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the collection and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received. Please see the "What's Covered" section for additional details.

Benefits	In-Network	Out-of-Network
Transplant Benefit Period	**In-Network Transplant Provider**	**Out-of-Network Transplant Provider**
	Starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	Starts one day before a Covered Transplant Procedure and continues to the date of discharge at an Out-of-Network Transplant Provider Facility.
Covered Transplant Procedure during the Transplant Benefit Period	**In-Network Transplant Provider Facility**	**Out-of-Network Transplant Provider Facility**
• **Precertification required**	During the Transplant Benefit Period, you will pay 0% Coinsurance after Deductible Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, or Office Visits depending upon where the service is performed.	Not covered
Covered Transplant Procedure during the Transplant Benefit Period	**In-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers**	**Out-of-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers**
	0% Coinsurance after Deductible	Not covered
Transportation and Lodging	No Deductible, Copayment, or Coinsurance Covered, as approved by us, up to $10,000 per transplant.	
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure	0% Coinsurance after Deductible	Not covered
• **Donor Search Limit**	Covered, as approved by us, up to $30,000 per transplant In-Network only. Benefits are not available Out-of-Network.	
Live Donor Health Services	0% Coinsurance after Deductible	Not covered

Benefits	In-Network	Out-of-Network
• **Donor Health Service Limit**	Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	

Prescription Drug Retail Pharmacy Benefits	In-Network	Out-of-Network
Each Prescription Drug may be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount. If the retail price for a covered Prescription and/or refill is less than the applicable Copayment amount, you will not be required to pay more than the retail price. The retail price paid will constitute the applicable cost sharing and will apply toward the Deductible, if any, and the Out-of-Pocket Limit in the same manner as a Copayment or Coinsurance.		
Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits and/or age limits and utilization guidelines.		
Retail Pharmacy (In-Network)	Up to 30 days If you receive more than a 30-day supply of medication at a Retail Pharmacy, you will have to pay the applicable Copayment / Coinsurance shown below for each additional 30-day supply of medication you receive. **Note:** A 90-day supply is available at Maintenance Pharmacies. When you get a 90-day supply at a Maintenance Pharmacy, three (3) Retail Pharmacy Copayments (one for each 30-day period) will apply. When you get a 30-day supply, one Copayment per Prescription Order will apply.	
Specialty Pharmacy	Up to 30 days* *See additional information in the “Specialty Drug Copayments / Coinsurance” section below.	
Note: For FDA-approved, Self-Administered Hormonal Contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies.		
Note: Prescription Drugs that we are required to cover by federal law under the “Preventive Care” benefit will be covered with no Deductible, Copayment, or Coinsurance when you use an In-Network Provider.		
Note: Prescription Drugs are not subject to any Deductible amounts shown in the “Deductible” section at the beginning of this “Schedule of Benefits.” Out-of-network providers may bill you for any charges that exceed the plan’s Maximum Allowed Amount.		
Retail Pharmacy Copayments / Coinsurance		
• Tier 1 Prescription Drugs	50% Coinsurance up to a maximum of $250 per Prescription Drug	50% Coinsurance up to a maximum of $250 plus all charges in excess of the Maximum Allowed Amount

Prescription Drug Retail Pharmacy Benefits	In-Network	Out-of-Network
• Tier 2 Prescription Drugs	50% Coinsurance up to a maximum of $250 per Prescription Drug	50% Coinsurance up to a maximum of $250 plus all charges in excess of the Maximum Allowed Amount
• Tier 3 Prescription Drugs	50% Coinsurance up to a maximum of $250 per Prescription Drug	50% Coinsurance up to a maximum of $250 plus all charges in excess of the Maximum Allowed Amount
• Tier 4 Prescription Drugs	50% Coinsurance up to a maximum of $250 per Prescription Drug	50% Coinsurance up to a maximum of $250 plus all charges in excess of the Maximum Allowed Amount
Home Delivery Pharmacy	Not Covered	

Specialty Drug Copayments / Coinsurance

Please note that certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy (unless you qualify for an exception). Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail Pharmacy" for further details. When you get Specialty Drugs from the Specialty Pharmacy, you will have to pay the same Copayments / Coinsurance you pay for a 30-day supply at a Retail Pharmacy.

Orally Administered Anti-Cancer Medications

With few exceptions, most orally administered anti-cancer medications are considered Specialty Drugs (see paragraph above). For orally administered anti-cancer medications that may be obtained through a Retail Pharmacy, the Copayment / Coinsurance for a 30-day supply will not exceed the lesser of the applicable Copayment / Coinsurance as stated in that section or $250.

Schedule II Controlled Substances

Prescription Orders for Schedule II controlled substances may be partially filled by a pharmacist, if requested by you or your Physician. A partial fill means a part of a Prescription Order filled that is of a quantity less than the entire prescription. For oral, solid dosage forms of prescribed Schedule II controlled substances that are partially filled, your cost share will be prorated accordingly.

How Your Plan Works

Introduction

Your Plan is a PPO plan. The Plan has two sets of benefits: In-Network and Out-of-Network. If you choose an In-Network Provider, you will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Coinsurance. If you use an Out-of-Network Provider, you will have to pay more out-of-pocket costs. (**Note:** If you receive services from any in-network health facility in California at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" in the "Claims Payment" section for more information.) Cost sharing for services with Copayments is the lesser of the Copayment amount or the Maximum Allowed Amount.

Reminder! Your University may offer a separate program which provides coverage for medical treatment or services obtained from the Student Health Center (SHC). Any such program is separate from, and its services are not covered under, this Plan.

Choice of Hospital, Skilled Nursing Facility, Attending Physician and Other Providers of Care

Nothing contained in this Booklet restricts or interferes with your right to select the Hospital, Skilled Nursing Facility, attending Physician or other Providers of your choice. However, your choice may affect the benefits payable according to this Plan.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

In-Network Services

When you use an In-Network Provider or get care as part of an Authorized Referral, Covered Services will be covered at the In-Network level. Benefits will be denied for care that is not a Covered Service. To maximize your benefits, be sure to confirm that the Provider you wish to see is an In-Network Provider with your Plan. Do not assume that an Anthem Provider is participating in the network of Providers participating in your Plan. Claims paid for Out-of-Network Provider services may mean a higher financial responsibility for you. However, if you receive services from any in-network health facility in California at which, or as a result of which, you receive non-Emergency Covered Services provided by Out-of-Network Providers, you will pay no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" in the "Claims Payment" section for more information.

In-Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers – SCPs), other professional Providers, Hospitals, and other Facilities who contract with us to care for you. Referrals are not needed to visit an In-Network Specialist, including behavioral health Providers.

It is important to understand that you may be referred by Anthem In-Network Providers to other Providers who may be contracted with Anthem for some types of plans, but are not part of your Plan's network of In-Network Providers.

While your Plan has provided a network of In-Network Providers, it is important to understand that Anthem has many contracting Providers who are not participating in the network of Providers for your Plan. Claims incurred with an Anthem participating Provider, who is not participating in your network panel of Providers, may be paid as Out-of-Network Provider services, even if you have been referred by another Anthem participating Provider. However, if you receive services from any in-network health facility in California at

which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see “Member Cost Share” in the “Claims Payment” section for more information.

To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor’s office may ask you for your Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

The First Thing To Do – Make an Appointment With Your PCP

Your PCP’s job is to help you stay healthy, not just treat you when you are sick. After you choose a PCP, make an appointment with your PCP. During this appointment, get to know your PCP and help your PCP get to know you. At you first appointment, talk to your PCP about:

- Personal health history
- Family health history
- Lifestyle
- Any health concerns you have

It is important to note, if you have not established a relationship with your PCP, they may not be able to effectively treat you. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have you Member Identification Card handy. The Doctor’s office may ask you for your Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any In-Network Specialist including a behavioral health Provider. You do not have to get a referral.

It is important to understand that you may be referred by Anthem In-Network Providers to other Providers who may be contracted with Anthem for some types of plans, but are not part of your Plan’s network of In-Network Providers.

While your Plan has provided a network of In-Network Providers, it is important to understand that Anthem has many contracting Providers who are not participating in the network of Providers for your Plan. Claims incurred with an Anthem participating Provider, who is not participating in your network panel of Providers, may be paid as Out-of-Network Provider services, even if you have been referred by another Anthem participating Provider. However, if you receive services from any in-network health facility in California at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see “Member Cost Share” in the “Claims Payment” section for more information.

In-Network Provider Services

For services from In-Network Providers:

- You will not need to file claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this Booklet.

- Precertification will be done by the In-Network Provider. (See the "Getting Approval for Benefits" section for further details.)

Please read the "Claims Payment" section for additional information on Authorized Referrals.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Out-of-Network Services

When you do not use an In-Network Provider or get care as part of an Authorized Referral, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Booklet.

For services from an Out-of-Network Provider:

- The Out-of-Network Provider can charge you the full amount of their bill; (**Note**: If you receive services from any in-network health facility in California at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" in the "Claims Payment" section for more information.)

- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments).

- You will have to pay for services that are not Medically Necessary.

- You will have to pay for non-Covered Services.

  You may have to file claims. Please see "Notice of Claim & Proof of Loss" in the section titled "Claims Payment" later in this Booklet for more information.

- You must make sure any necessary Precertification is done. (Please see "Getting Approval for Benefits" for more details.)

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network. **Please Note: It is very important that you select your specific Plan to receive an accurate list of In-Network Providers for your Plan.**

- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need details about a Provider's license or training, or help choosing a Doctor who is right for you, call the Member Services number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Please note that we have several networks, and that a Provider that is In-Network for one plan may not be In-Network for another. Be sure to check your Identification Card or call Member Services to find out which network this Plan uses.

Second Opinions

If you have a question about your condition or about a plan of treatment which your Physician has recommended, you may receive a second medical opinion from another Physician. This second opinion visit would be provided according to the benefits, limitations and Exclusions of this Booklet. If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose an In-Network Provider. You may also ask your Physician to refer you to an In-Network Provider to receive a second opinion.

Triage or Screening Services

If you have questions about a particular condition or you need someone to help you determine whether or not care is needed, triage or screening services are available to you from us by telephone. Triage or screening services are the evaluation of a Member's health by a Doctor or nurse who is trained to screen or triage for the purpose of determining the urgency of the Member's need for care. Please contact the 24/7 NurseLine at the telephone number listed on your Anthem Identification Card 24 hours a day, 7 days a week.

Continuity of Care

Transition Assistance for New Members

Transition Assistance is a process that allows for continuity of care for new Members receiving services from an Out-of-Network Provider. If you are a new Member, you may request Transition Assistance if any one of the following conditions applies:

- An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.
- A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by us in consultation with the Member and the Out-of-Network Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the time the Member enrolls with us.
- A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy. For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, completion of covered services for the maternal mental health condition shall not exceed twelve (12) months from the diagnosis or from the end of pregnancy, whichever occurs later. A maternal mental health condition is a mental health condition

that can affect a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.

- A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.
- The care of a newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the time the Member enrolls with us.
- Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 180 days of the time the Member enrolls with Anthem.

Please contact Member Services at the telephone number on the back of your Identification Card to request Transition Assistance or to obtain a copy of the written policy. Eligibility is based on the Member's clinical condition; it is not determined by diagnostic classifications. Transition Assistance does not provide coverage for services not otherwise covered under the Policy.

We will notify you by telephone, and the Provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, the Member will be financially responsible only for applicable Deductibles, Coinsurance and/or Copayments under this plan. Financial arrangements with Out-of-Network Providers are negotiated on a case-by-case basis. We will request that the Out-of-Network Provider agrees to negotiate reimbursement and/or contractual requirements that apply to In-Network Providers, including payment terms. If the Out-of-Network Provider does not agree to negotiate said reimbursement and/or contractual requirements, we are not required to continue that Provider's services. If the Member does not meet the criteria for Transition Assistance, the Member is afforded due process including having a Physician review the request.

Continuation of Care after Termination of Provider

Subject to the terms and conditions set forth below, we will pay benefits to a Member at the In-Network Provider level for Covered Services (subject to applicable Copayments, Coinsurance, Deductibles and other terms) rendered by a Provider whose participation in Anthem's Provider network has terminated, including when the termination is without cause.

- The Member must be under the care of the In-Network Provider at the time of our termination of the Provider's participation. The terminated Provider must agree in writing to provide services to the Member in accordance with the terms and conditions of his/her agreement with Anthem prior to termination. The Provider must also agree in writing to accept the terms and reimbursement rates under his/her agreement with Anthem prior to the termination. If the Provider does not agree with these contractual terms and conditions, we are not required to continue the Provider's services beyond the contract termination date.

- We will furnish such benefits for the continuation of services by a terminated Provider only for any of the following conditions (includes treatment for Mental Health and Substance Use Disorder, where applicable):

  - An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.
  - A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by Anthem in consultation with the Member and the terminated Provider and

consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.

- A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy. For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, completion of covered services for the maternal mental health condition shall not exceed twelve (12) months from the diagnosis or from the end of pregnancy, whichever occurs later. A maternal mental health condition is a mental health condition that can affect a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
- A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.
- The care of a newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.
- Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 180 days of the Provider's contract termination date.

- Such benefits will not apply to Providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.

- Please contact Member Services at the telephone number on the back of your Identification Card to request continuation of care or to obtain a copy of the written policy. Eligibility is based on the Member's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Contract.

We will notify you by telephone, and the Provider by telephone and fax, as to whether or not your request for continuation of care is approved. If approved, the Member will be financially responsible only for applicable Deductibles, Coinsurance and/or Copayments under this plan. Financial arrangements with terminated Providers are negotiated on a case-by-case basis. We will request that the terminated Provider agrees to negotiate reimbursement and/or contractual requirements that apply to In-Network Providers, including payment terms. If the terminated Provider does not agree to negotiate said reimbursement and/or contractual requirements, we are not required to continue that Provider's services. If you disagree with our determination regarding continuation of care, please refer to the "Grievance and External Review Procedures" section for additional details.

Your Cost Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost shares you must pay. Please read the "Schedule of Benefits" for details on your cost shares. Also read the "Definitions" section for a better understanding of each type of cost share.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard," which provides services to you when you are outside our Service Area. For more details on this program, please see "Inter-Plan Arrangements" in the "Claims Payment" section.

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Premiums for this Plan has the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

Getting Approval for Benefits

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

Reviewing Where Services Are Provided

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is reviewed, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting / place of care. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens the service can be requested again in another place and will be reviewed again for Medical Necessity. At times a different Provider or Facility may need to be used in order for the service to be considered Medically Necessary. Examples include:

- A service may be denied on an inpatient basis at a Hospital but may be approvable if provided on an outpatient basis at a Hospital.
- A service may be denied on an outpatient basis at a Hospital but may be approvable at a free standing imaging center, infusion center, Ambulatory Surgical Facility, or in a Physician's office.
- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate. "Clinically equivalent" means treatments that for most Members, will give you similar results for a disease or condition.

If you have any questions about the utilization review process, the medical policies or clinical guidelines, you may call the Member Services phone number on the back of your Identification Card.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if we decide your services are Medically Necessary. For benefits to be covered, on the date you get service:

- You must be eligible for benefits;
- The service or supply must be a Covered Service under your Plan;
- The service cannot be subject to an Exclusion under your Plan; and
- You must not have exceeded any applicable limits under your Plan.

Types of Reviews

- **Pre-service Review –** A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.

  - **Precertification –** A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in this Booklet. Please see the provision "If Precertification is Not Obtained" later in this section for information about the failure to obtain Precertification.

    For admissions following Emergency Care, you, your authorized representative or Doctor must tell us within 24 hours of the admission or as soon as possible within a reasonable period of time.

For childbirth admissions, Precertification is not needed for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require Precertification.

For inpatient Hospital stays for mastectomy surgery, including the length of Hospital stays associated with mastectomy, Precertification is not needed.

- **Continued Stay / Concurrent Review -** A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

  Both Pre-Service and Continued Stay / Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post service Review –** A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Services for which Precertification is required (i.e., services that need to be reviewed by us to determine whether they are Medically Necessary)are the following:

- All inpatient Facility and residential treatment admissions, including detoxification and rehabilitation except as follows:
  - Emergency admissions. You, Your authorized representative, or Physician must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time;
  - Admissions for childbirth, for the first 48 hours following a vaginal delivery or 96 hours following a cesarean section. Admissions longer than 48 or 96 hours require precertification;
  - Admissions for mastectomy surgery, including the length of Hospital stays associated with mastectomy and breast reconstruction surgery for breast cancer.
- Skilled Nursing Facility stays;
- Organ and Tissue Transplants, Coronary Artery Bypass Surgeries, peripheral stem cell replacement and similar procedures;
- Bariatric surgical procedures;
- All Infusion Therapy (in any setting) inclusive of Specialty Drugs and related services (for each Course of Therapy) in any setting, including a Physician's office, infusion center, outpatient Hospital or clinic, or your home or other residential setting;
- Home Health Care. This does not apply to services provided for outpatient mental health and substance use disorder;
- Surgical procedures, wherever performed, except as follows:
  - Mastectomy surgery and breast reconstruction surgery for breast cancer;
  - Male and female sterilization procedures, such as vasectomy and tubal ligation;
  - Surgeries performed for the treatment of Gender Dysphoria, as diagnosed by a Physician;
- All interventional spine pain, elective hip, knee, and shoulder arthroscopic / open sport medicine, and outpatient spine surgery procedures;

- The following diagnostic procedures, including advanced imaging procedures, wherever performed. This does not apply to services provided for outpatient mental health and substance use disorder.
  - Computerized Tomography (CT)
  - Computerized Tomography Angiography (CTA)
  - Magnetic Resonance Imaging (MRI)
  - Magnetic Resonance Angiography (MRA)
  - Magnetic Resonance Spectroscopy (MRS)
  - Nuclear Cardiology (NC)
  - Positron Emission Tomography (PET)
  - PET and PET/CT Fusion
  - QTC Bone Densitometry
  - Diagnostic CT Colonography
  - Echocardiogram
  - Magnetoencephalography (MEG)
  - Sleep study
  - Anesthesia for gastrointestinal endoscopic procedures
  - Capsule endoscopy-gastrointestinal track
  - Manipulation of spine under anesthesia;
- Hospice care;
- Non-Emergency ambulance services, except when provided for outpatient Mental Health and Substance Use Disorder services;
- Speech, Physical and Occupational Therapy. A specified number of visits may be authorized after your initial visit. While there is no limit on the number of covered visits for Medically Necessary speech, physical and occupational therapy, Precertification is required after your initial visit. This does not apply to services provided for outpatient mental health and substance use disorder;
- Chiropractic / Osteopathic / Manipulation therapy after the number of visits specified in the 'Schedule of Benefits". A specified number of additional visits may be authorized. While there is no limit on the number of covered visits for Medically Necessary manipulation therapy, additional visits in excess of the stated number of visits require Precertification;
- Transplant, bariatric, and transgender travel expense.

Who is Responsible for Precertification?

Typically, In-Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor ("requesting Provider") will get in touch with us to ask for a Precertification review. However, you may request a Precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
In Network	Provider	• The Provider must get Precertification when required
Out of Network/ Non-Participating	Member	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary.
BlueCard Provider	Member **(Except for Inpatient Admissions)**	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary. • **BlueCard Providers must obtain precertification for all Inpatient Admissions.**
NOTE: For an Emergency Care admission, precertification is not required. However, you, your authorized representative or Doctor must tell us within 24 hours of the admission or as soon as possible within a reasonable period of time.		

If Precertification is Not Obtained

For all services that require Precertification, the failure to obtain Precertification prior to the service, treatment or admission start date will result in the claim for the services being subject to post service review as described above. If the service, treatment or admission is determined not to be Medically Necessary, the claim will be denied as a non-Covered Service and you will have no benefits under this Plan for such service, treatment, or admission.

How Decisions are Made

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section "**Prescription Drugs Administered by a Medical Provider**". Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

If you are not satisfied with our decision under this section of your benefits, please refer to the "Grievance and External Review Procedures" section to see what rights may be available to you.

Decision and Notice Requirements

We will review requests for Medical Necessity according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we

will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Type of Review	Timeframe Requirement for Decision
Urgent Pre-service Review	72 hours from the receipt of the request
Non-Urgent Pre-service Review	5 business days from the receipt of the request
Urgent Continued Stay/ Concurrent Review when hospitalized at the time of the request and no previous authorization exists	24 hours from the receipt of the request. We may request additional information within the first 24 hours and then extend to 72 hours
Urgent Continued Stay / Concurrent Review when request is received at least 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received less than 24 hours before the end of the previous authorization	72 hours from the receipt of the request
Non-urgent Continued Stay / Concurrent Review	5 business days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting Provider of the specific information needed to finish the review. If we do not get the specific information we need by the required timeframe, we will make a decision based upon the information we have.

We will notify you and your Provider of our decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

For a copy of the Medical Necessity Review Process, please contact Member Services at the telephone number on the back of your Identification Card.

Revoking or modifying a Precertification Review decision. Anthem will determine **in advance** whether certain services (including procedures and admissions) are Medically Necessary and are the appropriate length of stay, if applicable. These review decisions may be revoked or modified prior to the service being rendered for reasons including the following:

- Your coverage under this Plan ends;
- The Contract with the University terminates;
- You reach a benefit maximum that applies to the service in question;
- Your benefits under the Plan change so that the service is no longer covered or is covered in a different way.

Important Information

Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) and/or offer an alternate benefit if in our discretion, such change furthers the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to take part in a program or a Provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Member. Anthem may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs or a Provider arrangement by checking your on-line Provider Directory, on-line pre-certification list, or contacting the Member Services number on the back of your ID card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Health Plan Individual Case Management

Our health plan individual case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen authorized representative, treating Doctor(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of you and Anthem and you or your authorized representative agree to the alternate or extended benefit. For alternate care, we will ask you or your authorized representative to agree in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your authorized representative in writing.

Acute Care at Home Programs

Anthem has programs available that offer acute care to Members where they live as an alternative to staying in a Facility, when the Member's condition and the Covered Services to be delivered, are appropriate for the home setting. We refer to these programs as Acute Care at Home Programs. These programs provide care for active, short-term treatment of a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. Acute care services are generally delivered by teams of health care Providers from a range of medical and surgical specialties. The Acute Care at Home Programs are separate from our Home Care Services benefit, are only available in certain Service Areas, and are only provided if the Member's home meets accessibility requirements.

Covered Services provided by Acute Care at Home Programs may include Physician services (either in-person or via telemedicine), diagnostic services, surgery, home care services, home infusion therapy, Prescription Drugs administered by a Provider, therapy services, and follow-up care in the community. Prescription Drugs at a Retail or Mail Order Pharmacy are not included in these Programs. Benefits for those Drugs are described under the "Prescription Drug Benefit at a Retail Pharmacy" section. Acute Care at Home

Programs may also include services required to set up telemedicine technology for in-home patient monitoring, and may include coverage for meals.

Members who qualify for these programs will be contacted by our Provider, who will discuss how treatment will be structured, and what costs may be required for the services. Benefit limits that might otherwise apply to outpatient or home care services, (e.g., home care visits, physical therapy, etc.), may not apply to these programs.

Your participation in these programs is voluntary. If you choose to participate, your Provider will discuss the length of time that benefits are available under the program (e.g., the Acute Care at Home Benefit Period) when you enroll. The Acute Care at Home Benefit Period typically begins on the date your Acute Care at Home Provider sets up services in your home, and lasts until the date you are discharged from the Program.

Any Covered Services received before or after the Acute Care at Home Benefit Period will be covered according to the other benefits of this Plan.

What's Covered

This section describes the Covered Services available under your Plan. Covered Services are subject to all the terms and conditions listed in this Booklet, including Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Please read the "Schedule of Benefits" for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read "How Your Plan Works" for more information on your Plan's rules. Read the "What's Not Covered" section for important details on Excluded Services. In addition, read "Getting Approval for Benefits" to determine when services require Precertification.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have surgery, benefits for your Hospital stay will be described under "Inpatient Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional Services." As a result, you should read all sections that might apply to your claims.

You should also know that many Covered Services can be received in several settings, including a Doctor's office, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where you choose to get Covered Services, and this can result in a change in the amount you need to pay. Please see the "Schedule of Benefits" for more details on how benefits vary in each setting.

Acupuncture

Please see "Therapy Services" later in this section.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Precertification is required for all non-Emergency ambulance transportation, except when provided for outpatient Mental Health and Substance Use Disorder services (see the part "Getting Approval for Benefits" for details).

Medically Necessary ambulance services are a Covered Service as described in this section when you are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. Ambulance services include medical and mental health Medically Necessary non-Emergency ambulance transportation, including psychiatric transportation for safety issues. Ambulance Services do not include transportation by car, taxi, bus, gurney van, wheelchair van and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Provider.

Ambulance services are a Covered Service when one or more of the following criteria are met:

- For ground ambulance, you are taken:
  - From your home, the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
  - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air (fixed wing and rotary wing air transportation) or water ambulance, you are taken:
  - From the scene of an accident or medical Emergency to a Hospital;

- Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
- Between a Hospital and an approved Facility.

Non-Emergency ambulance services are subject to Medical Necessity reviews by us. Emergency ambulance services do not require Precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider.

When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, no benefits will be available.

You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include trips to:

- A Doctor's office or clinic;
- A morgue or funeral home.

If provided through the 911 emergency response system, ambulance charges are covered if it is reasonably believed that a medical Emergency existed even if you are not transported to a Hospital. Payment of benefits for ambulance services may be made directly to the Provider of service unless proof of payment is received by us prior to the benefits being paid.

IN SOME AREAS A 911 EMERGENCY RESPONSE SYSTEM HAS BEEN ESTABLISHED. THIS SYSTEM IS TO BE USED ONLY WHEN THERE IS AN EMERGENCY MEDICAL CONDITION THAT REQUIRES AN EMERGENCY RESPONSE.

IF YOU REASONABLY BELIEVE THAT YOU ARE EXPERIENCING AN EMERGENCY, YOU SHOULD CALL 911 OR GO DIRECTLY TO THE NEAREST HOSPITAL EMERGENCY ROOM.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

For the Covered Services of an Out-of-Network air ambulance provider, you will pay no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network air ambulance provider. Out-of-Network air ambulance providers may not bill you for charges in excess of the Maximum Allowed Amount.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility or a rehabilitation facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats you cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Autism Services

Please see "Pervasive Developmental Disorder or Autism" later in this section.

Behavioral Health Services

Please see "Pervasive Developmental Disorder or Autism" and "Mental Health and Substance Use Disorder (Chemical Dependency) Services" later in this section.

Cardiac Rehabilitation

Please see "Therapy Services" later in this section.

Chemotherapy

Please see "Therapy Services" later in this section.

Chiropractor Services

Please see "Therapy Services" later in this section.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to you as a qualified insured in an approved clinical trial if the services are Covered Services under this Plan. A "qualified insured" means that you meet both of the following conditions:

a) You are eligible to participate in an approved clinical trial, according to the clinical trial protocol, for the treatment of cancer or another life-threatening disease or condition.

b) Either of the following applies:
   i. The referring health care professional is an In-Network Provider and has concluded that your participation in the clinical trial would be appropriate because you meet the conditions of subparagraph (a).
   ii. You provide medical and scientific information establishing that your participation in the clinical trial would be appropriate because you meet the conditions of subparagraph (a).

An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or another life-threatening disease or condition. The term "life-threatening disease or condition" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits are limited to the following trials:

- Federally funded trials approved or funded by one or more of the following:

- The National Institutes of Health.
- The Centers for Disease Control and Prevention.
- The Agency for Health Care Research and Quality.
- The Centers for Medicare & Medicaid Services.
- Cooperative group or center of any of the four entities described immediately above or the Department of Defense or the Department of Veterans Affairs.
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
  i. The Department of Veterans Affairs.
  ii. The Department of Defense.
  iii. The Department of Energy.

- Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

- Studies or investigations done for drug trials which are exempt from the investigational new drug application.

If one or more In-Network Providers is conducting an approved clinical trial, your Plan may require you to use an In-Network Provider to utilize or maximize your benefits if the In-Network Provider accepts you as a clinical trial participant. It may also require that an approved clinical trial be located in California, unless the clinical trial is not offered or available through an In-Network Provider in California.

Routine patient care costs include drugs, items, devices, and services provided to you in connection with an approved clinical trial that would otherwise be covered by this Plan, including:

- Drugs, items, devices, and services typically covered absent a clinical trial;
- Drugs, items, devices, and services required solely for the provision of an investigational drug, item, device, or service;
- Drugs, items, devices, and services required for the clinically appropriate monitoring of the investigational drug, item, device, or service;
- Drugs, items, devices, and services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service;
- Drugs, items, devices, and services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis and treatment of complications.

Cost sharing (Copayments, Coinsurance, and Deductibles) for routine patient care costs will be the same as that applied to the same services not delivered in a clinical trial, except that the In-Network cost sharing and Out-of-Pocket Limit will apply if the clinical trial is not offered or available through an In-Network Provider.

All requests for clinical trials services, including services that are not part of approved clinical trials, will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

- The Investigational item, device, or service itself; or
- Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

COVID-19 Diagnosis and Prevention

Benefits are provided for services and supplies for testing for the detection and diagnosis of the virus that causes COVID-19, that are approved, cleared, or authorized by the federal Food and Drug Administration and the administration of these products (reagents, instruments, and systems used in the diagnosis of COVID-19). This includes items and services furnished during an office visit (including both in-person and telehealth visits), Urgent Care Center visits, and Emergency Room visits that result in an order for or administration of a diagnostic product to test for COVID-19.

Also covered are items, services, and immunizations intended to prevent or mitigate COVID-19 that are evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force or an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (regardless of whether the immunization is recommended for routine use).

No medical management requirements, including precertification, will apply to any Covered Services listed in this provision.

Services and supplies provided for the diagnosis or prevention of COVID-19 are covered by this Plan with no Deductible, Copayments or Coinsurance whether you use an In-Network or Out-of-Network Provider. Services provided by In-Network Providers will be reimbursed at the Maximum Allowed Amount the provider has agreed to accept as payment in full for these services. Services provided by Out-of-Network Providers will be reimbursed at the cash price for the services listed by the provider on a public internet website, or at a rate we have negotiated with the provider, which will constitute payment in full for these services.

The benefits listed in this provision for the diagnosis and prevention of COVID-19 will remain in effect for the duration of the public health emergency determined on January 31, 2020, to exist nationwide as of January 27, 2020, by the Secretary of Health and Human Services pursuant to section 319 of the Public Health Service Act, as a result of COVID-19, including any subsequent renewals of that determination.

Dental Services For Members Up to Age 19

All Covered Services are subject to the terms, limitations and Exclusions of this Plan. See “Dental Services For Members Up to Age 19” in the “Schedule of Benefits” for additional information. See also APPENDIX I, at the end of this Booklet, for the CDT codes listing all coverage and limitations of Dental Services For Members Up to Age 19. Dental services provided under this benefit will not also be provided under “Dental Services (All Members / All Ages).”

We cover the following dental care services for Members through the end of the month in which they turn 19 years old when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, we will cover the least expensive.

Diagnostic and Preventive Services

Oral Exams.

- Periodic oral exams covered 1 time per 6 months
- Limited oral exams – problem focused
- Oral evaluation for a patient under three years of age and counseling with primary caregiver
- Comprehensive oral evaluation – new or established patient
- Detailed and extensive oral evaluation – problem focused, by report
- Re-evaluation – Limited or problem focused – covered 12 times per 12 months; covered 6 times per 3 months for temporomandibular joint conditions
- Re-evaluation – post operative office visit
- Comprehensive periodontal evaluation – new or established patient

Radiographs (X-rays)

- Complete full mouth series (includes bitewings) covered once per 36 months, per provider
- Periapicals – first radiographic image and each additional radiographic image covered 20 films per 12 months, per provider
- Intraoral – occlusal radiographic images covered 2 times per 6 months, per provider
- Extraoral 2D radiographic images covered once per day
- Extraoral posterior radiographic images covered 4 films per day
- Bitewings (single film) covered once per day
- Bitewings (two films) covered once per 6 months for Members age 10 and older, per provider
- Bitewings (three films) covered once per 6 months for Members age 10 and older, per provider
- Bitewings (four films) covered once per 6 months for Members age 10 and older, per provider
- Vertical bitewings – 7 to 8 radiographic images
- Sialography
- Temporomandibular joint arthrogram, including injection covered 3 times per day
- Tomographic survey covered twice per 12 months, per provider
- Panoramic film covered once per 36 months, per provider

Consultation with a medical health examiner

Pulp Vitality Tests

Diagnostic Casts. Covered as part of orthodontic care.

Dental Cleaning (Prophylaxis child or adult). Procedure to remove plaque, tartar (calculus), and stain from teeth. If you have periodontal maintenance (see Basic Restorative Services later in this subsection), that will count as an instance towards the dental cleaning benefit frequency. Covered 1 time per 6 months.

Fluoride Treatment (topical application or fluoride varnish). Covered 1 time per 6 months.

Nutritional Counseling

Tobacco Counseling for the control and prevention of oral disease

Oral Hygiene Instructions

Dental Sealant Treatments. Covered for first, second and third molars only. Covered once per tooth per 36 months per provider.

Sealant Repair(s). Covered once per tooth per 36 months per provider only on the occlusal surfaces that are free of decay and/or restorations. The original provider is responsible for any repair or replacement during the thirty-six (36) month period.

Preventive Resin Restoration is covered for the first, second and third molars in a pit or fissure of a tooth. Covered one (1) time per tooth per thirty-six (36) months per provider.

Interim caries arresting medicament application – per tooth

Caries Risk Assessment and Documentation (low, medium or high risk)

Space Maintainers (fixed and removable). Unilateral space maintainers are covered once per quadrant up to age 18. Bilateral space maintainers are covered once per arch up to age 18.

Recement or rebond Space Maintainers is covered once per provider per applicable quadrant or arch up to age 18.

Removal of Space Maintainer. Covered only when performed by a Provider that did not initially place the appliance.

Distal Shoe Space Maintainer – Fixed – Unilateral

Other Oral Pathology Procedures (by report)

Unspecified Diagnostic Procedure(s) by report

Basic Restorative Services

Emergency Treatment (also called palliative treatment). Covered for the temporary relief of pain or infection. Covered once per day.

Fillings (restorations). Amalgam (silver colored) and composite (tooth-colored) fillings are covered under this Plan. Fillings on primary teeth are covered once per tooth per 12 months. Fillings on permanent teeth are covered once per tooth per 36 months.

Periodontal Maintenance. Covered 4 times per 12 months and only 24 months after scaling and root planing. If you have a dental cleaning (see Diagnostic and Preventive Services), it will count as an instance toward the periodontal maintenance benefit frequency.

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth.
- Extraction of erupted tooth or exposed root.

Reattachment of Tooth Fragment, incisal edge or cusp.

Pins and Pin Build-Up. Covered when given with a restoration service, such as a filling.

Sedative Fillings. Covered once per 6 months.

Protective Restoration. Covered once per 6 months per provider.

Interim Therapeutic Restoration – primary dentition.

Restorative Foundation for an indirect restoration

Recement or rebond Inlay, Onlay, Veneer, or Partial Coverage Restoration. Covered once per tooth per 12 months, per provider.

Recement or rebond indirectly Fabricated or Prefabricated Post and Core

Recement or rebond Crown. Covered 12 months after initial placement of crown. Covered only when the procedure is completed by the same Provider that placed the crown.

Core buildup, including any pins when required.

Post and Core (in addition to crown), indirectly fabricated. Covered once per tooth.

Each Additional Prefabricated Post, same tooth

Post Removal Not in Conjunction With Endodontic Treatment

Additional Procedure to Construct New Crown Under Existing Partial Denture Framework

Prefabricated Crowns.
- Porcelain/ceramic on primary tooth covered once per 12 months.
- Stainless steel crown on primary tooth covered once per 12 months.
- Stainless steel crown on permanent tooth covered once per 36 months.
- Resin on primary tooth covered once per 12 months and resin on permanent tooth covered once per 36 months.
- Stainless steel with resin window covered once per 12 months for primary tooth and once per 36 months for permanent tooth.

Crown Repair necessitated by restorative material failure – covered 12 months after initial placement or repair of the crown by the same Provider

Unspecified Restorative Procedure

Miscellaneous Services.
- Consultation provided by dentist or Physician other than requesting dentist or Physician
- House calls are covered once per day
- Hospital or Ambulatory Surgical Facility call
- Office visits are covered once per day per provider
- Therapeutic drug injections are covered 4 times per day
- Application of desensitizing medicament covered once per 12 months per provider
- Treatment of complications (post-surgical) or unusual circumstances are covered once per day per provider and only within 30 days of an extraction
- Local anesthesia in and not in conjunction with operative or surgical procedures
- Regional block anesthesia (included in the fee for other procedures and not payable separately)
- Trigeminal division block anesthesia (included in the fee for other procedures and not payable separately)
- Inhalation of nitrous oxide
- Intravenous moderate (conscious) sedation/analgesia
- Non-Intravenous conscious sedation

Endodontic Services

Endodontic Therapy. Covered once per tooth on permanent teeth only:
- Root canal therapy.
- Root canal retreatment – covered 12 months after the initial root canal therapy when given by the same Provider as the root canal therapy.

Root Canal Obstruction

Internal Root Repair of Perforation Defects

Other Endodontic Treatments. Unless noted otherwise, the following services are covered once per tooth.
- Apexification – first visit

- Apexification – interim medication replacement
- Apicoectomy, anterior, bicuspid and molar(s) – covered 90 days after a root canal therapy by the same Provider or 24 months after apicoectomy/periradicular surgery by the same Provider.
- Therapeutic pulpotomy
- Pulpal debridement
- Partial pulpotomy for apexogenesis
- Pulpal therapy – anterior or posterior tooth (excluding final restoration)
- Unspecified Endodontic Procedure, by report

Pulp Cap – direct and indirect (excluding final restoration)

Apicoectomy – anterior teeth, bicuspids, molars, additional roots

Periradicular Surgery Without Apicoectomy

Retrograde Filling – per root

Surgical Procedure – Isolation of tooth with rubber dam

Periodontal Services

Periodontal Scaling and Root Planing. 1-3 teeth or 4 or more teeth. Covered 1 time per quadrant per 24 months. Covered for Members age 13 and older.

Biologic Materials to Aid Tissue Regeneration

Scaling in Presence of Generalized Moderate or Severe Gingival Inflammation – full mouth, after oral evaluation. Covered 1 time per quadrant per 24 months. Covered for Members age 13 and older.

Full Mouth Debridement

Chemotherapeutic Agents

Unscheduled Dressing Change, by someone other than treating dentist. Covered once per provider within 30 days of gingivectomy/gingivoplasty or osseous surgery for Members age 13 and older.

Complex Surgical Periodontal Care.
- Gingivectomy/gingivoplasty – One to three contiguous teeth or tooth bounded spaces per quadrant or four or more contiguous teeth or tooth bounded spaces per quadrant. Covered once per quadrant per 36 months for Members age 13 and older.
- Apically positioned flap
- Crown lengthening
- Osseous surgery – One to three contiguous teeth or tooth bounded spaces per quadrant or four or more contiguous teeth or tooth bounded spaces per quadrant, covered once per quadrant per 36 months for Members age 13 and older.

Unspecified Periodontal Service, by report – covered for Members age 13 and older.

Oral Surgery Services

Oral surgery services include post-operative care, such as, exams, removal of stitches, and treatment of post-surgical complications.

Complex Surgical Extractions. Surgical removal of 3rd molars is covered only when symptoms of pathology exist.
- Surgical removal of erupted tooth
- Surgical removal of impacted tooth – soft tissue, partially bony, completely bony and completely bony with

unusual surgical complications
- Surgical removal of residual tooth roots

Other Oral Surgery Procedures. Covered oral surgeries include:
- Biopsy of oral tissues (hard) – covered once per arch per day
- Biopsy of oral tissues (soft) – covered 3 times per day
- Excision and removal of lesions, cysts and tumors
- Removal of palatal torus and mandibular torus – covered once per quadrant per lifetime
- Frenulectomy (frenectomy or frenotomy) – covered once per arch per day
- Incision and drainage of abscesses – covered once per quadrant per day
- Oroantral fistula closure
- Sinus perforation – primary closure
- Tooth reimplantation and/or stabilization of accidently evulsed or displaced tooth
- Placement of device to facilitate eruption of impacted tooth – covered with orthodontia
- Sinus augmentation
- Surgical reduction of tuberosity – covered once per quadrant per day
- Sequestrectomy for osteomyelitis – covered once per quadrant per day and only after 30 days has passed since an extraction

Intravenous Conscious Sedation, IV Sedation, and General Anesthesia– Covered when given with a covered complex surgical service. The service must be given in a dentist's office by the dentist or an employee of the dentist that is certified in their profession to give anesthesia services. Non-intravenous conscious sedation may be used for Members under age 13 when they are uncooperative.

Local Anesthesia.
- Covered in conjunction with operative or surgical procedures (such as filling, crowns, or oral surgery) once per day per provider, but is not payable separately.
- Covered once per date of service when not in conjunction with operative or surgical procedures (such as a filling, crown, or oral surgery) to perform a different diagnosis or as an injection to eliminate or control a disease or abnormal state.

Nitrous Oxide.
- Covered for Members under age 13 when they are uncooperative.
- Not covered on the same date of service as deep sedation/general anesthesia (D9220 and D9221), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248) and when all associated procedures on the same date of service by the same provider are denied.
- Covered only when given in a dental office by a Provider that is acting within the scope of his or her license.

Major Restorative Services

Permanent Crowns. Covered 1 time per 60 months for Members age 13 and older. The following crowns are covered under this Plan:
- Resin (lab procedure)
- 3/4 resin-based composite (indirect)
- Resin with predominantly base metal
- Porcelain with ceramic substrate
- Porcelain fused to predominantly base metal
- 3/4 cast predominantly base metal
- 3/4 porcelain/ceramic
- Full cast predominantly base metal

Restorative Cast Post and Core Build Up. Covered once per tooth.

Additional Cast Post and Core Buildup Same Tooth

Occlusal Guards. Covered once per 12 months for Members ages 13 and up with temporomandibular joint disorders.

Occlusion Analysis, Occlusal Adjustment (limited and complete) – Each procedure covered once per 12 months per provider for Members age 13 and up with temporomandibular joint disorders.

Prosthodontic Services – Removable

Complete and Partial Dentures. Covered 1 time per 60 months for the replacement of extracted permanent teeth. If you have an existing denture or partial, a replacement is only covered if at least 60 months has passed and it cannot be repaired or adjusted. Types of partial dentures covered are resin base and cast metal with resin base.

Immediate Dentures (upper and lower). Covered once per arch per lifetime.

Immediate Partial Dentures (upper and lower). The approved materials for immediate partial dentures are:

- Resin based (including any conventional clasps, rests and teeth)
- Cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)

Overdenture (complete and partial).

Relines. Chairside or laboratory relines are covered once per 12 months following placement of a complete or partial denture without extractions. Covered once per 6 months following placement of a complete or partial denture with extractions.

Repairs and Replacement of Broken Clasps. Covered 2 times per 12 months per arch, up to 3 clasps per visit per provider. Covered if 6 months have passed from initial placement.

Replace Missing or Broken Teeth. Covered 2 times per 12 months per arch, up to 4 teeth per visit per provider. Covered after 6 months have passed from initial placement.

Add Tooth and Clasp to Existing Partial Denture. Covered for up to 3 teeth per visit per provider. Covered after 6 months have passed from initial placement.

Denture and Partial Denture Adjustments. Covered 2 times per 12 months per provider. Covered after 6 months have passed from initial placement, reline or repair.

Denture (complete), Resin Denture Base, Cast Framework Repairs. Covered 2 times per 12 months per arch, per provider. Covered after 6 months have passed from initial placement.

Tissue Conditioning (upper and lower). Covered 2 times each appliance per 36 months.

Precision attachment

Unspecified Removable Prosthodontic Procedure

Prosthodontic Services – Fixed

Bridges. This fixed prosthodontic appliance “bridges” the gap created by one (1) or more missing teeth. It involves creating a crown for the tooth or implant on either side of the missing tooth with a pontic in between. A bridge is covered 1 time per 60 months for the replacement of extracted permanent teeth. If you have an existing bridge, a replacement is only covered if at least 60 months have passed and it cannot be repaired or adjusted. A bridge made of the following material(s) is covered under this Plan:

- Porcelain fused to predominantly base metal
- Porcelain ceramic
- Resin with predominantly base metal

- Cast predominantly base metal

In addition, the following retainer crown(s) made of the following material(s) is covered under this Plan:

- 3/4 cast predominantly base metal
- 3/4 porcelain ceramic
- Full cast predominantly base metal

Bridge Adjustments and Repairs. Covered 12 months after initial placement or repair of crown by the same Provider.

Recementation of Bridge. Covered 12 months after initial placement of bridge. Covered only when given by the same Provider that placed the appliance.

Unspecified Fixed Prosthodontic Procedure

Implants Services

Surgical placement of implant bodies including endosteal, mini, eposteal, and transosteal implants

Implant supported structures.
- Semi-precision attachment
- Prefabricated
- Custom prefabricated

Implant/Abutment Supported Prosthetics including:
- Connecting bar – implant supported or abutment supported
- Prefabricated abutment – includes modification and placement
- Custom fabricated abutment – includes placement
- Abutment supported porcelain/ceramic crown
- Abutment supported porcelain fused to metal crown (high noble metal)
- Abutment supported porcelain fused to metal crown (predominantly base metal)
- Abutment supported porcelain fused to metal crown (noble metal)
- Abutment supported cast metal crown (high noble metal)
- Abutment supported cast metal crown (predominantly base metal)
- Abutment supported cast metal crown (noble metal)
- Implant supported porcelain/ceramic crown
- Implant supported crown (porcelain fused to high noble alloys)
- Implant supported metal crown (high noble alloys)
- Abutment supported retainer for porcelain/ceramic FPD
- Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
- Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
- Abutment supported retainer for porcelain fused to metal FPD (noble metal)
- Abutment supported retainer for cast metal FPD (high noble metal)
- Abutment supported retainer for cast metal FPD (predominantly base metal)
- Abutment supported retainer for cast metal FPD (noble metal)
- Implant supported retainer for ceramic FPD
- Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments
- Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure
- Implant supported crowns
- Provisional implant crown
- Repair implant supported prosthesis, by report
- Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment

- Recement implant/abutment supported crown is covered twelve (12) months after initial placement of crown by same Provider
- Recement implant/abutment supported fixed partial denture (bridge) is covered twelve (12) months after initial placement of crown by same Provider
- Abutment supported crown – (titanium) and titanium alloys
- Repair implant abutment, by report
- Remove broken retaining screw
- Abutment supported crown
- Implant supported retainers
- Implant removal, by report
- Implant/abutment supported removable denture for edentulous arch – maxillary
- Implant/abutment supported removable denture for edentulous arch – mandibular
- Implant/abutment supported removable denture for partially edentulous arch – maxillary
- Implant/abutment supported removable denture for partially edentulous arch – mandibular
- Implant/abutment supported fixed denture for edentulous arch – maxillary
- Implant/abutment supported fixed denture for edentulous arch – mandibular
- Implant/abutment supported fixed denture for partially edentulous arch – maxillary
- Implant/abutment supported fixed denture for partially edentulous arch – mandibular
- Radiographic/surgical implant index, by report
- Abutment supported retainer crown for FPD (titanium) and titanium alloys
- Unspecified implant procedure, by report

Alveoloplasty. Covered in conjunction with extractions. Alveoloplasty not in conjunction with extractions is covered after 6 months of any extraction.

Vestibuloplasty. Covered once per arch per 60 months. Vestibuloplasty that includes grafts and/or muscle reattachment is covered once per arch per lifetime.

Facial Prosthetics. Facial prosthetics are covered under this Plan, including:
- Facial moulage (sectional and complete)
- Nasal
- Auricular
- Orbital
- Ocular (permanent and interim)
- Facial
- Nasal septal
- Cranial
- Facial augmentation implant
- Mandibular resection, with and without guide flange
- Obturator (surgical, definitive and interim)
- Speech aids
- Palatal augmentation
- Palatal lift (definitive and interim)
- Obturator prosthesis (modification) – covered 2 times per 12 months

Facial Prosthetics Replacements – Nasal, Auricular, Orbital, Facial, Obturator (surgical and definitive)

Additional Maxillofacial Procedures – Includes:

- Speech aids (modification) – covered 2 times per 12 months.
- Palatal lift (modification) – covered 2 times per 12 months
- Trismus appliance (not for temporomandibular joint disorder treatment)
- Feeding aids – covered to age 18
- Surgical splint
- Surgical stent

- Radiation carrier and shield
- Radiation cone locater
- Fluoride gel carrier
- Commissure and surgical splint
- Vesiculobullous disease medicament carrier
- Unspecified maxillofacial prosthesis, by report

It is recommended that you get a pretreatment estimate for facial prosthetics so you fully understand the treatment and cost before having these services done.

Orthodontic Care

Orthodontic care is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Orthodontic care can be beneficial to generally prevent disease and promote oral health. Talk to your dentist about getting a pretreatment estimate for your orthodontic treatment plan, so you have an idea upfront what the treatment and costs will be. You or your dentist should send it to us so we can help you understand how much is covered by your benefits.

Medically Necessary Orthodontic Care. This Plan will only cover Orthodontic Care when it is Medically Necessary to restore the form and function of the oral cavity, such as through the result of an injury or from dysfunction resulting from congenital deformities. To be considered Medically Necessary Orthodontic Care, at least one of the following criteria must be present:

- Spacing between adjacent teeth that interferes with your biting function.
- Overbite that causes the lower front (anterior) teeth to impinge on the roof of your mouth when you bite.
- The position of your jaw or teeth impairs your ability to bite or chew.
- On an objective professional orthodontic severity index (such as the HLD Index) or consistent with current California Denti-Cal orthodontic criteria, your condition scores consistent with needing orthodontic care.

Orthodontic treatment may include the following:

- Pre-orthodontic Treatment Visits – covered once every 3 months.
- Periodic Treatment Visits – covered 4 times per year.
- Comprehensive or Complete Treatment – a full treatment case that includes all radiographs such as 2D cephalometric (2 films per 12 months) per provider, 2D oral/facial images covered 4 times per day, 3D photographic images, models, orthodontic appliances and office visits.
- Orthodontic Retention – covered once per arch per course of treatment. Repair or replacement of lost or broken retainer is covered once per appliance. Replacement covered only within 24 months of placement of orthodontic retainer.
- Complex Surgical Procedures – Surgical procedures given for orthodontic reasons, such as exposing impacted or unerupted teeth, or repositioning of teeth (once per arch per lifetime, with orthodontia), transseptal fiberotomy (once per arch per lifetime, with orthodontia).

How We Pay for Orthodontic Care

Because orthodontic treatment usually occurs over a long period of time, payments are made over the course of your treatment. In order for us to continue to pay for your orthodontic care, you must have continuous coverage under this Plan.

The first payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your dental Provider should submit the necessary forms telling us when your appliance is installed. Payments are then made at six month intervals until the treatment is finished or coverage under this Plan ends. Your cost share for Medically Necessary Orthodontic Care applies to your course of treatment, not individual benefit years within a multi-year course of treatment.

If your orthodontic treatment is already in progress (the appliance has been installed) when you begin coverage under this Plan, the orthodontic treatment benefit under this coverage will be on a pro-rated basis. We will only cover the portion of orthodontic treatment that you are given while covered under this Plan. We will not pay for any portion of your treatment that was given before your effective date under this Plan.

What Orthodontic Care Does NOT Include:

Coverage is NOT provided for:

- Monthly treatment visits that are billed separately – these costs will already be included in the total cost of your treatment.
- Orthodontic retention or retainers that are billed separately – these costs will already be included in the total cost of your treatment.
- Retreatment and services given due to a relapse.
- Inpatient or outpatient hospital expenses, unless covered by the medical benefits of this Plan.
- Any provisional splinting, temporary procedures or interim stabilization of the teeth.

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia
- Fluoride treatment

Treatment of Accidental Injury

Benefits are available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or mental condition.

Admissions for dental services up to three (3) days of inpatient Hospital services when a Hospital stay is Medically Necessary due to an unrelated medical condition.

Benefits are available for the services of a Physician or dentist treating an Accidental Injury to your natural teeth when you receive treatment within one (1) year following the injury or within one (1) year following your Effective Date, whichever is later. Emergency services to your natural teeth as a result of an Accidental Injury that occurs following your Effective Date are also eligible for coverage. Treatment excludes orthodontia. Damage to your teeth due to chewing or biting is not an Accidental Injury, unless the chewing or biting results from a medical or mental condition.

General anesthesia and associated Facility charges for dental procedures in a Hospital or surgery center are covered if the Member is:

- Under seven (7) years of age; or
- Developmentally disabled regardless of age; or
- The Member's health is compromised and general anesthesia is Medically Necessary, regardless of age.

Removal of Wisdom Teeth

Benefits are available for the surgical removal of impacted third molars (wisdom teeth), as Medically Necessary. Removal of wisdom teeth solely for orthodontic reasons is covered only for Members under the age of 19 (see "Orthodontic Care" in this section under "Dental Services for Members Up to Age 19", above).

Important: If you decide to receive dental services that are not covered under this Booklet, an In-Network Provider who is a dentist may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a Covered Service, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this Booklet, please call us at the Member Services telephone number listed on your Identification Card. To fully understand your coverage under this plan, please carefully review this Booklet.

Diabetes Equipment, Education, and Supplies

Benefits for Covered Services and supplies for the treatment of diabetes are provided on the same basis, at the same cost shares, as any other medical condition. Benefits will be provided for:

- The following Diabetes Equipment and Supplies:
  - Glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.
  - Insulin pumps and related necessary supplies.
  - Pen delivery systems for Insulin administration.
  - Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent and treat diabetes-related complications. These devices are covered under your Plan's benefits for Orthotics.
  - Visual aids (but not eyeglasses) to help the visually impaired to properly dose Insulin.

  These equipment and supplies are covered under your Plan's benefits for medical equipment (please see "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies" later in this section).

- The Diabetes Outpatient Self-Management Training Program, which:
  - is designed to teach a Member who is a patient, and covered Members of the patient's family, about the disease process and the daily management of diabetic therapy;
  - includes self-management training, education, and medical nutrition therapy to enable the Member to properly use the equipment, supplies, and medications necessary to manage the disease; and
  - is supervised by a Doctor.

  Diabetes education services are covered under the Plan benefits for professional services by Doctors.

- The following items are covered under your Prescription Drug benefits:
  - Insulin, glucagon, and other Prescription Drugs for the treatment of diabetes.
  - Insulin syringes.
  - Urine testing strips, lancets and lancet puncture devices.

  These items must be obtained from a retail Pharmacy.

  - Screenings for gestational diabetes and Type 2 Diabetes Mellitus are covered under "Preventive Care" in this section.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Certain diagnostic procedures, including advanced imaging procedures, wherever performed,

require Precertification (see the part “Getting Approval for Benefits” for details). Benefits include the following services:

Diagnostic Laboratory and Pathology Services

- Laboratory and pathology tests, such as blood tests.
- Genetic tests, when Precertification is obtained if required by this Plan (see “Getting Approval for Benefits”, earlier in this Booklet).

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services (including diagnostic radiologic services), which include:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

See “Therapy Services” later in this section.

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies

Covered Services are subject to change. For a list of current Covered Services, please call the Member Services telephone number listed on your Identification Card.

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Covered Services include:

- Standard curved handle or quad cane and replacement supplies.
- Standard or forearm crutches and replacement supplies.
- Dry pressure pad for a mattress.
- IV pole.
- Enteral pump and supplies.
- Bone stimulator.
- Cervical traction (over door).
- Phototherapy blankets for treatment of jaundice in newborns.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us, and we may determine that it is more cost-effective to purchase the equipment than to rent it, depending upon how long you will need the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services.

Orthotics

Benefits are available for Medically Necessary orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, adjustment and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include:

- Artificial limbs and accessories;
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes);
- Breast prosthesis (whether internal or external) and surgical bras after a mastectomy, as required by the Women's Health and Cancer Rights Act, and up to three brassieres required to hold a prosthesis every 12 months as required for Medically Necessary mastectomy;
- Colostomy supplies;
- Restoration prosthesis (composite facial prosthesis);

- Prosthetic devices (except electronic voice producing machines) to restore a method of speaking after laryngectomy;
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury or congenital defect;
- Benefits are also available for cochlear implants.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented).

Covered supplies include syringes, needles, surgical dressings, compression burn garments, lymphedema wraps and garments, splints, enteral formula required for tube feeding in accordance with Medicare guidelines, and other similar items that serve only a medical purpose.

Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Ostomy and Urological Supplies

Covered Services for ostomy (surgical construction of an artificial opening) and urological supplies include:

- Adhesives – liquid, brush, tube, disc or pad
- Adhesive removers
- Belts – ostomy
- Belts – hernia
- Catheters
- Catheter Insertion Trays
- Cleaners
- Drainage Bags / Bottles – bedside and leg
- Dressing Supplies
- Irrigation Supplies
- Lubricants
- Miscellaneous Supplies – urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; soma caps tape; colostomy plugs; ostomy inserts; irrigation syringes, bulbs and pistons; tubing; catheter clamps, leg straps and anchoring devices; penile or urethral clamps and compression devices
- Pouches – urinary, drainable, ostomy
- Rings – ostomy rings
- Skin barriers
- Tape – all sizes, waterproof and non-waterproof

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products. Benefits include Hospital services for blood, blood plasma, blood derivatives and blood factors, and blood transfusions, including blood processing and storage costs.

Diabetic Equipment and Supplies

Diabetic equipment and supplies for the treatment of diabetes are covered. Please see "Diabetes Equipment, Education, and Supplies" earlier in this section.

Asthma Treatment Equipment and Supplies

Benefits are available for inhaler spacers, nebulizers (including face masks and tubing), and peak flow meters when Medically Necessary for the management and treatment of asthma, including education to enable the Member to properly use the device(s).

Infusion Therapy Supplies

Your Plan includes coverage for all necessary durable, reusable supplies and durable medical equipment including: pump, pole, and electric monitor. Replacement blood and blood products required for blood transfusions associated with this therapy are also covered.

Emergency Care Services

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Emergency Services

Benefits are available for services and supplies to treat the onset of symptoms for an Emergency, which is defined below.

Emergency (Emergency Medical Condition)

Emergency or Emergency Medical Condition means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency includes being in active labor when there is inadequate time for a safe transfer to another Hospital prior to delivery, or when such a transfer would pose a threat to the health and safety of the Member or unborn child.

Emergency Medical Condition includes a Psychiatric Emergency Medical Condition, which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: a) an immediate danger to himself or herself or to others, or b) immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Emergency Care

"Emergency Care" means a medical or behavioral health exam including services routinely available to evaluate an Emergency Medical Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient.

Medically Necessary Emergency services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service, but you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount for covered services.

For Emergency Services rendered outside of California by an Out of Network provider, reimbursement is based on the Inter-Plan Arrangements for Out-of-Area Services.

Please note that Out-of-Network air ambulance providers may not bill you for charges in excess of the Maximum Allowed Amount. You will pay the Out-of-Network air ambulance provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network air ambulance provider.

Cost Shares paid for Out of Network Emergency care, including Emergency medical transportation (ambulance) and Emergency Hospital care, will apply to the In Network Out of Pocket Limit.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as possible. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See "Getting Approval for Benefits" for more details. If you or your Doctor do not call us, you may have to pay for services that are determined to be not Medically Necessary.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will be covered at the Out-of-Network level unless we agree to cover them as an Authorized Referral. (**Note**: If you receive services from any in-network health facility in California at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" in the "Claims Payment" section for more information.)

Fertility Preservation Services

Fertility preservation services to prevent iatrogenic infertility when medically necessary are covered. "Iatrogenic infertility" means infertility caused directly or indirectly, as a possible side effect, by a covered surgery, chemotherapy, radiation, or other covered medical treatment. "Caused directly or indirectly" means medical treatment with a possible side effect of infertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine Note that this benefit covers fertility preservation services only, as described. Fertility preservation services under this provision do not include testing or treatment of infertility.

Gene Therapy Services

Your Plan includes benefits for gene therapy services, when Anthem approves the benefits in advance through Precertification. See "Getting Approval for Benefits" for details on the Precertification process. To be eligible for coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is an In-Network Provider for other services it may not be an approved Provider for certain gene therapy services. Please call us to find out which providers are approved Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

Services Not Eligible for Coverage

Your Plan does not include benefits for the following:

i. Services determined to be Experimental / Investigational;

ii. Services provided by a non-approved Provider or at a non-approved Facility; or

iii. Services not approved in advance through Precertification.

Habilitative Services

Benefits also include habilitative health care services and devices that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the

expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Please see “Therapy Services” in this section for further details.

Home Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Provider in your home. Precertification is required for Home Care Services (see the part “Getting Approval for Benefits” for details). To be eligible for benefits, you must be substantially confined to your home (or a friend’s or relative’s home). Services must be prescribed by a Doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment
- Private duty nursing services

Home health care under this section does not include behavioral health treatment for Pervasive Developmental Disorder or autism. Services for behavioral health treatment for Pervasive Developmental Disorder or autism are covered under “Mental Health and Substance Use Disorder (Chemical Dependency) Services.”

When available in your area, benefits are also available for Intensive In-Home Behavioral Health Services. These do not require confinement to the home. These services are described in the “Mental Health and Substance Use Disorder Services” section below.

Home Infusion Therapy

See “Therapy Services” later in this section.

Hospice Care

You are eligible for hospice care if a Doctor has diagnosed you with a terminal illness and determines that your life expectancy is twelve (12) months or less. Precertification is required for Hospice Care (see the part “Getting Approval for Benefits” for details). You may access hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by your treating Provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Nursing care services on a continuous basis or short-term Inpatient Hospital care when needed in periods of crisis.
- Short-term respite care for the Member only when necessary to relieve the family members or other persons caring for the Member.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Medical social services under the direction of a Physician.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes or hyperalimentation.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties, for one year after the Member's death.
- Volunteer services provided by trained Hospice volunteers under the direction of a Hospice staff member.
- Medical direction, with the medical director being also responsible for meeting the general medical needs of the Member to the extent that these needs are not met by an attending Physician.

Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as chemotherapy and radiation therapy, are available to a Member in Hospice. These services are covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Specified transplants (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, and bone marrow/stem cell) are covered only when performed at an In-Network Transplant Provider (see below). All other transplants (e.g., cornea) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

Precertification is required for all services related to human organ and tissue transplants. See the part "Getting Approval for Benefits" for details. See also "Prior Approval and Precertification", below.

This section describes benefits for Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Booklet.

In this section you will see some key terms, which are defined below:

Covered Transplant Procedure

Any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, collection and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

In-Network Transplant Provider

A Provider that we have chosen as a Center of Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Excellence by us or has not been selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Transplant Benefit Period

At an In-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider details for services received at or coordinated by an In-Network Transplant Provider Facility.

At an Out-of-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts until the date of discharge.

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You should do this before you have an evaluation and/or work-up for a transplant. We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply. Call the Member Services phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant Procedure, you or your Provider should call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Not getting Precertification will result in the services being subject to post service review. If the transplant is determined not to be Medically Necessary, the services will be denied and no benefits will be provided. In addition, for services received from an Out of Network Provider, a financial penalty will apply even if coverage is approved. See the provision “If Precertification is not Obtained” under “Getting Approval for Benefits”, earlier in this booklet.

Coverage will not be denied, if otherwise available under this Plan for the costs of transplantation services based upon HIV status.

Please note that there are cases where your Provider asks for approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or collection and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are our covered Members, each will get benefits under their Plan.

- When the person getting the organ is our covered Member, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes other insurance, grants, foundations, and government programs.

- If our covered Member is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

Transportation and Lodging

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Our help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. Call us for complete information.

For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include:

- Child care,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Phone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation,

- Meals.

Infertility Services

Please see “Maternity and Reproductive Health Services” later in this section.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting and coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization.

Precertification is required for all inpatient Facility and residential treatment admissions except for Emergency admissions, inpatient Hospital stays for childbirth, and mastectomy surgery, including the length of Hospital stays associated with mastectomy and breast reconstruction surgery for breast cancer. For Emergency admissions, You, Your authorized representative or Physician must tell us within 24 hours of the admission or as soon as possible within a reasonable period of time. See the part “Getting Approval for Benefits” for details.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital’s average semi-private room rate unless it is Medically Necessary that you use a private room.
- A room in a special care or critical care unit if Medically Necessary. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother’s normal Hospital stay.
- Meals, special diets.
- General nursing services and special nursing care.
- Medical social services and discharge planning.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Biologicals.
- Blood, blood products, and their administration.
- Anesthesia and oxygen supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Durable medical equipment.
- Radioactive materials used for therapeutic purposes.
- Diagnostic services.
- Therapy services.

Skilled Nursing Facility

Precertification is required for Skilled Nursing Facility admissions (see the part “Getting Approval for Benefits” for details).

Covered Services are provided for up to 100 days per Skilled Nursing Day Allowance. A Skilled Nursing Day Allowance begins on the date the Member is admitted to a Hospital or Skilled Nursing Facility at a skilled level of care which must be above the level of custodial or intermediate care. A Skilled Nursing Day Allowance ends on the date the Member has not been an inpatient in a Hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new Skilled Nursing Day Allowance can begin only after any existing Skilled Nursing Day Allowance ends. A prior three-day stay in an acute care Hospital is not required to commence a Skilled Nursing Day Allowance.

Covered Services include:

- Physician and nursing services;
- Room and board;
- Drugs prescribed by a Physician as part of your care in the Skilled Nursing Facility;
- Durable medical equipment if Skilled Nursing Facilities ordinarily furnish the equipment;
- Imaging and laboratory services that Skilled Nursing Facilities ordinarily provide;
- Medical social services;
- Blood, blood products, and their administration;
- Medical supplies;
- Physical, Occupational, and Speech Therapy;
- Respiratory therapy.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. This service will be covered as a preventive care service (see the provision “Preventive Care” later in this section).
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and services needed for a miscarriage. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent and screening of a newborn for genetic diseases provided through a program established by law or regulation;
- Prenatal, postnatal, and postpartum services;
- Fetal screenings, which are genetic or chromosomal tests of the fetus; and
- Participation in the California Prenatal Screening Program, a statewide prenatal testing program administered by California's State Department of Public Health. Cost sharing will not be required for services you receive as part of this program.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care may be available at the In-Network level even if an Out-of-Network Provider is used. You will need to fill out a Continuation of Care Request Form and send it to us for review and approval. If approved, Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period. For additional information on the Continuation of Care process and how to begin, see the Transition Assistance for New Member provision in the section titled Continuity of Care.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. If the mother or newborn is discharged early, benefits include a post-discharge follow-up visit within 48 hours of the discharge, when prescribed by the treating Provider. This visit shall include, at a minimum, parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal or neonatal physical assessments. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Contraceptives are covered under the "Preventive Care" benefit as explained in that section. Please see that section for further details.

Contraceptive supplies prescribed by a Physician for reasons other than contraceptive purposes for Medically Necessary treatment such as decreasing the risk of ovarian cancer, eliminating symptoms of menopause or for contraception that is necessary to preserve life or health may also be covered.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.

Abortion Services

Benefits include services for abortions.

Mental Health and Substance Use Disorder (Chemical Dependency) Services

This Plan provides coverage for the Medically Necessary treatment of Mental Health and Substance Use Disorder. This coverage is provided according to the terms and conditions of this Plan that apply to all other medical conditions, except as specifically stated in this section, and is not limited to short-term or acute treatment.

You must obtain Precertification for non-Emergency inpatient Facility admissions for the treatment of Mental Health and Substance Use Disorder and Pervasive Developmental Disorder or autism. (See "Pervasive Developmental Disorder or Autism" in this section and the "Getting Approval for Benefits" section for details.)

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include the following:
  - Inpatient psychiatric hospitalization, including room and board, drugs, and services of physicians and other providers who are licensed health care professionals acting within the scope of their license,
  - Psychiatric observation for an acute psychiatric crisis,
  - Detoxification — medical management of withdrawal symptoms, including room and board, physician services, drugs, dependency recovery services, education and counseling,
  - Residential treatment which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
    - Treatment in a crisis residential program:
      - Observation and assessment by a psychiatrist weekly or more often,
      - Rehabilitation and therapy.
  - Transitional residential recovery services for substance use disorder (chemical dependency).

- **Outpatient Office Visits** including the following:
  - Individual and group mental health evaluation and treatment,
  - Individual and group chemical dependency counseling,
  - Intensive In-Home Behavioral Health Services (when available in your area),
  - Services to monitor drug therapy,
  - Methadone maintenance treatment,
  - Medical treatment for withdrawal symptoms,
  - Behavioral health treatment for Pervasive Developmental Disorder or autism delivered in an office setting.

- **Online Visits** when available in your area. Covered Services include a visit with the Doctor using the internet by a webcam, voice or Chat Therapy. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

- **Other Outpatient Services** including the following:
  - Partial Hospitalization Programs and Intensive Outpatient Programs,
  - Outpatient psychological testing,
  - Outpatient substance use disorder day treatment programs,
  - Multidisciplinary treatment in an intensive outpatient psychiatric treatment program,
  - Electroconvulsive therapy,

- Behavioral health treatment for Pervasive Developmental Disorder or autism delivered at home.

- **Behavioral health treatment for Pervasive Developmental Disorder or autism**. Inpatient services, office visits, and other outpatient items and services are covered under this section. See "Pervasive Developmental Disorder or Autism" later in this section for a description of additional services that are covered.

Coverage is also provided for Emergency services for treatment of a Psychiatric Emergency Medical Condition, which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: a) an immediate danger to himself or herself or to others, or b) immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder. Cost sharing for Emergency Services received from Out-of-Network Providers will be the same as In-Network Providers.

Examples of Providers from whom you can receive Covered Services include the following:

- Psychiatrist
- Psychologist
- Licensed clinical social worker (L.C.S.W.)
- Mental health clinical nurse specialist
- Licensed marriage and family therapist (L.M.F.T.)
- Licensed professional counselor (L.P.C.)
- Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals. See the definitions of these in the "Pervasive Developmental Disorder or Autism" section below
- Registered psychological assistant, as described in the California Business and Professions Code
- Psychology trainee or person supervised as set forth in the California Business and Professions Code
- Associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to the California Business and Professions Code
- Associate clinical social worker functioning pursuant to the California Business and Professions Code
- Associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to the California Business and Professions Code.

Occupational Therapy

Please see "Therapy Services" later in this section.

Office Visits and Doctor Services

Covered Services include:

Office Visits for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury.

Consultations between your Primary Care Physician and a Specialist, when approved by Anthem.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the "Home Care Services" benefit described earlier in this Booklet.

Retail Health Clinic Care for limited basic health care services to Members on a "walk-in" basis. These clinics are normally found in major Pharmacies or retail stores. Health care services are typically given by

Physician's Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor's Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor's office.

Urgent Care as described in "Urgent Care Services" later in this section.

Online Visits when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, coverage or payment questions, asking for Referrals to Doctors outside the online care panel, benefit Precertification, or Doctor to Doctor discussions. For Mental Health and Substance Use Disorder Online Visits, see the "Mental Health and Substance Use Disorder (Chemical Dependency) Services" section.

Prescription Drugs Administered in the Office

Orthotics

See "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies" earlier in this section.

Outpatient Facility Services

Precertification is required for specific outpatient services, including diagnostic treatment and other services (see the part "Getting Approval for Benefits" for details).

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Ambulatory Surgical Facility,
- Mental Health / Substance Use Disorder Facility, or
- Other Facilities that are appropriately licensed, certified, or authorized and are acting within the scope of their authority.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Outpatient professional services,
- Prescription Drugs, including Specialty Drugs dispensed through the Facility,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services.

Pervasive Developmental Disorder or Autism

Benefits are provided for behavioral health treatment for Pervasive Developmental Disorder or autism. This coverage is provided according to the terms and conditions of this Booklet that apply to all other medical conditions, except as specifically stated in this section.

Behavioral health treatment services covered under this Plan are subject to financial requirements (deductibles, co-insurance, and co-payments) and treatment limitations that are no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits in the same classification or sub-classification.

Precertification is required for all non-Emergency inpatient Facility and residential treatment admissions related to Pervasive Developmental Disorder or autism (see the part “Getting Approval for Benefits” for details).

Behavioral Health Treatment

The behavioral health treatment services covered by this Booklet are those professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder or autism and that meet all of the following requirements:

- The treatment must be prescribed by a licensed Physician and surgeon (an M.D. or D.O.) or developed by a licensed psychologist,

- The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional, and

- The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of applied behavioral analysis services and intensive behavioral intervention services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:

  - Describes the patient's behavioral health impairments to be treated,
  - Designs an intervention plan that includes the service type, number of hours, and parental participation needed (if any) to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported,
  - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or autism, and
  - Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

- The treatment plan must not be used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and must not be used to reimburse a parent for participating in the treatment program. The treatment plan must be made available to us upon request.

Our network of Providers is limited to licensed Qualified Autism Service Providers who contract with Anthem and who may supervise and employ Qualified Autism Service Professionals or Paraprofessionals who provide and administer behavioral health treatment.

For purposes of this section, the following definitions apply:

Applied Behavior Analysis means the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.

Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings, across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

Pervasive Developmental Disorder or autism as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

Qualified Autism Service Paraprofessional is an unlicensed and uncertified individual who meets all of the following requirements:

- Is supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice,
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations,
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers, and
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Qualified Autism Service Professional is a Provider who meets all of the following requirements:

- Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider,
- Is supervised by a Qualified Autism Service Provider,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Is a behavioral service Provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program,
- Has training and experience in providing services for Pervasive Developmental Disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code, and
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Qualified Autism Service Provider is either of the following:

- A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the person who is nationally certified; or
- A person licensed as a Physician and surgeon (M.D. or D.O.), physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to state law, who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the licensee.

You must obtain Precertification for all non-Emergency inpatient facility and residential treatment admissions related to behavioral health treatment services for the treatment of Pervasive Developmental Disorder or autism (see the "Getting Approval for Benefits" section for details).

Phenylketonuria (PKU)

Benefits for the testing and treatment of phenylketonuria (PKU) are paid on the same basis as any other medical condition. Coverage for treatment of PKU shall include those formulas and special food products that are part of a diet prescribed by a licensed Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the Plan. The diet must be deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

The cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. "Formula" means an enteral product or products for use at home. The formula must be prescribed by a Physician or nurse practitioner, or ordered by a registered dietician upon Referral by a health care Provider authorized to prescribe dietary treatments, and is Medically Necessary for the treatment of PKU. Formulas and special food products used in the treatment of PKU that are obtained from a Pharmacy are covered under your plan's Prescription Drug benefits. Formulas and special food products that are not obtained from a Pharmacy are covered under this benefit.

"Special food product" means a food product that is all of the following:

- Prescribed by a Physician or nurse practitioner for the treatment of PKU, and
- Consistent with the recommendations and best practices of qualified health professionals with expertise in the treatment and care of PKU, and
- Used in place of normal food products, such as grocery store foods, used by the general population.

Note: It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.

Physical Therapy

Please see "Therapy Services" later in this section.

Preventive Care

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. Preventive care services are covered by this Plan with no Deductible, Copayments or Coinsurance whether you use an In-Network or Out-of-Network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under the "Diagnostic Services" benefit instead of this benefit, if the coverage does not fall within the state or ACA-recommended preventive services.

Covered preventive care services fall under the following broad groups. The lists of services shown below are not exhaustive.

- Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF). Examples include screenings for:
  - Breast cancer,
  - Cervical cancer,

- Colorectal cancer,
- High blood pressure,
- Type 2 Diabetes Mellitus,
- Cholesterol,
- Child and adult obesity,
- Pre-exposure prophylaxis (PrEP) for prevention of HIV infection.

- Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

- Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration;

- Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:

  - All FDA-approved contraceptive Drugs, devices, and other products for women, including over-the-counter items, as prescribed by a Physician. This includes contraceptive Drugs, injectable contraceptives, patches and devices such as diaphragms, intrauterine devices (IUDs) and implants, as well as voluntary sterilization procedures, contraceptive education and counseling. It also includes follow-up services related to the Drugs, devices, products and procedures, including management of side effects, counseling for continued adherence, and device insertion and removal.

    If the FDA has approved more than one therapeutic equivalent of a contraceptive Drug, device, or product, at least one of the FDA-approved items will be covered as Preventive Care under this section. If a covered form of contraception is not available or is deemed not medically advisable by the Physician, the prescribed FDA-approved form of contraception will be covered as Preventive Care under this section.

    In order to be covered as Preventive Care, contraceptive Prescription Drugs must be Generic contraceptives. Brand Drugs will be covered as a Preventive Care benefit when Medically Necessary according to your attending Provider or when there is no Generic equivalent; otherwise they will be covered under the “Prescription Drug Benefit at a Retail Pharmacy.”

    For FDA-approved, Self-Administered Hormonal Contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies.

  - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.

  - Gestational diabetes screening.

  - Preventive prenatal and postnatal care.

- Preventive care services for smoking cessation and tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:

  - Counseling

  - Prescription Drugs obtained at a Retail Pharmacy

  - Nicotine replacement therapy products obtained at a Retail Pharmacy when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

- Screening, risk assessment, education, and counseling for Human Immunodeficiency Virus (HIV) in accordance with USPSTF recommendations for adults, adolescents, all pregnant women, and those with risk factors for HIV infection. The Member’s Physician will decide if the Member is part of a high risk

group. Also covered is pre-exposure prophylaxis (PrEP) medication and related services consistent with USPSTF recommendations including:

  - HIV and other testing to initiate PrEP
  - Follow-up and monitoring including:
    - HIV testing every three months)
    - Office visits to a Primary Care Provider or Specialist
    - Additional testing to monitor the effects of the PrEP medication
    - Sexually transmitted infection screening

- Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:

  - Aspirin
  - Statins
  - Breast cancer preventive medications (tamoxifen 20mg, raloxifene 60mg, aromatase inhibitors)
  - Folic acid supplements
  - Bowel preparations

  Please note that certain age and gender and quantity limitations apply.

You may call Member Services at the number on your Identification Card for more details about these services or view the federal government's web sites, https://www.healthcare.gov/what-are-my-preventive-care-benefits, http://www.ahrq.gov, and http://www.cdc.gov/vaccines/acip/index.html.

Examples of preventive care Covered Services are provided below.

Well Baby and Well Child Preventive Care

- Office Visits.
- Routine physical exam including medically appropriate laboratory tests, procedures and radiology services in connection with the exam.
- Screenings including blood lead levels for children at risk for lead poisoning; vision; and hearing screening in connection with the routine physical exam. Vision screening includes tests to detect amblyopia or its risk factors.
- Immunizations including those recommended by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices.
- Health education on pediatric wellness to prevent common sickness including asthma.
- Hepatitis B and varicella zoster (chicken pox) injectable vaccines and other age appropriate injectable vaccinations as recommended by the American Academy of Pediatrics and the office visit associated with administering the injectable vaccination when ordered by your Physician.
- Human papillomavirus (HPV) test for cervical cancer.

Adult Preventive Care

- Routine physical exams.
- Medically appropriate laboratory tests and procedures and radiology procedures in connection with the routine physical exam.

- Cholesterol, osteoporosis (periodic bone density screening for menopausal or post-menopausal women), vision (eye chart only), and hearing screenings in connection with the routine physical exam.
- Immunizations including those recommended by the U.S. Public Health Service and the Advisory Committee on Immunization Practices for Members age 19 and above.
- Health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided.
- Preventive counseling and risk factor reduction intervention services in connection with tobacco use and tobacco use-related diseases.
- FDA-approved cancer screenings including appropriate screening for breast cancer including breast exams and mammography testing; ovarian and cervical cancer screening tests, including pap examinations and the human papillomavirus (HPV) test for cervical cancer; BRCA-related cancer screening (risk assessment, genetic counseling, and genetic testing); colorectal cancer screening; prostate cancer screenings, including digital rectal exam and prostate specific antigen (PSA) test; lung cancer screening (with low dose computed tomography), skin cancer (counseling), and the office visit related to these services.

Prosthetics

See “Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies” earlier in this section.

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitative Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Please see “Therapy Services” in this section for further details.

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service. Precertification is required for Skilled Nursing Facility

services (see the part “Getting Approval for Benefits” for details). Please see “Inpatient Services” earlier in this section.

Smoking Cessation

Please see the “Preventive Care” section in this Booklet.

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Most surgical procedures, wherever performed, require Precertification (see the part “Getting Approval for Benefits” for details). Covered Services include:

- Medically Necessary operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

Bariatric Surgery

Anthem has established a network of designated Hospitals to provide services for bariatric surgical procedures.

Note: An In-Network Provider is not necessarily a designated Hospital. Information on designated Hospitals can be obtained by calling the Member Services phone number on the back of your Identification Card.

Services and supplies will be provided in connection with Medically Necessary surgery for weight loss, only for morbid obesity and only when performed at a designated Hospital.

Note: Charges for bariatric procedures and related services are covered only when the bariatric procedure and related services are performed at a designated Hospital. Precertification is required.

Bariatric Travel Expense. Certain travel expenses incurred in connection with an approved, specified bariatric surgery, performed at a designated Hospital that is fifty (50) miles or more from the Member’s place of residence, are covered, provided the expenses are authorized by Anthem in advance.

- Transportation for the Member and/or one companion to and from the designated Hospital.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Meals, tobacco, alcohol and drug expenses are excluded from coverage.

Member Services will confirm if the bariatric travel benefit is provided in connection with access to the selected designated Hospital. Details regarding reimbursement can be obtained by calling the Member

Services phone number on the back of your Identification Card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. dental implants) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, ectodermal dysplasia, or other craniofacial anomalies associated with cleft palate. Medically Necessary dental or orthodontic services are covered if they are integral to reconstructive surgery for cleft palate procedures.
- Orthognathic surgery for any condition directly affecting the upper or lower jawbone or associate bone joints and is Medically Necessary to attain functional capacity of the affected part. Dental services are excluded.
- Oral / surgical correction of Accidental Injuries as indicated in the "Dental Services (All Members / All Ages)" section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Reconstructive Surgery

Benefits include reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible. Benefits include surgery performed to restore symmetry after a mastectomy.

Note: This section does not apply to orthognathic surgery, except as specifically stated in this Booklet or required by law. See "Oral Surgery" above for that benefit.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

Telehealth

Benefits are provided for Covered Services that are appropriately provided through Telehealth, subject to the terms and conditions of this Booklet. "Telehealth" is the mode of providing health care or other health services using information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's health care. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. Telehealth does not include consultations between the patient and the health care Provider, or between health care Providers, by telephone, facsimile machine, electronic mail or Chat Therapy. If you have any questions about this coverage, or receive a bill please contact Member Services at the number on the back of your Identification Card.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Precertification is required for certain diagnostic procedures and tests and most surgeries (see the part "Getting Approval for Benefits" for details). Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. Precertification is required for physical therapy, speech therapy and speech-language pathology services, and occupational therapy after your initial visit (see the part "Getting Approval for Benefits" for details). Therapy services listed here can serve both rehabilitative and habilitative purposes. Services that are rehabilitative in nature involve goals to improve your level of function in a reasonable period of time. Services that are habilitative in nature help you to learn, maintain, or improve skills and functioning for daily living. Covered Services include:

- **Physical therapy** – The treatment, by physical means, to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices. It does not include massage therapy services.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

  Coverage may be limited to a certain number of visits per Benefit Period but additional visits may be approved. Precertification is required for additional visits to be covered (see the part "Getting Approval for Benefits" for details). See the "Schedule of Benefits" for any visit limit that applies to this service.

  If you receive chiropractic services from an Out-of-Network Provider and you need to submit a claim to us, please send it to the address listed below. If you have any questions or are in need of assistance, please call us at the Member Services telephone number listed on your ID card.

  American Specialty Health
  P.O. Box 509001
  San Diego, CA 92150-9001

- **Acupuncture –** Treatment by an acupuncturist who acts within the scope of their license using needles along specific nerve pathways to ease pain. All supplies used in conjunction with the acupuncture treatment will be included in the payment for the visit and will not be reimbursed in addition to the visit.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation –** Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy –** Treatment of an illness by chemical or biological antineoplastic agents. See the section **"**Prescription Drugs Administered by a Medical Provider**"** for more details.
- **Dialysis –** Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis. Coverage for equipment and medical supplies required for home hemodialysis and home peritoneal dialysis is limited to the standard item of equipment or supplies that adequately meets your medical needs.
- **Infusion Therapy –** Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home or provided in a Facility on either an inpatient or outpatient basis. Also includes Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). Precertification is required for Infusion Therapy in all settings (see the part "Getting Approval for Benefits" for details). See the section **"**Prescription Drugs Administered by a Medical Provider**"** for more details.
- **Pulmonary Rehabilitation –** Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation Therapy –** Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy –** Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transgender Services

Benefits are provided for services and supplies in connection with Gender Transition when a Physician has diagnosed you with Gender Dysphoria. This coverage is provided according to the terms and conditions of this Booklet that apply to all other mental health conditions, as described under "Mental Health and Substance Use Disorder (Chemical Dependency) Services. In addition, Covered Services for the treatment of Gender Dysphoria are subject to financial requirements (deductibles, co-insurance, and co-payments) and treatment limitations that are no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits in the same classification or sub-classification.

Coverage includes Medically Necessary services related to Gender Transition such as transgender surgery, reconstructive surgeries including genital (sex reassignment) surgery, male to female top surgery, tracheal shaving, hormone therapy, psychotherapy, and vocal training.

Precertification is required for inpatient Facility admissions for the treatment of Gender Dysphoria. Please refer to "Getting Approval for Benefits" for information on how to obtain the proper reviews.

Transgender Surgery Travel Expense. Certain travel expenses incurred in connection with an approved transgender surgery will be covered provided the expenses are authorized in advance by us.

Travel expenses include the following for you and one companion:

- Ground transportation to and from the approved Facility when the Facility is 75 miles or more from your place of residence. Air transportation by coach is available when the distance is 300 miles or more.
- Lodging.
- Our maximum payment for travel expenses will not exceed $10,000 per transgender surgery, or series of surgeries (if multiple surgical procedures are performed).

The Calendar Year Deductible will not apply and no Copayments or Coinsurance will be required for transgender travel expenses authorized in advance by us. We will provide benefits for lodging, transportation, and other reasonable expenses up to the current limits set forth in the Internal Revenue Code, not to exceed the maximum amount specified above. This travel expense benefit is not available for non-surgical transgender services.

When you request reimbursement of covered travel expenses, you must submit a completed travel reimbursement form and itemized, legible copies of all applicable receipts. Credit card slips are not acceptable. Covered travel expenses are not subject to the Deductible or Copayments. Please call Member Services at the phone number on the back of your Identification Card for further information and/or to obtain the travel reimbursement form.

Travel expenses that are not covered include: meals, alcohol, tobacco, or any other non-food item; child care; mileage within the city where the approved Facility is located, rental cars, buses, taxis or shuttle services, except as specifically approved by us; frequent flyer miles, coupons, vouchers or travel tickets; prepayments or deposits; services for a condition that is not directly related to, or a direct result of, the transgender procedure; telephone calls; laundry; postage; or entertainment.

Transplant Services

See “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services” earlier in this section.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. Urgent Care benefits are for those services necessary to prevent serious deterioration of your health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, injury or complication of an existing condition, including pregnancy. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for Urgent Care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Vision Services For Members Up to Age 19

These vision care services are covered for Members until the end of the month in which they turn 19. See "Vision Services For Members Up to Age 19" in the "Schedule of Benefits" for additional information. To get In-Network benefits, you must use a Blue View Vision eye care provider. If you need help finding one, try Find a Doctor on our website or call us at the number on the back of your ID card. Vision services provided under this benefit will not also be provided under "Vision Services (All Members / All Ages)."

For information on the formulary, including covered lenses and frames, contact our Member Services department toll free at the telephone number on the back of your Identification Card.

Routine Eye Exam

Your Plan covers a complete routine eye exam with dilation as needed. The exam is used to check all aspects of your vision. Note: Refraction is covered only when you go to a Blue View Vision provider.

Eyeglass Lenses

Covered eyeglass lenses include standard plastic (CR39) or glass lenses up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive, or
- lenticular

There are a number of additional covered lens options that are available through your Blue View Vision provider. The following lens options are included at no extra cost when received In-Network: fashion and gradient tinting; oversized and glass-grey #3 prescription sunglass lenses; blended segment lenses; intermediate vision lenses; standard, premium, select and ultra progressive lenses; photochromic glass lenses, plastic photosensitive lenses; polarized lenses, standard, premium and ultra anti-reflective coating; high index lenses, polycarbonate lenses, scratch-resistant coating.

Frames

Your Blue View Vision provider will have a collection of frames for you to choose from. They can tell you which frames are included at no extra charge and which ones will cost you more.

Contact Lenses

Each year you get a lens benefit for eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options in a given Benefit Period. Your Blue View Vision provider will have a selection of various types of contact lenses for different eye conditions and prescriptions for you to choose from. They can tell you which contacts are included at no extra charge and which ones will cost you more.

- Elective Contact Lenses – contacts you choose for comfort or appearance;

- Non-Elective Contact Lenses – contacts that are prescribed for certain eye conditions:

  - Aniridia and aphakia.
  - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
  - High Ametropia exceeding -12D or +9D in spherical equivalent.
  - Anisometropia of 3D or more.
  - When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Note: This is not an exhaustive list. Non-elective contacts may be prescribed for other conditions.

Special Note: We will not pay for Non-Elective Contact Lenses for any Member who has had elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

Low Vision

Low vision is when you have a significant loss of vision, but not total blindness. Your Plan covers services for this condition when you go to a Blue View Vision provider who specializes in low vision. They include a comprehensive low vision exam, optical/non-optical aids, and supplemental testing and follow-up care.

Vision Services For Members Age 19 and Older

These vision care services are covered for Members age 19 and older. See "Vision Services For Members Age 19 and Older" in the "Schedule of Benefits" for additional information. To get In-Network benefits, you must use a Blue View Vision eye care provider. If you need help finding one, try Find a Doctor on our website or call us at the number on the back of your ID card. Vision services provided under this benefit will not also be provided under "Vision Services (All Members / All Ages)."

Routine Eye Exam

Your Plan covers a complete routine eye exam with dilation as needed, once per Benefit Period. The exam is used to check all aspects of your vision. Note: Refraction is covered only when you go to a Blue View Vision provider. This benefit covers only the routine eye exam. This benefit does not cover any other services, including eyeglass lenses, frames, or contact lenses or eye exams for contact lenses or their fitting.

Vision Services (All Members / All Ages)

Benefits include medical and surgical treatment of injuries and illnesses of the eye.

Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.

Benefits do not include glasses or contact lenses except as listed in the "Prosthetics" section of this Booklet.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs, including Specialty Drugs that must be administered to you as part of a Doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. This may include Drugs for Infusion Therapy, chemotherapy, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to you in a medical setting. Subject to the terms and conditions explained in this section, and the exclusions shown in the "What's Not Covered" section, this Plan covers all Medically Necessary Prescription Drugs, including disposable devices that are Medically Necessary for the administration of a covered outpatient Prescription Drug.

Benefits for Drugs that you inject or get through your Pharmacy benefits (i.e., self-administered Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail Pharmacy" section.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before we can decide if the Prescription Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, we have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,
- Use of an Anthem Prescription Drug List (a formulary developed by Anthem) which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

Exceptions to the step therapy requirement or for a Drug that that is not on the Prescription Drug List may be requested. Please see the "Prior Authorization" provision in the section "Prescription Drug Benefit at a Retail Pharmacy" for step therapy exceptions and the "Exception Request for a Drug not on the Prescription Drug List (non-formulary exceptions)" provision in the same section for a non-formulary drug exception.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and Controlled Substances must be prescribed by a licensed Provider with an active DEA license. In addition, drugs and other products that are available over-the-counter and do not legally require a Prescription, but are recommended by the USPSTF for certain individuals (such as aspirin to prevent cardiovascular disease), are covered as preventive care services when prescribed by a licensed Provider.

Compound drugs are a Covered Service when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound Drug 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 are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Precertification

Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. Requests for precertification must be submitted by your Provider using the required uniform prior authorization form. If you are requesting an exception to the step therapy process, your Provider must use the same form.

Upon receiving the completed form, for either precertification or step therapy exceptions, we will review the request and give our decision to both you and your Provider within the following time periods:

- 72 hours for non-urgent requests, or
- 24 hours if exigent circumstances exist. Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a Drug not covered by the Plan.

For a list of Prescription Drugs that need precertification, please call the phone number on the back of your Identification Card or review the formulary on our website at www.anthem.com. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

If precertification is denied you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section of this Booklet.

Note that antiretroviral Drugs that are Medically Necessary for the prevention of AIDS/HIV, including pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP), are not subject to Precertification or step therapy. Also, if the United States Food and Drug Administration has approved one or more therapeutic equivalents of a Drug, device, or product for the prevention of AIDS/HIV, then at least one therapeutically equivalent version will be covered without Precertification or step therapy.

Designated Pharmacy Provider

Anthem may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. An In-Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the In-Network Provider must have signed a Designated Pharmacy Provider Agreement with us. You or your Provider can contact Pharmacy Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to you or your Provider and administered in your Provider's office, you and your Provider are required to order from a Designated Pharmacy Provider. A Patient Care coordinator will work with you and your Provider to obtain Precertification and to assist shipment to your Provider's office.

We may also require you to use a Designated Pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions. We reserve our right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to you. Anthem may, from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug if such change can help provide cost effective, value based and/or quality services.

If you are required to use a Designated Pharmacy Provider and you choose not to obtain your Prescription Drug from a Designated Pharmacy Provider, coverage will be provided at the Out-of-Network level.

You can get the list of the Prescription Drugs covered under this section by calling Pharmacy Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. For questions or issues about therapeutic Drug substitutes, call Pharmacy Member Services at the phone number on the back of your Identification Card.

Prescription Drug Benefit at a Retail Pharmacy

Your Plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Subject to the terms and conditions explained in this section, and the exclusions shown in the "What's Not Covered" section, this Plan covers all Medically Necessary Prescription Drugs, including disposable devices that are Medically Necessary for the administration of a covered outpatient Prescription Drug, such as spacers and inhalers for the administration of aerosol outpatient Prescription Drugs and syringes for self-injectable medications that are not dispensed in pre-filled syringes.

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you by a medical Provider in a medical setting (e.g., Doctor's office visit, home care visit, or outpatient Facility) are covered under the **"**Prescription Drugs Administered by a Medical Provider**"** benefit. Please read that section for important details.

This section applies also to Prescription Drugs needed for treatment of Mental Health and Substance Use Disorder (Chemical Dependency).

Prescription Drug Benefits

Prescription Drug benefits may require prior authorization to determine if your Drugs should be covered. Your In-Network Pharmacist will be told if prior authorization is required and if any additional details are needed for us to decide benefits.

Prior Authorization

Prescribing Providers must obtain prior authorization in order for you to get benefits for certain Drugs. At times, your Provider will initiate a prior authorization on your behalf before your Pharmacy fills your Prescription. At other times, the Pharmacy may make you or your Provider aware that a prior authorization or other information is needed. In order to determine if the Prescription Drug is eligible for coverage, we have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration;
- Specific clinical criteria including requirements regarding age, test result requirements, and/or presence of a specific condition or disease;
- Specific Provider qualifications including REMS certification (Risk, Evaluation and Mitigation Strategies);
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated;
- Use of a Prescription Drug List (as described below).

You or your Provider can get the list of the Drugs that require prior authorization by calling Pharmacy Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with us to

verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Requests for prior authorization must be submitted by your Provider using the required uniform prior authorization form. If you're requesting an exception to the step therapy process, your Provider must use the same form. Upon receiving the completed form, for either precertification or step therapy exceptions, we will review the request and give our decision to both you and your Provider within the following time periods:

- 72 hours for non-urgent requests, or
- 24 hours if exigent circumstances exist. Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a Drug not covered by the Plan.

Anthem may, from time to time, waive, enhance, change or end certain prior authorization and/or offer alternate benefits, if such change furthers the provision of cost effective, value based and/or quality services.

If prior authorization is denied you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section of this Booklet.

You may need to try a Drug other than the one originally prescribed if we determine that it should be clinically effective for you. However, if we determine through the prior authorization process that the Drug originally prescribed is Medically Necessary, you will be provided the Drug originally requested at the applicable Copayment. If approved, Drugs requiring prior authorization will be provided to you after you make the required Copayment. (If, when you first become a Member, you are already being treated for a medical condition with a Drug that has been appropriately prescribed and is considered safe and effective for your medical condition and you underwent a prior authorization process under a prior plan which required you to take different Drugs, we will not require you to try a Drug other than the one you are currently taking.)

Note that antiretroviral Drugs that are Medically Necessary for the prevention of AIDS/HIV, including pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP), are not subject to prior authorization or step therapy. Also, if the United States Food and Drug Administration has approved one or more therapeutic equivalents of a Drug, device, or product for the prevention of AIDS/HIV, then at least one therapeutically equivalent version will be covered without prior authorization or step therapy.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy. Controlled Substances must be prescribed by a licensed Provider with an active Drug Enforcement Administration (DEA) license. In addition, drugs and other products that are available over-the-counter and do not legally require a Prescription, but are recommended by the USPSTF for certain individuals (such as aspirin to prevent cardiovascular disease), are covered as preventive care services when prescribed by a licensed Provider.

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy;
- Specialty Drugs;
- Self-administered Drugs. These are Drugs that do not require administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that require Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Orally administered anti-cancer medications used to kill or slow the growth of cancerous cells;

- Compound Drugs when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound Drug 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 are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings. Coverage is also provided for up to a 12-month supply of FDA-approved, Self-Administered Hormonal Contraceptives, when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies. Contraceptives are covered under the "Preventive Care" benefit as explained in that section. Please see that section for more details.
- Special food products, formulas or supplements (e.g., for the treatment of Phenylketonuria (PKU)) when prescribed by a Doctor if they are Medically Necessary.
- Flu Shots (including administration). These will be covered under the "Preventive Care" benefit.
- Immunizations (including administration) required by the "Preventive Care" benefit.
- AIDS vaccine (when approved)
- Appropriate pain management medications for terminally ill patients.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older. These products will be covered under the "Preventive Care" benefit.
- Prescription Drugs used to treat sexual or erectile dysfunctions or inadequacies. Documentation of a confirmed diagnosis of erectile dysfunction must be submitted to us for review.

Where You Can Get Prescription Drugs

In-Network Pharmacy

You can visit one of the local Retail Pharmacies in our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when you get the Drug. If the retail price for a covered Prescription and/or refill is less than the applicable Copayment amount, you will not be required to pay more than the retail price. The retail price paid will constitute the applicable cost sharing and will apply toward the deductible, if any, and the Out-of-Pocket Limit in the same manner as a Copayment or Coinsurance. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to us with a written request for payment.

Important Note: If our records show that you may be using Prescription Drugs, such as narcotics, anxiolytics, skeletal muscle relaxants, sedative hypnotics, and/or amphetamines, in a harmful or abusive manner, or with harmful frequency, we will inform you in writing that if you continue to use Prescription Drugs in this manner, you may be enrolled in our Pharmacy Home Program. This letter will also tell you how to appeal our assessment. The Pharmacy Home Program uses a single Pharmacy, known as your Pharmacy Home, to provide and coordinate all of your Pharmacy services for the next 12 months and benefits will only be paid if you use your Pharmacy Home. If review of our records 60 days after the above notification shows that use of a single In-Network Pharmacy is still needed, we will notify you of the date you will be enrolled in the Pharmacy Home Program and provide you with a list of Pharmacies from which to select an In-Network Pharmacy Home within 15 days. We will also inform you how you can appeal our decision. If you do not select an In-Network Pharmacy within 15 days, we will select a Pharmacy Home for you. You will be given 30

days from our notice of enrollment to appeal our decision before your enrollment in a Pharmacy Home becomes effective. (For more information regarding appealing our decision, please see the section entitled "Grievance and External Review Procedures.") If you are enrolled in the Pharmacy Home Program, we will review our decision in 12 months and notify you that we have discontinued your enrollment in the Pharmacy Home Program if the review shows that you are not using Prescription Drugs in a harmful or abusive manner. If you have an Emergency, we will exempt you from the Pharmacy Home Program for at least 72 hours. You may be removed from the Program if it is Medically Necessary for you to use more than one Pharmacy or if your Physician requests that you be removed from the Program.

In addition, if we determine that you may be using Controlled Substance Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of In-Network Providers for Controlled Substance Prescription may be limited. If this happens, we may require you to select a single In-Network Provider that will provide and coordinate all Controlled Substance Prescriptions. Benefits for Controlled Substance Prescriptions will only be paid if you use the single In-Network Provider. We will contact you if we determine that use of a single In-Network Provider is needed and give you options as to which In-Network Provider you may use. If you do not select one of the In-Network Providers we offer within 31 days, we will select a single In-Network Provider for you. If you disagree with our decision, you may ask us to reconsider it as outlined in the "Grievance and External Review Procedures" section of this Booklet.

Maintenance Pharmacy

You may also obtain a 90-day supply of Maintenance Medications from a Maintenance Pharmacy. A Maintenance Medication is a Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication or need to determine if your Pharmacy is a Maintenance Pharmacy, please call Pharmacy Member Services at the number on the back of your Identification Card or check our website at www.anthem.com for more details.

Specialty Pharmacy

We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time. We may require you or your doctor to order certain Specialty Drugs from the PBM's Specialty Pharmacy (see below).

When you use the PBM's Specialty Pharmacy, its patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to your home or your preferred address. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Specialty Drugs by calling Pharmacy Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Specialty Drugs that require special handling, provider coordination, or patient education that cannot be provided by a retail Pharmacy must be obtained through the specialty pharmacy program unless you qualify for an exception. When these Specialty Drugs are not obtained through the specialty pharmacy program (and you don't have an exception), you will not receive any benefits for these Drugs under this plan. You will have to pay the full cost of Specialty Drugs you get from a retail Pharmacy that should have been obtained from the specialty pharmacy program.

Exceptions to the specialty pharmacy program:

This requirement does not apply to:

- The first month's supply of a specified Specialty Drug which is available through a retail In-Network Pharmacy (limited to a 30-day supply);
- Specialty Drugs that do not require special handling, provider coordination, or patient education that cannot be provided by a retail Pharmacy;

- Drugs, which, due to Medical Necessity, are needed urgently and must be administered to the Member immediately.

How to obtain an exception to the specialty pharmacy program. If you believe that you should not be required to get your medication through the specialty pharmacy program, for any of the reasons listed above or others, you or your Physician must complete an "Exception to the Specialty Pharmacy Program" form to request an exception and send it to us. The form can be faxed or mailed to us. If you need a copy of the form, you may call the Pharmacy Member Services number listed on your Identification Card to request one. You can also get the form online at www.anthem.com. If we have given you an exception, it will be good for a limited period of time. The exception period will be determined based on the reason for the exception. When the exception period ends, if you believe that you should still not be required to get your medication through the specialty pharmacy program, you must again request an exception. If we deny your request for an exception, it will be in writing and will tell you why we did not approve the exception.

Urgent or Emergency need of a Specialty Drug subject to the specialty pharmacy program. If you are out of a Specialty Drug which must be obtained through the specialty pharmacy program, we will authorize an override of the specialty pharmacy program requirement for 72 hours, or until the next business day following a holiday or weekend, to allow you to get a 72-hour Emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your Doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment or Coinsurance, if any.

If you order your Specialty Drug through the specialty pharmacy program and it does not arrive, if your Physician decides that it is Medically Necessary for you to have the Drug immediately, we will authorize an override of the specialty pharmacy program requirement for a 30-day supply or less to allow you to get an Emergency supply of medication from an In-Network Pharmacy near you. A Pharmacy Member Services representative from the specialty pharmacy program will coordinate the exception and you will not be required to pay an additional Copayment.

Oral Anti-Cancer Prescription Drugs. With few exceptions, most orally administered anti-cancer medications are considered Specialty Drugs. For orally administered anti-cancer medications, the Deductible, if any, will not apply and the Copayment will not exceed the lesser of the applicable Copayment shown in the "Schedule of Benefits" or $250 for a 30-day supply for medications obtained at a retail Pharmacy.

Out-of-Network Pharmacy

You may also use a Pharmacy that is not in our network. You will be charged the full retail price of the Drug and you will have to send your claim for the Drug to us. (Out-of-Network Pharmacies won't file the claim for you.) You can get a claims form from us or the PBM. You must fill in the top section of the form and ask the Out-of-Network Pharmacy to fill in the bottom section. If the bottom section of this form cannot be filled out by the pharmacist, you must attach a detailed receipt to the claim form. The receipt must show:

- Name and address of the Out-of-Network Pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;
- Name of the Drug;
- Cost of the Drug;
- Quantity (amount) of each covered Drug or refill dispensed.

You must pay the amount shown in the "Schedule of Benefits." This is based on the Maximum Allowed Amount as determined by our normal or average contracted rate with network Pharmacies on or near the date of service.

What You Pay for Prescription Drugs

Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier contains preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier contains non-preferred and high cost Drugs. This includes Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3. This tier contains high cost Drugs including Specialty Drugs that may be Generic, single source Brand Drugs or multi-source Brand Drugs.

We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Prescription Drug List

We also have an Anthem Prescription Drug List (a formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. The formulary is updated quarterly to ensure that the list includes Drugs that are safe and effective. You can get a copy of the list by calling us at the phone number on the back of your Identification Card or visiting our website at www.anthem.com. See "Exception Request for a Drug not on the Prescription Drug List (non-formulary exceptions)" below for information about obtaining Drugs that are not on our Prescription Drug List.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons. Not all forms of a Prescription Drug may be included on the Drug List. The inclusion of a Prescription Drug on the Drug List may vary by the dosage and administration (i.e., oral, injection, topical or inhaled) of the Prescription Drug. See "Exception Request for a Drug not on the Prescription Drug List (non-formulary exceptions)" below for information about obtaining dosages or forms of Drugs that are not on our Prescription Drug List.

You may request a copy of the covered Prescription Drug list by calling the Pharmacy Member Services telephone number on the back of your Identification Card or visiting our website at www.anthem.com. The Drug List is subject to change. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Exception Request for a Drug not on the Prescription Drug List (non-formulary exceptions)

Your Prescription Drug benefit covers those Drugs listed on our Prescription Drug List. This Prescription Drug List contains a limited number of Prescription Drugs, and may be different than the Prescription Drug List for other Anthem products. In cases where your Doctor prescribes a medication that is not on the Prescription Drug List, it may be necessary to obtain a non-formulary exception in order for the Prescription Drug to be a covered benefit. Your Doctor must complete a non-formulary exception form and return it to us. You or your Doctor can get the form online at www.anthem.com or by calling the number listed on the back of your ID card.

When we receive a non-formulary exception request, we will make a coverage decision within a certain period of time, depending on whether exigent circumstances exist.

Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a Drug not covered by the Plan. In this case, we will make a coverage decision within 24 hours of receiving your request. If we approve the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency. If we deny coverage of the Drug, you have the right to request an external review by an Independent Review Organization (IRO). The IRO will make a coverage decision within 24 hours of receiving your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency.

When exigent circumstances do not exist, we will make a coverage decision within 72 hours of receiving your request for a non-formulary exception. If we approve the coverage of the Drug, coverage of the Drug will be provided for the duration of the prescription, including refills. If we deny coverage of the Drug, you have the right to request an external review by an IRO. The IRO will make a coverage decision within 72 hours of receiving your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of the prescription.

Requesting a non-formulary exception or having an IRO review your request for a non-formulary exception does not affect your right to submit a grievance or request an Independent Medical Review. Please see the section entitled “Grievance and External Review Procedures” for details.

Coverage of a Drug approved as a result of your request or your Doctor’s request for an exception will only be provided if you are a Member enrolled under the Plan.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the “Schedule of Benefits.” In most cases, you must use a certain amount of your Prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. We will work with the Pharmacy to decide when this should happen.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Pharmacy Member Services at the number on the back of your Identification Card.

You may be able to also get partial fills of prescribed Schedule II controlled substances, if requested by you or your Physician. A partial fill means a part of a Prescription Order filled that is of a quantity less than the entire prescription. For oral, solid dosage forms of prescribed Schedule II controlled substances that are partially filled, your cost share will be prorated accordingly.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected “once daily dosage” Drugs on our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a “½ tablet daily.” The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Single Tablet Regimen for HIV

For combination antiretroviral Drug treatments that are Medically Necessary for the treatment of AIDS/HIV, this Plan will cover a single-tablet Drug regimen that is as effective as a multitablet regimen unless, consistent with clinical guidelines and peer-reviewed scientific and medical literature, the multitablet regimen is clinically equally or more effective and more likely to result in adherence to a Drug regimen.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. For questions or issues about therapeutic Drug substitutes, call Pharmacy Member Services at the phone number on the back of your Identification Card.

Split Fill Dispensing Program

The split fill dispensing program is designed to prevent and/or minimize wasted Prescription Drugs if your Prescription Drugs or dose changes between fills, by allowing only a portion of your prescription to be filled. This program also saves you out of pocket expenses. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side-effects. This program allows you to get your Prescription Drug in a smaller quantity and at a prorated copay so that if your dose changes or you have to stop taking the Prescription Drug, you can save money by avoiding costs for Prescription Drugs you may not use. You can access the list of these Prescription Drugs by calling the toll-free number on your member ID card or log on to the website at www.anthem.com.

Special Programs

Except when prohibited by law or regulation, from time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time.

Rebate Impact on Prescription Drugs You Get at Retail Pharmacies

Anthem and/or its PBM may also, from time to time, enter into agreements that result in Anthem receiving rebates or other funds (“rebates”) directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others.

You will be able to take advantage of a portion of the cost savings anticipated by Anthem from rebates on Prescription Drugs purchased by you from Retail or Specialty Pharmacies under this section. If the Prescription Drug purchased by you is eligible for a rebate, most of the estimated value of that rebate will be used to reduce the Maximum Allowable Amount for the Prescription Drug. Any Deductible or Coinsurance would be calculated using that reduced amount. The remaining value of that rebate will be used to reduce the cost of coverage for all Members enrolled in coverage of this type.

It is important to note that not all Prescription Drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the ultimate rebate will not be known at the time you purchase the Prescription Drug, the amount of the rebate applied to your claim will be based on an estimate. Payment on your claim will not be adjusted if the later determined rebate value is higher or lower than our original estimate.

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 those services listed below. This Exclusion does not apply to Medically Necessary services to treat Mental Health and Substance Use Disorder as required by state law.
  - 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 Mental Health and Substance Use Disorder 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 it is Medically Necessary that you take it rather than the clinically equivalent Drug. Benefits for the Prescription Drug will be reviewed 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. This exclusion does not apply to any services and supplies that are covered as part of Reconstructive Surgery for breast symmetry after a mastectomy, surgery to correct birth defects and birth abnormalities, services provided for the treatment of Gender Dysphoria, or any surgery to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomology or creating a normal appearance.
- **Court Ordered Testing.** Court ordered testing or care unless Medically Necessary.
- **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 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.
- 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, and 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.
- Hemisection of deciduous teeth.
- Crowns are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.
- Inlays.
- Services or supplies that are not Medically Necessary.

- **Drugs Contrary to Generally Accepted Medical and Professional Standards.** Drugs given to you or prescribed in a way that is against generally accepted standards of medical practice or inconsistent with FDA approvals (except covered off-label use).
- **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 Pharmacy).
- **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.
- **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.
- **Educational Services.** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based. This Exclusion does not apply to Medically Necessary services to treat Mental Health and Substance Use Disorder as required by state law, or to educational and counseling services related to screening for or the treatment of asthma, diabetes, HIV, tobacco use prevention and cessation, family planning and contraceptive management, breastfeeding, nutritional counseling, or educational services in the treatment of mental health or substance use disorder.
- **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; 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".
- **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, 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.
- **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 Mental Health and Substance Use Disorder as required by state law, or to "Hospice Care" as specified in the section "What's Covered".
- **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.
- **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.
- **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 that are not Medically Necessary for the diagnosis and treatment of a covered illness or injury. This Exclusion does not apply to Medically Necessary preventive care services as specified in the "Preventive Care" provision in the section "What's Covered".
- **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 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.
- **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 Mental Health and Substance Use Disorder 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. This includes wigs and scalp hair prosthetics.
- **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 Mental Health and Substance Use Disorder 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 Mental Health and Substance Use Disorder as required by state law, or to immunizations required or recommended for travel to countries outside the United States.
- **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 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.

- **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 or as stated under “Vision Services For Members Age 19 and Older” in “What’s Covered”.
  - 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 or oversize lenses or sunglasses, unless specifically listed in this Booklet.
  - 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 Mental Health and Substance Use Disorder as required by state law.

What's Not Covered Under Your Prescription Drug Retail Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail 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 generally accepted standards of medical practice or inconsistent with FDA approvals (except covered off-label use).
- **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 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.
- **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 Pharmacy).
- **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.
- **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.

- **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.
- **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.
- **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 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 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 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.** Prescription Drugs dispensed by any 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 Mental Health and Substance Use Disorder 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.
- **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.
- **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.

Claims Payment

This section describes how we reimburse claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you. If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will file your claim for you, although they are not required to do so. If you file the claim, use a claim form as described later in this section.

Maximum Allowed Amount

General

This section describes the term "Maximum Allowed Amount*"* as used in this Booklet, and what the term means to you when obtaining Covered Services under this Plan. The Maximum Allowed Amount is the total reimbursement payable under your Plan for Covered Services you receive from In-Network and Out-of-Network Providers. It is our payment towards the services billed by your Provider combined with any Deductible, Coinsurance or Copayment owed by you. In some cases, you may be required to pay the entire Maximum Allowed Amount. For instance, if you have not met your Deductible under this Plan, then you could be responsible for paying the entire Maximum Allowed Amount for Covered Services. In addition, if these services are received from an Out-of-Network Provider, you may be billed by the Provider for the difference between their charges and our Maximum Allowed Amount. In many situations, this difference could be significant. If you receive services from any in-network health facility in California at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" below for more information.

We have provided three examples below, which illustrate how the Maximum Allowed Amount works. These examples are for illustration purposes only.

Example: The Plan has a Member Coinsurance of 30% for In-Network Provider services after the Deductible has been met.

- The Member receives services from an In-Network surgeon. The charge is $2,000. The Maximum Allowed Amount under the Plan for the surgery is $1,000. The Member's Coinsurance responsibility when an In-Network surgeon is used is 30% of $1,000, or $300. This is what the Member pays. We pay 70% of $1,000, or $700. The In-Network surgeon accepts the total of $1,000 as reimbursement for the surgery regardless of the charges.

Example: The Plan has a Member Coinsurance of 50% for Out-of-Network Provider services after the Deductible has been met.

- The Member receives services from an Out-of-Network surgeon. The charge is $2,000. The Maximum Allowed Amount under the Plan for the surgery is $1,000. The Member's Coinsurance responsibility when an Out-of-Network surgeon is used is 50% of $1,000, or $500. We pay the remaining 50% of $1,000, or $500. In addition, the Out-of-Network surgeon could bill the Member the difference between $2,000 and $1,000. So the Member's total out-of-pocket charge would be $500 plus an additional $1,000, for a total of $1,500.

Example: The Member receives outpatient surgery services from an Out-of-Network Facility. The Deductible has not been met, which means that the Plan won't cover anything until the Member meets their Deductible.

- The charge is $3,500. The Maximum Allowed Amount under the Plan for the outpatient Facility surgery is $2,000. The outpatient Facility charges are capped at a maximum benefit payable of $380 per admission. The Plan calculates benefits based on 50% of the Maximum Allowed Amount ($1,000), up to the maximum benefit payable of $380, which is the amount applied to the Member's Deductible. Since the Deductible has not been met, the Member is responsible for paying any charges in excess of the $380 maximum benefit payable that the Provider may bill.

When you receive Covered Services, we will, to the extent applicable, apply claim processing rules to the claim submitted. We use these rules to evaluate the claim information and determine the accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying these rules may affect the Maximum Allowed Amount if we determine that the procedure and/or diagnosis codes used were inconsistent with procedure coding rules and/or reimbursement policies. For example, if your Provider submits a claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed, the Maximum Allowed Amount will be based on the single procedure code.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

In-Network Providers: For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for your Plan is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Member Services at the telephone number on the back of your Identification Card for help in finding an In-Network Provider or visit www.anthem.com.

Out-of-Network Providers or Other Eligible Providers: Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers or Other Eligible Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary Providers. For Covered Services you receive from an Out-of-Network Provider or Other Eligible Provider, other than Emergency Care, the Maximum Allowed Amount will be based on the applicable Anthem Out-of-Network Provider or Other Eligible Provider rate or fee schedule for your Plan, an amount negotiated by us or a third party vendor which has been agreed to by the Out-of-Network Provider or Other Eligible Provider, an amount based on or derived from the total charges billed by the Out-of-Network Provider or Other Eligible Provider, an amount based on information provided by a third party vendor or an amount based on reimbursement or cost information from the Centers for Medicare & Medicaid Services ("CMS"). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually. For Emergency Care rendered by an Out-of-Network Provider, reimbursement is based on the greater of the following:

1. the median of our In-Network Provider rates for the Emergency Care, excluding any In-Network Provider Copayment or Coinsurance;
2. the amount for the Emergency Care calculated using the same method we generally use to determine payments for Out-of-Network Provider services, excluding any In-Network Provider Copayment or Coinsurance;
3. the amount that would be paid under Medicare for the Emergency Care, excluding any In-Network Provider Copayment or Coinsurance.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the methods shown above unless the contract between us and that Provider specifies a different amount.

Unlike In-Network Providers, Out-of-Network Providers and Other Eligible Providers may send you a bill and collect for the amount of the Out-of-Network Provider's or Other Eligible Provider's charge that exceeds the Maximum Allowed Amount under this Plan. This amount can be significant. (**Note**: If you receive services from any in-network health facility in California at which, or as a result of which, you receive non-Emergency Covered Services from Out-of-Network Providers, you will pay no more than the same cost sharing that you would pay for those same non-Emergency Covered Services received from an In-Network Provider, and you will not have to pay the Out-of-Network Provider more than the In-Network cost sharing for such non-

Emergency Covered Services. Please see “Member Cost Share” below for more information.) Choosing an In-Network Provider will likely result in lower out-of-pocket costs to you. Please call the Member Services telephone number on the back of your Identification Card for help in finding an In-Network Provider or visit our website at www.anthem.com. Member Services is also available to assist you in determining your Plan’s Maximum Allowed Amount for a particular Covered Service from an Out-of-Network Provider or Other Eligible Provider. Please see “Inter-Plan Arrangements” later in this section for additional details.

Please see your “Schedule of Benefits” for your payment responsibility.

For Covered Services rendered outside Anthem’s Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan’s non-participating provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by us using Prescription Drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services, and depending on your Plan design, you may be required to pay all or a part of the Maximum Allowed Amount as your cost share amount (Deductible, Copayment, and/or Coinsurance). Your cost share amount and Out-of-Pocket Limits may be different depending on whether you received Covered Services from an In-Network Provider, Out-of-Network Provider or Other Eligible Provider. Specifically, you may be required to pay higher cost-sharing amounts or may have limits on your benefits when using Out-of-Network Providers or Other Eligible Providers. However, if you receive services from any in-network health facility in California at which, or as a result of which, you receive non-Emergency Covered Services from Out-of-Network Providers, you will pay no more than the same cost sharing that you would pay for those same non-Emergency Covered Services received from an In-Network Provider, and you will not have to pay the Out-of-Network Provider more than the In-Network cost sharing for such non-Emergency Covered Services. Please see your “Schedule of Benefits” in this Booklet for your cost share responsibilities and limitations, or call Member Services at the telephone number on the back of your Identification Card to learn how this Plan’s benefits or cost share amounts may vary by the type of Provider you use.

Anthem will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network Provider, Out-of-Network Provider or Other Eligible Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/ visit limits.

In some instances you may be asked to pay only the lower In-Network Provider cost share percentage when you use an Out-of-Network Provider. For example, if you receive services from any in-network health facility in California at which, or as a result of which, you receive non-Emergency Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist providing services at the facility, you will pay no more than the same cost sharing that you would pay for those same non-Emergency Covered Services received from an In-Network Provider and you will not have to pay the Out-of-Network Provider more than the In-Network cost sharing for such non-Emergency Covered Services. The In-Network Provider cost share percentage will apply to any In-Network Deductible and the In-Network Out-of-Pocket Limit. However, if you consent in writing to receive non-Emergency Covered Services from an Out-of-Network Provider while you are receiving services from an In-Network Facility, the Plan will pay such Out-of-Network services based on the applicable Out-of-Network cost sharing stated in your “Schedule of Benefits” in this Booklet. The written consent to receive non-Emergency Covered Services from Out-of-Network Providers while you are receiving services from an In-Network Facility must demonstrate satisfaction of all the following criteria:

- At least 24 hours in advance of care, you consent in writing to receive services from the identified Out-of-Network Provider;

- The consent was obtained by the Out-of-Network Provider in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent was not obtained by the Facility or any representative of the Facility at the time of admission or at any time when you were being prepared for surgery or any other procedure;

- At the time of consent, the Out-of-Network Provider gave you a written estimate of your total Out-of-Pocket cost of care, based on the Provider's billed charges for the services to be provided. The Out-of-Network Provider shall not attempt to collect more than the estimated amount without receiving a separate written consent from you or your authorized representative, unless the Provider was required to make changes to the estimate due to circumstances during the delivery of services that were unforeseeable at the time the estimate was given;

- The consent advises that you may elect to seek care from an In-Network Provider or that you may make arrangements with your Plan to receive services from an In-Network Provider for lower Out-of-Pocket costs;

- The consent and estimate was provided to you in the language you speak, if the language is a Medi-Cal threshold language, as defined in subdivision (d) of Section 128552.

- The consent advises you that any costs incurred as a result of your use of the Out-of-Network benefits are in addition to the In-Network cost-sharing amounts and may not count toward the annual In-Network Out-of-Pocket Limit or In-Network Deductible.

Authorized Referrals

In some circumstances, we may authorize In-Network Provider cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you or your Physician must contact us in advance of obtaining the Covered Service. It is your responsibility to ensure that we have been contacted. If we authorize an In-Network Provider cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. If you receive prior authorization for an Out-of-Network Provider due to network adequacy issues, you will not be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount. Please contact Member Services at the telephone number on the back of your Identification Card for Authorized Referrals information or to request authorization.

It is important to understand that you may be referred by Anthem In-Network Providers to other Providers who may be contracted with Anthem for some types of plans, but are not part of your Plan's network of In-Network Providers. In such case, claims incurred may be paid as Out-of-Network Provider services, even though the Provider may be a participating Provider with Anthem and you were referred to that Provider by another Anthem participating Provider.

It is generally your responsibility to confirm that the Provider you are seeing or have been referred to see is an In-Network Provider with your Plan. Claims paid for Out-of-Network Provider services may mean a higher financial responsibility for you and confirming that the Provider is an In-Network Provider with this Plan will help protect you from this additional cost. Please note however that if you receive services from any in-network health facility in California at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing you would pay for the same Covered Services received from an In-Network Provider, and in this case you are not expected to confirm that the Provider is an In-Network Provider with this Plan.

Please note that if you receive services from any in-network health facility in California at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, even if you or your Physician did not contact us in advance and we did not authorize that you receive the services, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" above for more information.

Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. Such balance billing must meet the criteria set forth in applicable state law. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim in order for benefits to be provided.

In-Network Providers will submit claims for you. They are responsible for ensuring that claims have the information we need to determine benefits. If the claim does not include enough information, we will ask them for more details, and they will be required to supply those details within certain timeframes.

Out-of-Network claims can be submitted by the Provider if the Provider is willing to file on your behalf. However if the Provider will not submit the claim on your behalf, you will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claim form, you can send a written request to us, or contact Member Services and ask for a claim form to be sent to you. If you do not receive the claims form, you can still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:

- Name of patient.
- Patient’s relationship to the Student.
- Identification number.
- Date, type, and place of service.
- Your signature and the Provider’s signature.

Out-of-Network claims must be submitted within 180 days after the date of service. In certain cases, state or federal law may allow additional time to file a claim if you could not reasonably file within the 180-day period. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask you for more details and inform you of the time by which we need to receive that information. Once we receive the required information, we will process the claim according to the terms of your Plan.

Claims submitted by a public (government operated) Hospital or clinic will be paid by us directly, as long as you have not already received benefit under that claim. We will pay all claims within 30 days after we receive proof of loss. If you are dissatisfied with our denial or amount of payment, you may request that we review the claim a second time, and you may submit any additional relevant information.

Please note that failure to submit the information we need by the time listed in our request could result in the denial of your claim, unless state or federal law requires an extension. Please contact Member Services if you have any questions or concerns about how to submit claims.

Time of Payment of Claim

Any benefits determined to be due under this Plan shall be paid within thirty (30) working days after we receive a complete written proof of loss and determination that benefits are payable. A claim together with all additional information reasonably necessary to determine our obligation under this Plan and reasonable access to information concerning provider services is required. Information necessary to determine our obligation under this Plan includes reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for us to determine the Medical Necessity for the health care services provided.

Physical Examination

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

Member's Cooperation

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

Payment of Benefits

You authorize us to make payments directly to Providers for Covered Services. In no event, however, shall our right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. We reserve the right to make payments directly to you as opposed to any Provider for Covered Service, at our discretion. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to, an Alternate Recipient (which is defined herein as any child of a Student who is recognized, under a "Qualified Medical Child Support Order", as having a right to enrollment under the University's Plan), or that person's custodial parent or designated representative. Any payments made by us (whether to any Provider for Covered Service or you) will discharge our obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, any applicable state or federal law.

We will pay Out-of-Network Providers and other Providers of service directly when Emergency services and care are provided to you or one of your Dependents or one of your Dependents. We will continue such direct payment until the Emergency Care results in stabilization. You may be responsible for any charges in excess of the Maximum Allowed Amount that may be billed by an Out-of-Network Provider.

If you receive services from any in-network health facility in California at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. You will not have to pay the Out-of-Network Provider more than the In-Network cost sharing for such non-Emergency Covered Services. Please see "Member Cost Share" above for more information.

Once a Provider performs a Covered Service, we will not honor a request to withhold payment of the claims submitted.

The coverage, rights, and benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and/or law, sue or otherwise begin legal action, or request Plan

documents or any other information that a Participant or beneficiary may request under applicable law. Any assignment made without written consent from the Plan will be void and unenforceable.

Legal Actions

No action at law or at equity may be brought to recover on this Plan sooner than sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Plan. No such action may be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Inter-Plan Arrangements

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area we serve (the "Anthem Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that you obtain from a Pharmacy and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, we will still fulfill our contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When you receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Anthem by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Plan on your behalf, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

E. Nonparticipating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem's Service Area by non-participating providers, we may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment we will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency services.

2. Exceptions

In certain situations, we may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount we will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we make for the Covered Services as set forth in this paragraph.

F. Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177.

If you need inpatient hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need Emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Getting Approval for Benefits" section in this Booklet for further information. You can learn how to get preauthorization when you need to be admitted to the hospital for Emergency or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core®

In most cases, when you arrange inpatient hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core®; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need Blue Cross Blue Shield Global Core® claim forms you can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core® Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

You will find the address for mailing the claim on the form.

Coordination of Benefits When Members Are Covered Under More Than One Plan

If you are covered by more than one health plan, your benefits under This Plan will be coordinated with the benefits of those Other Plans so that the benefits and services you receive from all coverages do not exceed 100% of the Maximum Allowed Amount. These coordination provisions apply separately to each Member, per Benefit Period, and are largely determined by California law. Any coverage you have for medical or dental benefits will be coordinated as shown below.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appears in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this “Definitions” provision.

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

The following are not an Allowable Expense:

1. Use of a private Hospital room is not an Allowable Expense unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for private Hospital rooms.

2. If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.

3. If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.

4. If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.

5. The amount of any benefit reduction by the Principal Plan because you did not comply with the plan’s provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, utilization review requirements, and network provider arrangements.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.
4. Any coverage under governmental programs, and any coverage required or provided by any statute, unless, by law, its benefits are secondary to those of any private insurance program or other non-governmental program.

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

Coordination of Benefits does not apply to Student Accidental Death and Dismemberment insurance, Repatriation of Remains Expense insurance, or Emergency Medical Evacuation Expense insurance if included in this Plan.

Principal Plan is the plan which will have its benefits determined first.

This Plan is that portion of This Plan which provides benefits subject to this provision.

EFFECT ON BENEFITS

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.
3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

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

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision.

2. A plan which covers you as the primary insured (such as a student or an employee) pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before the plan which covers you as a retired employee.

3. For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the calendar year pays before the plan of the parent whose birthday falls later in the calendar year. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

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

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

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

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

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

4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 6. applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays last. If the order of benefit determination provisions of the Other Plan does not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.

6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

OUR RIGHTS UNDER THIS PROVISION

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

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

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

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

Third Party Liability and Reimbursement

Under some circumstances, a third party may be liable or legally responsible by reason of negligence, an intentional act, or the breach of a legal obligation of such third party for an injury, disease, or other condition for which a Member receives Covered Services. In that event, any benefits we pay under this Booklet for such Covered Services will be subject to the following:

- We will automatically have a lien upon any amount you receive from the third party or the third party's insurer or guarantor by judgment, award, settlement or otherwise. Our lien will be in the amount of the benefits we pay under this Booklet for treatment of the illness, injury, disease, or condition for which the third party is liable. Our lien will not exceed the amount we actually paid for those services if we paid the Provider other than on a capitated basis. If we paid the Provider on a capitated basis, our lien will not exceed 80% of the usual and customary charges for those services in the geographic area in which they were rendered. In addition, if you engaged an attorney to gain your Recovery from the third party, our lien shall not be for a sum in excess of one-third of the monies due you under any final judgment, compromise, or settlement agreement. If you did not engage an attorney, our lien shall not be for a sum in excess of one-half of the monies due you under any final judgment, compromise, or settlement agreement. Where a final judgment includes a special finding by a judge, jury or arbitrator that you were partially at fault, our lien shall be reduced by the same comparative fault percentage by which your Recovery was reduced. Our lien is subject to a pro rata reduction commensurate with your reasonable attorney's fees and costs in accordance with the common fund doctrine.

- You agree to advise us in writing of your claim against a third party within sixty (60) days of making such claim, and that you will take such action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our lien rights. You agree not to take any action that may prejudice our rights or interests under the Plan. You agree also that failing to give us such notice, or failing to cooperate with us, or taking action that prejudices our rights will be a material breach of the Plan. In the event of such material breach, you will be personally responsible and liable for reimbursing to us the amount of benefits we paid.

- We will be entitled to collect on our lien even if the amount recovered by or for the Member (or his or her estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss suffered by the Member.

Member Rights and Responsibilities

As a Member you have rights and responsibilities when receiving health care. As your health care partner, we want to make sure your rights are respected while providing your health benefits. That means giving you access to our network health care Providers and the information you need to make the best decisions for your health. As a Member, you should also take an active role in your care.

You have the right to:

- Speak freely and privately with your health care Providers about all health care options and treatment needed for your condition, no matter what the cost or whether it is covered under your Plan.
- Work with your Doctors to make choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private by following our privacy policies, and state and federal laws.
- Get the information you need to help make sure you get the most from your health Plan, and share your feedback. This includes information on:
  - Our company and services.
  - Our network of health care Providers.
  - Your rights and responsibilities.
  - The rules of your health Plan.
  - The way your health Plan works.
- Make a complaint or file an appeal about:
  - Your health Plan and any care you receive.
  - Any Covered Service or benefit decision that your health Plan makes.
- Say no to care, for any condition, sickness or disease, without having an effect on any care you may get in the future. This includes asking your Doctor to tell you how that may affect your health now and in the future.
- Get the most up-to-date information from a health care Provider about the cause of your illness, your treatment and what may result from it. You can ask for help if you do not understand this information.

You have the responsibility to:

- Read all information about your health benefits and ask for help if you have questions.
- Follow all health Plan rules and policies.
- Choose an In-Network Primary Care Physician, also called a PCP, if your health Plan requires it.
- Treat all Doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call your health care Provider's office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your health care Providers to make a treatment plan that you all agree on.
- Inform your health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the health care plan that you have agreed on with your health care Providers.

- Give us, your Doctors and other health care Providers the information needed to help you get the best possible care and all the benefits you are eligible for under your health Plan. This may include information about other health insurance benefits you have along with your coverage with us.
- Inform Member Services if you have any changes to your name, address or Dependents covered under your Plan.

If you would like more information, have comments, or would like to contact us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

We want to provide high quality benefits and customer service to our Members. Benefits and coverage for services given under the Plan are governed by the Booklet and not by this Member Rights and Responsibilities statement.

Grievance and External Review Procedures

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. If you have a question about your eligibility, your benefits under this Booklet, or concerning a claim, please call our Member Services department at the telephone number on the back of your Identification Card. Our Member Services staff will answer your questions or assist you in resolving your issue.

If you are dissatisfied and wish to file a Grievance, you may request a copy of the Grievance form from Anthem. You may ask the Member Services representative to complete the form for you over the telephone or you may submit a Grievance form online in the "Members" section at www.anthem.com. You may also submit a Grievance to the following address:

For Medical and Prescription Drug or Pharmacy Issues:
Anthem Blue Cross Life and Health Insurance Company
Attn: Grievances and Appeals
21215 Burbank Blvd.
Woodland Hills, CA 91367

A "Grievance" means a written or oral expression of dissatisfaction regarding the Plan and/or Provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by a Member or the Member's representative. Where we are unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. "Complaint" is the same as "Grievance."

You must submit your Grievance to us no later than 180 days following the date of the denial notice from us that you allege to be improper or any other incident or action with which you are dissatisfied. You must include all pertinent information from your Identification Card and the details and circumstances of your concern or problem. Upon receipt of your Grievance, your issue will become part of our formal Grievance process and will be resolved accordingly.

Grievances received by us will be acknowledged in writing as required by law. Except for Grievances that concern the Prescription Drug List, we will review and respond to your Grievance within the following timeframes:

- After we have received your Grievance, we will send you a written statement on its resolution or pending status within thirty (30) days.

- If your case involves an imminent and serious threat to your health, including severe pain or the potential loss of life, limb, or major bodily function, or you believe this Plan has been or will be improperly cancelled, rescinded, or not renewed, review of your Grievance will be expedited, and we will provide you with a written statement on the disposition or pending status of the Grievance no later than three (3) days from the receipt of the Grievance.

If you are dissatisfied with the resolution of your Grievance, or if your Grievance has not been resolved after at least thirty (30) days, you may submit your Grievance to the California Department of Insurance (CDI) for review prior to binding arbitration (see the section entitled COMPLAINT NOTICE, at the beginning of this Booklet for the CDI's address, telephone numbers, and internet address). If your case involves an imminent and serious threat to your health, as described above, or a cancellation or non-renewal of coverage under this Booklet, you are not required to complete our Grievance process, but may immediately submit your Grievance to the California Department of Insurance for review.

If, after a denial of benefits, we consider, rely on or generate any new or additional evidence in connection with your claim, we will provide you with that new or additional evidence, free of charge. We will not base our Grievance decision on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If we fail to follow the Grievance procedures outlined under this section the Grievance process may be deemed exhausted. However, the Grievance process will not be deemed exhausted due to de minimis violations that do not cause, and are not

likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond our control.

You may at any time pursue your ultimate remedy, which is binding arbitration (see “Binding Arbitration” in this section for additional details).

Independent Medical Review Based Upon the Denial of Experimental or Investigational Treatment

If a Member has had coverage denied because proposed treatment is determined by us to be Experimental or Investigational, that Member may ask for review of that denial by an Independent Medical Review (“IMR”) organization contracting with the California Department of Insurance . A request for review may be submitted to the California Department of Insurance in accordance with the procedures described under “INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE.” To qualify for IMR, all of the following conditions must be satisfied:

- The Member has a life-threatening or seriously debilitating condition.
  - A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the condition or disease is interrupted and/or a condition or disease with a potentially fatal outcome where the end-point of clinical intervention is survival.
  - A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- The proposed treatment must be recommended by an In-Network Provider, or a board certified or board eligible Physician qualified to treat the Member, who has certified in writing that it is more likely to be beneficial than standard treatment, and who has provided the supporting evidence.
- If an IMR is requested by the Member or by a qualified Out-of-Network Provider, as described above, the requester must supply two items of acceptable medical and scientific evidence (as defined below).

Within three (3) business days of our receipt from the California Department of Insurance of a request by a qualified Member for an IMR, we will provide the IMR organization designated by the Department with a copy of all relevant medical records and documents for review, and any information submitted by the Member or the Member’s Physician. Any subsequent information received will be forwarded to the IMR organization within three (3) business days. Additionally, any newly developed or discovered relevant medical records identified by us or our In-Network Providers after the initial documents are provided will be forwarded immediately to the IMR organization. The IMR organization will render its determination within thirty (30) days of the request (or seven (7) days in the case of an expedited review), except the reviewer may ask for three (3) more days if there was any delay in receiving the necessary records.

“Acceptable medical and scientific evidence” means the following sources:

- Peer reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- Medical journals recognized by the Secretary of Health and Human Services under Section 1861 (t) (2) of the Social Security Act;
- Either of the following reference compendia: The American Hospital Formulary Service’s-Drug Information or the American Dental Association Accepted Dental Therapeutics;
- Any of the following reference compendia, if recognized by the federal Centers for Medicare & Medicaid Services as part of an anticancer chemotherapeutic regimen:
  - The Elsevier Gold Standard’s Clinical Pharmacology.

- The National Comprehensive Cancer Network Drug and Biologics Compendium.
- The Thomson Micromedex DrugDex.

- Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, MEDLARS database Health Services Technology Assessment Research;
- Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and
- Peer reviewed abstracts accepted for presentation at major medical association meetings.

Independent Medical Review of Grievances Involving A Disputed Health Care Service

You may request an Independent Medical Review ("IMR") of disputed health care services from the California Department of Insurance if you believe that we have improperly denied, modified, or delayed health care services. A "disputed health care service" is any health care service eligible for coverage and payment under your Plan that has been denied, modified, or delayed by us, in whole or in part, because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We must provide you with an IMR application form with any Grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service.

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

1. a. Your Doctor has recommended a health care service as Medically Necessary,
   b. You have received Urgent Care or Emergency services that a Provider determined was Medically Necessary, or
   c. You have been seen by an In-Network Provider for the diagnosis or treatment of the medical condition for which you seek independent review;

2. The disputed health care service has been denied, modified, or delayed by us based in whole or in part on a decision that the health care service is not Medically Necessary; and

3. You have filed a Grievance with us and the disputed decision is upheld or the Grievance remains unresolved after thirty (30) days. If your Grievance requires expedited review you may bring it immediately to the CDI's attention. The CDI may waive the requirement that you follow our Grievance process in extraordinary and compelling cases.

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

For non-urgent cases, the IMR organization designated by the CDI must provide its determination within thirty (30) days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within three (3) business days.

For more information regarding the IMR process, or to request an application form, please call our Member Services department at the telephone number listed on the back of your Identification Card.

Questions About Your Prescription Drug Coverage

If you have outpatient Prescription Drug coverage and you have questions or concerns, you may call Pharmacy Member Services at the telephone number on the back of your Identification Card. If you are dissatisfied with the resolution of your inquiry and want to file a Grievance, you may write to us at Anthem Blue Cross Life and Health Insurance Company, Grievances and Appeals, 21215 Burbank Blvd., Woodland Hills, CA 91367, or ask the Pharmacy Member Services representative to help you and follow the formal Grievance process.

Prescription Drug List Exceptions

Please refer to the "Exception Request for a Drug not on the Prescription Drug List" section in "Prescription Drug Benefit at a Retail Pharmacy" for the process to submit an exception request for Drugs not on the Prescription Drug List.

Binding Arbitration

ALL DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Insurance Code Section 10123.19 and Code of Civil Procedure Section 1295 require disclosures in this regard, including the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration." YOU AND ANTHEM BLUE CROSS LIFE AND HEALTH AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL OR TO PARTICIPATE IN A CLASS ACTION IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply.

The arbitration findings will be final and binding except to the extent that state or federal law provides for the judicial review of arbitration proceedings.

The arbitration is initiated by the Member making written demand on Anthem Blue Cross Life and Health. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the Member and Anthem Blue Cross Life and Health, or by order of the court, if the Member and Anthem Blue Cross Life and Health cannot agree.

In the case of any medical malpractice claim or dispute, for which the total amount of damages claimed is fifty thousand dollars ($50,000) or less, a single neutral arbitrator shall be selected as mutually agreed upon by the Member and Anthem Blue Cross Life and Health, who shall have no jurisdiction to award more than fifty thousand dollars ($50,000). If the Member and Anthem Blue Cross Life and Health are unable to agree on the selection of a single neutral arbitrator, the method provided in Section 1281.6 of the Code of Civil Procedure shall be utilized.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, Anthem Blue Cross Life and Health will assume all or a portion of the Member's costs of the arbitration. Unless you and Anthem Blue Cross Life and Health agree otherwise, the arbitrator may not consolidate more than one person's claims, and may not otherwise preside over any form of a representative or class proceeding. Anthem Blue Cross Life and Health will provide Members, upon request, with an application, or information on how to obtain an application from the neutral arbitration entity, for relief of all or a portion of their share of the fees and expenses of the neutral arbitration entity. Approval or denial of an application in the case of extreme financial hardship will be determined by the neutral arbitration entity.

Please send all binding arbitration demands in writing to:

Anthem Blue Cross Life and Health
21215 Burbank Blvd
Woodland Hills, CA 91365-4310

Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please contact the University.

Who is Eligible for Coverage

Students

All students meeting the University's rules for coverage are eligible for coverage under this Plan.

All international students at Santa Monica College who are engaged in full-time educational activities outside their home country or country of regular domicile as non-resident aliens are eligible to be enrolled in the International Student Health Insurance Plan (ISHIP) on a mandatory basis. Any international student who is registered and attending classes at the College is eligible and is automatically insured under this plan. No waiver is permitted.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. If you do not meet this minimum attendance requirement, your coverage will be terminated on the premium due date coinciding with or following the date you do not meet this requirement. Coverage will not be terminated retroactively or rescinded. Home study, correspondence, and television (TV) courses do not fulfill the eligibility requirements that the student actively attend classes.

Medical Leave - A student on an approved medical leave of absence may remain on the plan for a maximum 12 months. Student must maintain an active visa status.

Dependents

To be eligible for coverage to enroll as a Dependent, You must be enrolled by the Student using the online enrollment process provided through the University and meet all Dependent eligibility criteria. The following may be enrolled as Dependents of the Student:

- The Student's legal spouse. A spouse does not include any person who is covered as a Student or Domestic Partner.
- The Student's Domestic Partner, provided the Student and Domestic Partner have completed and filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, and the Domestic Partnership has not terminated. A Domestic Partner does not include any person who is covered as a Student or spouse. For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse and a Domestic Partner's child, Adopted Child or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.
- The Student's or the Student's spouse's or Domestic Partner's children under age twenty six (26), including Newborn and Adopted Children, stepchildren, and any child for whom the Student has assumed a parent-child relationship.
- Children under age twenty-six (26) for whom the Student or the Student's spouse or Student's Domestic Partner is a legal guardian.

Coverage of a Dependent child may be continued past the age limit of twenty-six (26) as an overage Dependent if he or she is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, and is chiefly dependent upon the Student for support and maintenance. To qualify as an overage Dependent, the Dependent's disability must start before the end of the period he or she would become ineligible for coverage.

Anthem shall determine whether the Dependent meets these criteria before the Dependent attains the limiting age.

- Ninety (90) days before the Dependent reaches the age limit of twenty-six (26), we will issue a request for proof that the Dependent continues to meet the criteria for continued coverage.
- The Student must submit written proof of such dependency within sixty (60) days of receiving the request.
- Before the date the Dependent reaches the age limit of twenty-six (26), we will determine whether the Dependent meets the criteria for continued coverage.
- Two (2) years after receipt of the initial proof, we may require proof no more than annually of the continuing disability and dependency.

A new Student who enrolls in the Plan may also enroll an overage dependent who cannot work to support himself or herself by reason of intellectual or physical disability if the Dependent meets the criteria listed above as determined by Anthem. We may request a new Student to provide information regarding a Dependent with a continuing physically or mentally disabling injury, illness or condition at the time of enrollment and not more than annually thereafter for proof that the Dependent meets the criteria for continued coverage. The Student must submit written proof of such dependency within sixty (60) days of receiving the request.

We may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children for whom you are the legal guardian, we may require you to give us a copy of any legal documents awarding guardianship of such child(ren) to you.

Types of Coverage

Your University offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Student only (also referred to as single coverage);
- Student and spouse; or Domestic Partner;
- Student and one child;
- Student and children;
- Student and family.

When You Can Enroll

Enrollment

Students are automatically enrolled if they are eligible.

To enroll Dependents, the Student must add the Dependents to the Plan using the online enrollment process provided through the University within 31 days from the eligibility date.]

We must receive notification of enrollment within 90 days. If any of these steps are not followed, coverage may be denied.

Effective Date of Coverage

The effective date of coverage is subject to the timely payment of premium on your behalf. The date coverage becomes effective is determined as follows:

- Students meeting the University's rules for coverage are covered on the first day of the current term.
- If Dependents are enrolled for coverage before, on, or within 31 days after your eligibility date, then their coverage will begin on the later of (i) the date the Student's coverage begins, or (ii) the first day of the month after the Dependent becomes eligible. If the Student becomes eligible before the Plan takes effect, coverage begins on the effective date of the Plan, provided the online enrollment process has been properly completed.
- If Dependents are not enrolled within 31 days after the Student's eligibility date, they must wait until the next term to enroll.

Special Enrollment Periods

If a Student or Dependent does not apply for coverage when they are first eligible, they may be able to enroll in the Plan as a result of a qualifying event.

Unless specifically stated otherwise, the Student or Dependent has sixty (60) calendar days from the date of a qualifying event to enroll.

Qualifying Events:

- Involuntary loss of Minimum Essential Coverage (loss of Minimum Essential Coverage includes loss of eligibility of coverage as a result of legal separation, divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment. Loss of eligibility does not include a loss due to the failure of the employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Eligible Students who involuntarily lose coverage under another insurance plan are eligible to purchase coverage under this Plan the day after their prior coverage ends if the enrollment request is received by Anthem within 30 days following the loss of prior coverage.
- Gain a Dependent or become a Dependent through marriage, Domestic Partnership, birth, adoption, placement for adoption or appointment of Domestic Partnership
- Mandated to be covered as a Dependent pursuant to a valid state or federal court order
- Release from incarceration
- Health coverage issuer substantially violated material provision of health coverage contract
- Access to new health benefit plans due to permanent move
- Loss of services from a contracting Provider under another health benefit plan, as defined in Sections 10965 of the Insurance Code or 1399.845 of the Health and Safety Code, for a condition described in Health and Safety Code § 1373.96(c) (an acute condition, serious chronic condition, pregnancy, terminal illness, care of Newborn between birth and 36 months of age, or performance of a surgery or other procedure that has been recommended and documented by the Provider) and that Provider is no longer participating in the health benefit plan
- Member of the Reserve Forces of the U.S. military returning from active duty or member of the California National Guard returning from active duty under Title 32 of the U.S. Code.

Effective Dates for special enrollment periods:

- In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption; and
- In the case of marriage, Domestic Partnership or in the case where an Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after You complete the online enrollment process.

You must elect coverage and complete the online enrollment process within sixty (60) days.

Effective Dates for special enrollment due to loss of Minimum Essential Coverage apply when the loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

- Legal separation, dissolution of Domestic Partnership or divorce;
- Cessation of Dependent status, such as attaining the maximum age;
- Death of an employee;
- Termination of employment;
- Reduction in the number of hours of employment; or
- Any loss of eligibility for coverage after a period that is measured by reference to any of the following:
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which the Plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

Eligible Students who involuntarily lose coverage under another group insurance plan are also eligible to purchase coverage under this Plan the day after prior coverage ends if the enrollment request is received by Anthem within 30 days from the loss of prior coverage.

There is no special enrollment for loss of Minimum Essential Coverage when the loss includes termination or loss due to:

- Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
- Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Late Enrollees

If the Student does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they will not be eligible to enroll until the next school term.

Enrolling Dependent Children

Newborn and Adopted Children

Newborn children are covered automatically from the moment of birth. Following the birth a child, you must submit an application / change form to the Policyholder within 31 days to add the newborn to your Plan. Even if no additional Premium is required, you must still submit an application / change form to the Policyholder to add the newborn to your Plan, to make sure we have accurate records and are able to cover your claims.

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption. The adopted child's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event.

Failure to submit a membership change form to the Policyholder to add a newborn or adopted child to your coverage during the thirty-one (31) day period following birth or adoption will result in no coverage for the newborn or adopted child beyond the first thirty-one (31) days.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by applicable state or federal law, to enroll your child in this Plan, and the child is otherwise eligible for coverage under the terms of this Plan, we will permit the child to enroll at any time and will provide the benefits of this Plan according to the applicable requirements of such order. However, a child's coverage will not extend beyond the age limit specified above.

Individuals not eligible for Dependent coverage

- Spouses of Dependent children are not eligible for coverage under this Plan.
- Children, including Newborns and Adopted Children, of Dependent children are not eligible for coverage under this Plan unless that child meets other coverage criteria established under State law.
- Temporary custody is not sufficient to establish eligibility under this Plan.
- Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Plan unless required by the laws of this State.]

Updating Coverage and/or Removing Dependents

You are required to notify the Policyholder of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Policyholder and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Dissolution of a domestic partnership;
- Death of an enrolled Dependent (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see “Termination and Continuation of Coverage”);
- Enrolled Dependent child either becomes totally or permanently impaired, or is no longer impaired.

The Policyholder is required to notify us of these changes. We must be notified of any of these changes as soon as possible but no later than within sixty (60) days of the event. All notifications must be in writing and on approved forms. Failure to notify us of persons no longer eligible for services will not obligate us to pay for such services. Acceptance of premium for persons no longer eligible for services will not obligate us to pay for such services.

Contact Member Service at the telephone number listed on your ID Card or send your request to us at:

Anthem Blue Cross Life and Health Insurance Company

21215 Burbank Blvd.

Woodland Hills, California 91367

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, race, color, religion, sex, gender, gender identity, gender expression, national origin, ancestry, sexual orientation or identity, or age.

Statements and Forms

All students or applicants (including applicants to be covered as a Dependent) for coverage must complete and submit to the Policyholder applications or other forms or statements that may be reasonably requested or required. All information you provide in any such forms or documents must be true, correct, and complete to the best of your knowledge and belief. Any statement you make in the application or that is a part of the policy that is fraudulent or constitutes an intentional misrepresentation of material fact under the terms of the Plan may result in termination or rescission of your coverage.

Termination and Continuation of Coverage

Termination

Except as otherwise provided, your coverage may terminate in the following situations:

- When the Contract between the Policyholder and us terminates. It will be the Policyholder's responsibility to notify you of the termination of coverage.
- If the Policyholder no longer provides coverage for the class of Members to which you belong.
- If you or your Dependents choose to terminate your coverage.
- If you cease to meet the eligibility requirements of the Plan, subject to any applicable continuation requirements. If you cease to be eligible, the Policyholder and/or you must notify us immediately. Your coverage will end as of the Premium due date coinciding with or following the date you no longer meet the requirements.
- When the required Premiums are not paid, we may terminate your coverage and may also terminate the coverage of your Dependents upon first mailing a written Notice of Start of Grace Period to the Policyholder at least thirty-one (31) days, or if longer, the period required by federal law, prior to that termination.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Policyholder. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.

You will be notified in writing of the date your coverage ends by either us or the Policyholder.

Exception

Medical withdrawal or school authorized breaks. If you are an insured Student and the premiums have been paid to us on your behalf, your coverage may continue for one semester during a medical withdrawal or school breaks approved by the Policyholder.

IMPORTANT: All of Your coverage will be terminated as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if your coverage is in effect at the time such services are provided.

Improper termination or non-renewal (Grievance):

If you believe that your coverage has been improperly cancelled, rescinded, or not renewed, you may file a Grievance in accordance with the Grievance process outlined in "Grievance and External Review Procedures." You should file your grievance as soon as possible after you receive notice that your coverage will end. You may also send a grievance to the California Department of Insurance. If your coverage is still in effect when you submit a grievance, we will continue to provide coverage to you under the terms of this Plan until a final determination of your Grievance has been made, including any review by the California Department of Insurance (this does not apply if your coverage is cancelled for non-payment of premium). If your coverage is maintained in force pending outcome of the Grievance, premium must still be paid to us on your behalf.

Removal of Members

Upon written request through the Policyholder, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Benefits After Termination Of Coverage

Any benefits available under this section are subject to all the other terms and conditions of this Plan.

If you are Totally Disabled on the Policyholder's termination date, and you are not eligible for regular coverage under another similar health plan, benefits will continue for treatment of the disabling condition(s). Benefits will continue until the earliest of:

1. The date you cease to be Totally Disabled;
2. The end of a period of 12 months in a row that follows the Policyholder termination date;
3. The date you become eligible for regular coverage under another health plan; or
4. The payment of any benefit maximum.

Benefits will be limited to coverage for treatment of the condition or conditions causing Total Disability.

General Provisions

Assignment

The Policyholder cannot legally transfer this Booklet, without obtaining written permission from us. Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any Member without obtaining written permission from us, unless in a way described in this Booklet.

Availability of Care

If there is an epidemic or public disaster we will use our best efforts to ensure health care services are provided to Members. In the unfortunate event of an epidemic or public disaster, Hospitals and other In-Network Providers will do their best to provide the services you may need. If you or your eligible Dependents cannot obtain care from one of these In-Network Providers, you may need to seek services from any available Emergency Facility. You will have the same amount of time to submit any claims as stated in the "Notice of Claim & Proof of Loss" section.

Care Coordination

We pay In-Network Providers in various ways to provide Covered Services to you. For example, sometimes we may pay In-Network Providers a separate amount for each Covered Service they provide. We may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, we may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, we may pay In-Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate In-Network Providers for coordination of Member care. In some instances, In-Network Providers may be required to make payment to us because they did not meet certain standards. You do not share in any payments made by In-Network Providers to us under these programs.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Policyholder or us.

Confidentiality and Release of Information

Applicable state and federal law requires us to undertake efforts to safeguard your medical information.

For informational purposes only, please be advised that a statement describing our policies and procedures regarding the protection, use and disclosure of your medical information is available on our website and can be furnished to you upon request by contacting our Member Services department.

Obligations that arise under state and federal law and policies and procedures relating to privacy that are referenced but not included in this Booklet are not part of the contract between the parties and do not give rise to contractual obligations.

Conformity with Law

Any term of the Plan which is in conflict with the laws of the state in which the Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Policyholder, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Policyholder and us, Anthem Blue Cross Life and Health, and that we are an independent corporation licensed to use the Blue Cross name and mark in the state of California. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Policyholder, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem shall be held accountable or liable to the Policyholder for any of Anthem's obligations to the Policyholder created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Entire Contract

This Booklet, the Blanket Contract, the Policyholder application, any riders, amendments, endorsements or attachments, and the individual applications of the Student and Dependents constitute the entire Contract between the Policyholder and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the Policyholder and any and all statements made to the Policyholder by us are representations and not warranties. No such statement, except fraudulent misstatement, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of Anthem.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payer. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Legal Actions

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

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. 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.

Modifications

This Booklet allows the Policyholder to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Contract, or by mutual agreement between the Policyholder and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the Policyholder about the change. Written notice will be given at least 60 days before the change becomes effective. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

Not Liable for Provider Acts or Omissions

We are not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against Anthem based on the actions of a Provider of health care, services, or supplies.

Payment Innovation Programs

We pay In-Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by us from time to time, but they will be generally designed to tie a certain portion of an In-Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, In-Network Providers may be required to make payment to us under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect your access to health care. The Program payments are not made as payment for specific Covered Services provided to you, but instead, are based on the In-Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by us or to us under the Program(s), and you do not share in any payments made by Network Providers to us under the Program(s).

Payment to Providers and Provider Reimbursement

Physicians and other professional Providers are paid on a fee-for-service basis, according to an agreed schedule. Hospitals or other health care Facilities may be paid either a fixed fee or on a discounted fee-for-service basis. We may pay the benefits of this Booklet directly to In-Network Providers (e.g., Hospitals and medical transportation Providers). We may pay Hospitals, Physicians and other Providers of service or the person or persons having paid for your Hospital or medical services directly when you assign benefits in writing no later than the time of submitting a claim. These payments fulfill our obligation to you for those services.

We will pay Out-of-Network Providers and other Providers of service directly when Emergency Medical Condition services and care are provided to you or one of your Dependents. We will continue such direct payment until the Emergency Care results in stabilization. You may be responsible for any charges in excess of the Maximum Allowed Amount that may be billed by an Out-of-Network Provider.

If you or one of your Dependents receive Covered Services other than Emergency Care from an Out-of-Network Provider, payment may be made directly to the Student and you will be responsible for payment to that Provider. An assignment of benefits, to an Out-of-Network Provider, even if assignment includes the Provider's right to receive payment, is generally void. However, there are certain situations in which an assignment of benefits is permitted. For example, if you receive services from any in-network health facility in California at which, or as a result of which, you receive non-Emergency Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist, an assignment of benefits to such Out-of-Network Provider will be permitted. Please see "Member Cost Share" in the "Claims Payment" section for more information. Any payments for the assigned benefits fulfill our obligation to you for those services.

Policies and Procedures

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Contract, we have the authority, in our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management, care management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time.

Program Incentives

We may offer incentives from time to time, at our discretion, in order to introduce you to covered programs and services available under this Plan. The purpose of these incentives includes making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. We may discontinue an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Protection of Coverage

We do not have the right to cancel the coverage of any Member under the Contract while:

- The Contract is still in effect, and
- The Member is still eligible, and
- The Member's Premiums are paid according to the terms of the Contract.

Note: These are subject to the conditions listed in the "Termination and Continuation of Coverage" section.

Public Policy Participation

We have established a public policy committee (that we call our Consumer Relations Committee) to advise our Board of Directors. This Committee advises the Board about how to assure the comfort, dignity and convenience of the people we cover. The Committee consists of Members covered by our health plan, In-Network Providers and a member of our Board of Directors. The Committee may review our financial information, and information about the nature, volume and resolution of the complaints we receive. The Consumer Relations Committee reports directly to our Board.

Receipt of Information

We are entitled to receive from any Provider of service information about you which is necessary to administer claims on your behalf. By submitting an application for coverage, you have authorized every Provider who has furnished or is furnishing care to disclose all facts, opinion or other information pertaining to your care, treatment, and physical conditions, upon our request. You agree to assist in obtaining this information if needed. Failure to assist us in obtaining the necessary information when requested may result in the delay or rejection of your claims until the necessary information is received.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES REGARDING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. PLEASE CONTACT OUR MEMBER SERVICES DEPARTMENT AT THE TELEPHONE NUMBER ON THE BACK OF YOUR IDENTIFICATION CARD TO OBTAIN A COPY.

Relationship of Parties (Policyholder-Member-Anthem)

The Policyholder is responsible for passing information to you. For example, if we give notice to the Policyholder, it is the Policyholder's responsibility to pass that information to you. The Policyholder is also responsible for passing eligibility data to us in a timely manner. If the Policyholder does not give us timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

Your In-Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or Referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

Responsibility to Pay Providers

In accordance with Anthem's In-Network Provider agreements, Members will not be required to pay any In-Network Provider for amounts owed to that Provider by us (not including Copayments, Deductibles and services or supplies that are not a benefit of this Booklet), even in the unlikely event that Anthem fails to pay

the Provider. Members are liable, however, to pay Out-of-Network Providers for any amounts not paid to those Providers by Anthem. If you receive services from any in-network health facility in California at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. You will not have to pay the Out-of-Network Provider more than the In-Network cost sharing for such non-Emergency Covered Services. Please see "Member Cost Share" in the "Claims Payment" section for more information.

Right of Recovery and Adjustment

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, we have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of doing so exceeds the overpayment or underpayment amount. We reserve the right to deduct or offset, including cross plan offsetting on In-Network claims and on Out-Of-Network claims where the Out-Of-Network Provider agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

Termination of Providers

We will provide you with a notice of termination of a general acute Hospital from which you are receiving a course of treatment at least sixty (60) days in advance of the effective date of termination. To locate another Hospital in your area, call our Member Services department at the telephone number on the back of your Identification Card.

Terms of Coverage

- In order for you to be entitled to benefits under this Booklet, both the Contract (Policyholder) and your coverage under the Contract must be in effect on the date the expense giving rise to a claim for benefits is incurred.

- The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which a charge is made.

- The Contract and this Booklet are subject to amendment, modification or termination according to the provisions of the Contract without your consent or concurrence. Your entitlement to any increase in benefits as a result of any amendment or modification of the Contract or this Booklet is subject to the provisions found under the Part entitled "Eligibility and Enrollment – Adding Members."

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

For purposes of Recovery, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which we encourage you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. (If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.)

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by the Policyholder to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If the Policyholder has selected one of these options to make available to all employees, you may receive non-cash or cash equivalent incentives by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Policyholder may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the Member Services number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Waiver

No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf of to us if we have made or makes payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Member Services at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Ambulatory Surgical Facility

A freestanding Facility, with a staff of Doctors, that:

- Is licensed as required;
- Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
- Gives treatment by or under the supervision of Doctors and nursing services when the patient is in the Facility;
- Does not have Inpatient accommodations; and
- Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health)

Anthem Blue Cross Life and Health is a health insurance company that is regulated by the California Department of Insurance.

Authorized Referral

Authorized Referral occurs when you, because of your medical needs, require the services of a Specialist who is an Out-of-Network Provider, or require special services or facilities not available at a contracting Hospital, but only when the referral has been authorized by us before services are rendered and when the following conditions are met:

- there is no In-Network Provider who practices in the appropriate specialty, or there is no contracting Hospital which provides the required services or has the necessary facilities;
- that meets the adequacy and accessibility requirements of state or federal law; and
- the Member is referred to a Hospital or Physician that does not have an agreement with Anthem for a Covered Service by an In-Network Provider.

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Policyholder's effective or renewal date and lasts for 12 months. (See your Policyholder for details.) The "Schedule of Benefits" shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends. For information on Benefit Period, please contact the Policyholder.

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Biosimilar/Biosimilars

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product.

Blanket Contract (Contract)

The Contract between us, Anthem Blue Cross Life and Health, and the University. It includes this Booklet, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Contract is kept on file by the Policyholder. If a conflict occurs between the Contract and this Booklet, the Contract controls.

Booklet

This document (also called the Evidence of Coverage), which describes the terms of your benefits. It is part of the Blanket Contract with your University, and is also subject to the terms of the Blanket Contract.

Brand Name Drugs (Brand Drugs)

Prescription Drugs that we classify as Brand Drugs or that our PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Excellence (COE) Network

A network of health care Facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Excellence Agreement with us.

Chat Therapy

A synchronous text-message style communication session between a licensed Psychologist, Clinical Social Worker (L.C.S.W.), Marriage and Family Therapist (L.M.F.T.) or Professional Counselor (L.P.C.) and a patient that provides one-to-one virtual interactive counseling sessions. Each scheduled session lasts approximately one hour and can be accessed via a computer or mobile device using a secured platform arranged for by Anthem.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is $100, your Coinsurance would be $20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the “Schedule of Benefits” for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments (except as described in the “Prescription Drug Benefit at a Retail Pharmacy” section).

Contract (Blanket Contract)

The Blanket Contract we have issued to the Policyholder. See “Blanket Contract” above.

Controlled Substances

Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) which are divided into five schedules.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a $15 Copayment for an office visit, but a $150 Copayment for Emergency Room Services. See the “Schedule of Benefits” for details. Your Copayment will be the lesser of the amount shown in the “Schedule of Benefits” or the Maximum Allowed Amount.

Cosmetic Services

Any type of care performed to alter or reshape normal structure of the body in order to improve appearance.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider’s license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date you enter the Facility except as described in “Benefits After Termination Of Coverage.”

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the “What’s Covered” section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,

- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is $1,000, your Plan won't cover anything until you meet the $1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Designated Pharmacy Provider

An In-Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with us or an In-Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Diabetes Equipment and Supplies

The following items for the treatment of Insulin-using diabetes or non-Insulin-using diabetes and gestational diabetes as Medically Necessary or medically appropriate:

- glucose monitors
- blood glucose testing strips
- glucose monitors designed to assist the visually impaired
- Insulin pumps and related necessary supplies
- ketone urine testing strips
- lancets and lancet puncture devices
- pen delivery systems for the administration of Insulin
- podiatric devices to prevent or treat diabetes-related complications
- Insulin syringes
- visual aids, excluding eyewear, to assist the visually impaired with proper dosing of Insulin

Diabetes Outpatient Self-Management Training Program

Training provided to a qualified Member after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of Diabetes Equipment and Supplies; additional training authorized on the diagnosis of a Physician or other health care practitioner of a significant change in the qualified Member's symptoms or condition that requires changes in the qualified Member's self-management regime; and periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes. Diabetes Outpatient Self-Management Training must be provided by a health care practitioner or Provider who is licensed, registered or certified in California to provide appropriate health care services.

Doctor

See the definition of "Physician."

Domestic Partner (Domestic Partnership)

Both persons have filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code and, at the time of filing, all additional requirements of Domestic Partnership under the California Family Code have been met.

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Enrollment Date

The first day you are covered under the Plan.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental and Experimental Procedures

Any medical, surgical and/or other procedures, services, products, drugs or devices, including implants used for research, except as specifically stated under "Clinical Trials" in the "What's Covered" section.

Facility

A Facility including a Hospital, Ambulatory Surgical Facility, Mental Health / Substance Use Disorder Facility, Residential Treatment Center, Skilled Nursing Facility, or Home Health Care Agency, as defined in this Booklet, and other Facilities approved by us. The Facility must be licensed, accredited, registered or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by us.

Gender Dysphoria (Gender Identity Disorder)

Gender Dysphoria, formerly known as Gender Identity Disorder, is a formal diagnosis used by psychologists and Physicians to describe people who experience significant dysphoria (discontent) with the sex they were assigned at birth and/or the gender roles associated with that sex.

Gender Transition

The process of changing one's physical appearance, including sex characteristics, as well as non-visual aspects such as speech and behavior, to accord with his or her actual gender identity.

Generally Accepted Standards of Mental Health and Substance Use Disorder Care

Standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to state law. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

Generic Drugs (Generic)

Prescription Drugs that we classify as Generic Drugs or that our PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Home Health Care Agency

A Facility, licensed in the state in which it is located, that:

- Gives skilled nursing and other services on a visiting basis in your home; and
- Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

An agency or organization providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A Hospice must be currently licensed as a Hospice pursuant to Health and Safety Code Section 1747 or a licensed Home Care Health Agency with federal Medicare certification pursuant to Health and Safety Code Sections 1726 and 1747.1. A list of In-Network Hospices meeting these criteria is available upon request.

Hospital

Hospital is a health Facility which provides diagnosis, treatment and care of persons who need acute inpatient Hospital care under the supervision of Physicians, and it must be licensed to provide general acute inpatient and outpatient services according to state and local laws. It must also be registered as a general Hospital by the American Hospital Association and meet accreditation standards of The Joint Commission.

The term “Hospital” includes an acute psychiatric Facility which is a Hospital specializing in psychiatric treatment or a designated psychiatric unit of a Hospital licensed by the state to provide 24-hour acute inpatient care. For the purpose of this Plan, the term acute psychiatric Facility also includes a psychiatric health Facility which is an acute 24-hour Facility as defined in California Health and Safety code 1250.2. It must be:

- licensed by the California Department of Health Care Services,
- qualified to provide short-term inpatient treatment according to state law,
- accredited by The Joint Commission,
- staffed by an organized medical and professional staff which includes a Physician as medical director, and
- actually providing an acute level of care.

Identification Card

The card we give you that shows your Member identification, group or policy numbers, and the Plan you have.

Infusion Therapy

The administration of Drugs (Prescription substances) by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. For the purpose of this Booklet, it shall also include Drugs administered by aerosol (into the lungs) and by a feeding tube.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements under this Plan. A Provider that is In-Network for one plan may not be In-Network for another. Please see “How to Find a Provider in the Network” in the section “How Your Plan Works” for more information on how to find an In-Network Provider for this Plan.

In-Network Transplant Provider

Please see the “What’s Covered” section for details.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive In-Home Behavioral Health Services

A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the Members and others at risk of harm.

Intensive Outpatient Program

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week.

Interchangeable Biologic Product

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

Investigational and Investigational Procedures

Procedures, treatments, supplies, devices, equipment, facilities, or drugs (all services) that do not meet one (1) or more of the following criteria:

- have final approval from the appropriate governmental regulatory body; or
- have the credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community which permits reasonable conclusions concerning the effect of the procedure, treatment, supply, device, equipment, facility or drug (all services) on health outcomes; or
- be proven materially to improve the net health outcome; or
- be as beneficial as any established alternative; or
- show improvement outside the Investigational settings.

Recommendations of national Physician specialty societies, nationally recognized professional healthcare organizations and public health agencies, as well as information from the practicing community, may also be considered.

Late Enrollees

Students or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

Maintenance Medications

Please see the "Prescription Drug Benefit at a Retail Pharmacy" section for details.

Maintenance Pharmacy

An In-Network Retail Pharmacy that is contracted with our PBM to dispense a 90-day supply of Maintenance Medication.

Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the "Claims Payment" section.

Medical Necessity (Medically Necessary)

Medically Necessary shall mean health care services that a Physician, exercising professional clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice,
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease,

- Not primarily for the convenience of the patient, Physician or other health care Provider, and
- Not more costly than an alternative service, including the same service in an alternative setting, or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's injury, disease, illness or condition.

For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in a Physician's office or the home setting.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician specialty society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

For purposes of treatment of Mental Health and Substance Use Disorder, in addition to the above, Medically Necessary also means a service or product addressing the specific needs of that patient for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is both of the following:

- In accordance with the Generally Accepted Standards of Mental Health and Substance Use Disorder Care, and
- Not primarily for the economic benefit of Anthem and the Member.

Member

People, including the Student and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Booklet.

Mental Health and Substance Use Disorder

A condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of conditions of mental health and substance use disorder in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect these conditions as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

Other Eligible Providers

Nurse anesthetists and blood banks that do not enter into participating agreements with us, and these Providers must be licensed according to state and local laws to provide covered medical services.

Out-of-Network Provider

A Provider that does *not* have an agreement or contract with us, or our subcontractor(s), to give services to our Members under this Plan.

You will often get a lower level of benefits when you use Out-of-Network Providers. (**Note**: if you receive services from any in-network health facility in California at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received

from an In-Network Provider. Please see “Member Cost Share” in the “Claims Payment” section for more information.)

Out-of-Network Transplant Provider

Please see the “What’s Covered” section for details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does not include your Premium, amounts over the Maximum Allowed Amount, or charges for health care services, supplies or treatment that your Plan doesn’t cover. Please see the “Schedule of Benefits” for details.

Partial Hospitalization Program

Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week.

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Pharmacy Benefits Manager (PBM)

A Pharmacy benefits management company that manages Pharmacy benefits on Anthem’s behalf. Anthem’s PBM has a nationwide network of Retail Pharmacies and clinical services that include Prescription Drug List management.

The management and other services the PBM provides include managing a network of Retail Pharmacies and operating a mail service Pharmacy. Anthem’s PBM, in consultation with Anthem, also provides services to promote and assist Members in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, drug interactions or drug/pregnancy concerns.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) legally licensed to practice medicine and perform surgery,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and

- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The benefit Plan your University has purchased, which is described in this Booklet.

Policyholder

The University, or other educational entity, which has a Contract with us, Anthem, for this Plan.

Precertification

Please see the section "Getting Approval for Benefits" for details.

Premium

The amount that you and/or the Policyholder must pay to be covered by this Plan. This may be based on your age and will depend on the Policyholder's Contract with us.

Prescription Drug (Drug) (Also referred to as Legend Drug)

A medicine that is approved by the Food & Drug Administration (FDA) to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on their original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- Compound (combination) medications, when 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 are not essentially the same as an FDA-approved product from a drug manufacturer.
- Insulin, diabetic supplies, and syringes.

Prescription Order

A written request by a Provider, as permitted by law, for a Prescription Drug or medication, and each authorized refill.

Primary Care Physician ("PCP")

A Physician who gives or directs health care services for you. The Physician may work in family/general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan. A PCP supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, Physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs or helps you get a range of health care services.

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license or is permitted by California law to provide health care services. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Psychiatric Emergency Medical Condition

A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others.
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Reconstructive Surgery

A surgery that is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease in order to do either of the following: (1) improve function; or (2) create a normal appearance, to the extent possible.

Recovery

Please see the "Third Party Liability and Reimbursement" section for details.

Referral

Please see the "How Your Plan Works" section for details.

Residential Treatment Center(s)

An inpatient treatment Facility where the patient resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a Mental Health or Substance Use Disorder condition. The Facility must be licensed to provide psychiatric treatment of Mental Health or Substance Use Disorder conditions according to state and local laws. The facility must be fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a "walk-in" basis. These clinics are often found in major Pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Self-Administered Hormonal Contraceptives

Hormonal contraception products with the following routes of administration are considered self-administered:

- Oral;
- Transdermal;
- Vaginal;
- Depot Injection.

Service Area

A Service Area is a specific region where a Member can get Covered Services under this Plan. For your Plan, the Service Area is the state of California. If you are outside of California and receive Covered Services, please see the provision in this section titled "Inter-Plan Arrangements" for additional information on how health care services you obtain from such providers are covered.

Skilled Nursing Facility

A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than you can get at home. It must be licensed by the appropriate agency and accredited by The Joint Commission or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by us. A Skilled Nursing Facility gives the following:

- Inpatient care and treatment for people who are recovering from an illness or injury;
- Care supervised by a Doctor;
- 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, or a place for rest, educational, or similar services.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the "Eligibility and Enrollment – Adding Members" section for more details.

Specialist (Specialty Care Physician / Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drugs

Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These Drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail Pharmacies. They may be administered in many forms including injectable, infused, oral and inhaled.

Student

A student of the University who is the primary Member who is eligible for and has enrolled in the Plan.

Substance Use Disorder

Please see the definition of Mental Health and Substance Use Disorder.

Total Disability (or Totally Disabled)

A person who is unable because of the disability to engage in any occupation to which he or she is suited by reason of training or experience, and is not in fact employed.

Transplant Benefit Period

Please see the “What’s Covered” section for details.

Urgent Care

Those services necessary to prevent serious deterioration of your health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgent Care services are not Emergency services.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for Urgent Care.

Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures, and/or facilities.

APPENDIX I – CDT CODES FOR DENTAL SERVICES

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D0120	Periodic oral evaluation - established patient – once per 6 months
D0140	Limited oral evaluation - problem focused
D0145	Oral evaluation for a patient under three (3) years of age and counseling with primary caregiver
D0150	Comprehensive oral evaluation - new or established patient
D0160	Detailed and extensive oral evaluation - problem focused, by report
D0170	Re-evaluation - limited, problem focused (established patient; not post- operative visit) – covered twelve (12) times per twelve (12) months. Covered six (6) times per three (3) months for temporomandibular joint conditions.
D0171	Re-evaluation – post-operative office visit
D0180	Comprehensive periodontal evaluation - new or established patient
D0210	Intraoral - complete series of radiographic images – one complete series of x-rays, including bitewings, per provider every thirty-six (36) months
D0220	Intraoral - periapical first radiographic image – twenty (20) films per twelve (12) months, per provider includes D0230 below
D0230	Intraoral - periapical each additional radiographic image – twenty (20) films per twelve (12) months, includes D0220 above
D0240	Intraoral - occlusal radiographic image – two (2) times per six (6) months per provider except when documented as essential for a follow-up/post-operative exam (such as after oral surgery)
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector – one (1) film per day
D0251	Extra-oral posterior dental radiographic image – four (4) films per day
D0270	Bitewing - single radiographic image – once per date of service
D0272	Bitewings - two radiographic images - once per six (6) months, per provider, ages ten (10) and over. Six (6) months must have passed since Complete Full Mouth
D0273	Bitewings - three radiographic images – once per six (6) months per provider, ages ten (10) and over. Six (6) months must have passed since Complete Full Mouth)
D0274	Bitewings - four radiographic images - once per (6) months per provider, ages ten (10) and over. Six (6) months must have passed since Complete Full Mouth
D0277	Vertical bitewings - 7 to 8 radiographic images
D0310	Sialography
D0320	Temporomandibular joint arthrogram, including injection – three (3) times per day
D0322	Tomographic survey – twice per twelve (12) months, per provider
D0330	Panoramic radiographic image - once per thirty-six (36) months per provider (except when documented as essential for a follow-up/post- operative exam.)
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis – two (2) times every twelve (12) months per provider
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally – four (4) times per day
D0351	3D photographic image - covered as part of orthodontic care
D0460	Pulp vitality tests
D0470	Diagnostic casts - covered as part of orthodontic care
D0502	Other oral pathology procedures, by report
D0601	Caries risk assessment and documentation, with a finding of low risk
D0602	Caries risk assessment and documentation, with a finding of moderate risk
D0603	Caries risk assessment and documentation, with a finding of high risk
D0999	Unspecified diagnostic procedure, by report
D1110	Prophylaxis - adult – one (1) time per six (6) months, frequency includes D1120 below
D1120	Prophylaxis - child – one (1) time per six (6) months, frequency includes D01110 above
D1206	Topical application of fluoride varnish – one (1) time per six (6) months, frequency includes D1208 below

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D1208	Topical application of fluoride – excluding varnish - one (1) time per six (6) months, frequency includes D1206 above
D1310	Nutritional counseling for control of dental disease
D1320	Tobacco counseling for the control and prevention of oral disease
D1330	Oral hygiene instructions
D1351	Sealant - per tooth – for 1st, 2nd and 3rd molars. Covered one (1) time per tooth per thirty-six (36) months per provider.
D1352	Preventive resin restoration in a moderate to high caries risk patient for 1st, 2nd and 3rd molars in a pit or fissure of a tooth. Covered one (1) time per tooth per thirty-six (36) months per provider.
D1353	Sealant repair – per tooth. Covered one (1) time per tooth per thirty-six (36) months per provider on the occlusal surfaces that are free of decay and/or restorations. The original provider is responsible for any repair or replacement during the thirty-six (36) month period.
D1354	Interim caries arresting medicament application - per tooth
D1510	Space maintainer - fixed - unilateral – one (1) time per quadrant up to age 18
D1516	Space maintainer - fixed - bilateral, maxillary - one (1) time per arch up to age 18
D1517	Space maintainer - fixed - bilateral, mandibular - one (1) time per arch up to age 18
D1520	Space maintainer - removable - unilateral – one (1) time per quadrant up to age 18
D1526	Space maintainer - removable - bilateral - maxillary - one (1) time per arch up to age 18
D1527	Space maintainer - removable - bilateral - mandibular - one (1) time per arch up to age 18
D1551	Re-cement or re-bond bilateral space maintainer – maxillary - covered up to age 18
D1552	Re-cement or re-bond bilateral space maintainer – mandibular - covered up to age 18
D1553	Re-cement or re-bond bilateral space maintainer – per quadrant - covered up to age 18
D1556	Removal of fixed unilateral space maintainer - per quadrant - covered only by provider *other than* who placed space maintainer
D1557	Removal of fixed unilateral space maintainer - maxillary - covered only by provider *other than* who placed space maintainer
D1558	Removal of fixed unilateral space maintainer - mandibular - covered only by provider *other than* who placed space maintainer
D1575	Distal shoe space maintainer – fixed – unilateral – per quadrant
D2140	Amalgam - one surface, primary or permanent – once per tooth per twelve (12) months for primary teeth; once per tooth per thirty-six (36) months for permanent teeth
D2150	Amalgam - two surfaces, primary or permanent – once per tooth per twelve (12) months for primary teeth; once per tooth per thirty-six (36) months for permanent teeth
D2160	Amalgam - three surfaces, primary or permanent – once per tooth per twelve (12) months for primary teeth; once per tooth per thirty-six (36) months for permanent teeth
D2161	Amalgam - four or more surfaces, primary or permanent – once per tooth per twelve (12) months for primary teeth; once per tooth per thirty-six (36) months for permanent teeth
D2330	Resin-based composite - one surface, anterior – once per tooth per twelve (12) months for primary teeth; once per tooth per thirty-six (36) months for permanent teeth
D2331	Resin-based composite - two surfaces, anterior – per tooth per twelve (12) months for primary teeth; once per tooth per thirty-six (36) months for permanent teeth
D2332	Resin-based composite - three surfaces, anterior –once per tooth per twelve (12) months for primary teeth; once per tooth per thirty-six (36) months for permanent teeth
D2335	Resin-based composite four or more surfaces or involving incisal angle (anterior) – once per tooth per twelve (12) months for primary teeth; once per tooth per thirty-six (36) months for permanent teeth
D2390	Resin-based composite crown, anterior – once per tooth per twelve (12) months for primary teeth; once per tooth per thirty-six (36) months for permanent teeth
D2391	Resin-based composite – one surface, posterior – once per tooth per twelve (12) months for primary teeth; once per tooth per thirty-six (36) months for permanent teeth
D2392	Resin-based composite - two surfaces, posterior – once per tooth per twelve (12) months for primary teeth; once per tooth per thirty-six (36) months for permanent teeth

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D2393	Resin-based composite - three surfaces, posterior – once per tooth per twelve (12) months for primary teeth; once per tooth per thirty-six (36) months for permanent teeth
D2394	Resin-based composite - four or more surfaces, posterior – once per tooth per twelve (12) months for primary teeth; once per tooth per thirty-six (36) months for permanent teeth
D2710	Crown - resin-based composite (indirect) – once per tooth per sixty (60) months, age 13 and older
D2712	Crown - 3/4 resin-based composite (indirect) – once per tooth per sixty (60) months, age 13 and older
D2721	Crown - resin with predominantly base metal – once per tooth per sixty (60) months, age 13 and older
D2740	Crown - porcelain/ceramic substrate - once per tooth per sixty (60) months, age 13 and older
D2751	Crown - porcelain fused to predominantly base metal – once per tooth per sixty (60) months, age 13 and older
D2781	Crown - 3/4 cast predominantly base metal – once per tooth per sixty (60) months, age 13 and older
D2783	Crown - 3/4 porcelain/ceramic - once per tooth per sixty (60) months, age 13 and older
D2791	Crown - full cast predominantly base metal - once per tooth per sixty (60) months, age 13 and older
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration – once per tooth per twelve (12) months per provider
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core
D2920	Re-cement or re-bond crown - covered twelve (12) months after initial placement of crown by same provider
D2921	Reattachment of tooth fragment, incisal edge or cusp
D2929	Prefabricated porcelain/ceramic crown – primary tooth – once per twelve (12) months
D2930	Prefabricated stainless steel crown - primary tooth - once per twelve (12) months
D2931	Prefabricated stainless steel crown - permanent tooth – once per thirty six (36) months. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2932	Prefabricated resin crown –once per tooth per twelve (12) months for primary teeth; once per thirty-six (36) months for permanent teeth. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2933	Prefabricated stainless steel crown with resin window – once per tooth per twelve (12) months for primary teeth; once per thirty-six (36) months for permanent teeth. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2940	Protective restoration – once per six (6) months per provider
D2941	Interim therapeutic restoration – primary dentition
D2949	Restorative foundation for an indirect restoration
D2950	Core buildup, including any pins when required
D2951	Pin retention - per tooth, in addition to restoration – once per tooth
D2952	Post and core in addition to crown, indirectly fabricated – once per tooth
D2953	Each additional indirectly fabricated post - same tooth
D2954	Prefabricated post and core in addition to crown – once per tooth
D2955	Post removal - not covered in conjunction with endodontic treatment
D2957	Each additional prefabricated post - same tooth
D2971	Additional procedures to construct new crown under existing partial denture framework
D2980	Crown repair necessitated by restorative material failure - covered twelve (12) months after initial placement or repair of crown by same provider
D2999	Unspecified restorative procedure, by report
D3110	Pulp cap - direct (excluding final restoration)
D3120	Pulp cap - indirect (excluding final restoration)
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament - once per primary tooth
D3221	Pulpal debridement, primary and permanent teeth - once per tooth
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development - once per tooth

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - once per tooth
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) - once per tooth
D3310	Endodontic therapy, anterior tooth (excluding final restoration) - covered once per tooth on permanent teeth only
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration) - covered once per tooth on permanent teeth only
D3330	Endodontic therapy, molar (excluding final restoration) - covered once per tooth on permanent teeth only
D3331	Treatment of root canal obstruction; non-surgical access
D3333	Internal root repair of perforation defects. Must be performed in conjunction with endodontic procedures and not separately
D3346	Retreatment of previous root canal therapy - anterior - covered once per permanent tooth; twelve (12) months after initial root canal by same provider
D3347	Retreatment of previous root canal therapy - bicuspid - covered once per permanent tooth; twelve (12) months after initial root canal by same provider
D3348	Retreatment of previous root canal therapy - molar - covered once per permanent tooth; twelve 12 months after initial root canal by same provider
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.) – once per permanent tooth
D3352	Apexification/recalcification – interim medication replacement – once per permanent tooth
D3410	Apicoectomy - anterior - covered ninety (90) days after root canal therapy on a permanent tooth and by same provider or twenty-four (24) months after apicoectomy/periradicular surgery on a permanent tooth by same provider
D3421	Apicoectomy - bicuspid (first root) - covered ninety (90) days after root canal therapy on a permanent tooth and by same provider or twenty four (24) months after apicoetomy/periradicular surgery on a permanent tooth by same provider
D3425	Apicoectomy - molar (first root) - covered ninety (90) days after root canal therapy on a permanent tooth and by same provider or twenty four (24) months after apicoectomy/periradicular surgery on a permanent tooth by same provider
D3426	Apicoectomy (each additional root)
D3427	Periradicular surgery without apicoectomy
D3430	Retrograde filling - per root
D3910	Surgical procedure for isolation of tooth with rubber dam
D3999	Unspecified endodontic procedure, by report
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant – once per quadrant per thirty-six (36) months, age 13 and older
D4211	Gingivectomy or gingivoplasty - one (1) to three (3) contiguous teeth or tooth bounded spaces per quadrant - once per quadrant per thirty-six (36) months, age 13 and older
D4249	Clinical crown lengthening – hard tissue
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four (4) or more contiguous teeth or tooth bounded spaces per quadrant - once per quadrant per thirty-six (36) months, age 13 and older
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one (1) to three (3) contiguous teeth or tooth bounded spaces per quadrant – once per quadrant per thirty-six (36) months, age 13 and older
D4265	Biologic materials to aid in soft and osseous tissue regeneration
D4341	Periodontal scaling and root planing - four or more teeth per quadrant – once per quadrant per twenty (24) months, age 13 and older

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D4342	Periodontal scaling and root planing - one to three teeth per quadrant – once per quadrant per twenty (24) months, age 13 and older
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation – once per quadrant per twenty four (24) months, age 13 and older
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
D4910	Periodontal maintenance – four (4) times per twelve (12) months; up to twenty-four (24) months following scaling and root-planing, frequency includes D1110 and D1120 above (adult and child prophylaxis)
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff) - once per provider within thirty (30) days of gingivectomy/gingivoplasty or osseous surgery, age 13 and older. Dental codes are D4210, D4211, D4260, or D4261.
D4999	Unspecified periodontal procedure, by report, age 13 and older
D5110	Complete denture - maxillary – once per 60 months. All adjustments made for six (6) months after the date of service, by the same provider, are included in the fee for this procedure.
D5120	Complete denture - mandibular – once per 60 months. All adjustments made for six (6) months after the date of service, by the same provider, are included in the fee for this procedure.
D5130	Immediate denture - maxillary – once per arch per lifetime. All adjustments made for six (6) months after the date of service, by the same provider, are included in the fee for this procedure.
D5140	Immediate denture - mandibular – once per arch per lifetime. All adjustments made for six (6) months after the date of service, by the same provider, are included in the fee for this procedure.
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) - once per sixty (60) months. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) - once per sixty (60) months. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) – once per sixty (60) months. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) – once per sixty (60) months. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5221	Immediate maxillary partial denture – resin base (including conventional clasps, retentive/clasping materials, rests and teeth) - covered once per arch per lifetime. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5222	Immediate mandibular partial denture – resin base (including conventional retentive/clasping materials, rests and teeth) - covered once per arch per lifetime. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, conventional clasps, rests and teeth) - covered once per arch per lifetime. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, conventional clasps, rests and teeth) - covered once per arch per lifetime. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5410	Adjust complete denture - maxillary – two (2) times per twelve (12) months per provider; six (6) months after initial placement, reline, or repair
D5411	Adjust complete denture - mandibular - two (2) times per twelve (12) months per provider; six (6) months after initial placement, reline, or repair

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D5421	Adjust partial denture - maxillary - two (2) times per twelve (12) months per provider; six (6) months after initial placement, reline, or repair
D5422	Adjust partial denture - mandibular - two (2) times per twelve (12) months per provider; six (6) months after initial placement, reline, or repair
D5511	Repair broken complete denture base, mandibular – two (2) times per twelve (12) months per arch, per provider; six (6) months after initial placement, reline, or repair
D5512	Repair broken complete denture base, maxillary – two (2) times per twelve (12) months per arch, per provider; six (6) months after initial placement, reline, or repair
D5520	Replace missing or broken teeth - complete denture (each tooth) – two (2) times per twelve (12) months per arch and up to four (4) teeth per visit per provider. All adjustments made for six months after the date or repair, in the same arch and by the same provider are included in the fee for this procedure
D5611	Repair resin denture base, mandibular – two (2) times per twelve (12) months per arch, per provider. All adjustments made for six months after the date or repair, in the same arch and by the same provider are included in the fee for this procedure.
D5612	Repair resin denture base, maxillary - two (2) times per twelve (12) months per arch, per provider. All adjustments made for six months after the date or repair, in the same arch and by the same provider are included in the fee for this procedure.
D5621	Repair cast framework, mandibular – two (2) times per twelve (12) months per arch, per provider. All adjustments made for six months after the date or repair, in the same arch and by the same provider are included in the fee for this procedure.
D5622	Repair cast framework, maxillary – two (2) times per twelve (12) months per arch, per provider. All adjustments made for six months after the date or repair, in the same arch and by the same provider are included in the fee for this procedure.
D5630	Repair or replace broken clasp - per tooth – two (2) times per twelve (12) months per arch and up to three (3) clasps per visit per provider. All adjustments made for six months after the date or repair, in the same arch and by the same provider are included in the fee for this procedure.
D5640	Replace broken teeth - per tooth – two (2) times per twelve (12) months per arch and up to four (4) teeth per visit per provider. All adjustments made for six months after the date or repair, in the same arch and by the same provider are included in the fee for this procedure.
D5650	Add tooth to existing partial denture - covered up to three (3) teeth per visit per provider. All adjustments made for six months after the date or repair, in the same arch and by the same provider are included in the fee for this procedure.
D5660	Add clasp to existing partial denture -covered up to three (3) clasps per visit per provider. All adjustments made for six months after the date or repair, in the same arch and by the same provider are included in the fee for this procedure.
D5730	Reline complete maxillary denture (chairside) – once per six (6) months following D5130/D5863 with extractions; once per twelve (12) months following D5110/D5863 without extractions. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5731	Reline complete mandibular denture (chairside) – once per six (6) months following D5140/D5865 with extractions; once per twelve (12) months following D5120/D5865 without extractions. Not a benefit within 12 months of a laboratory reline complete mandibular denture. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5740	Reline maxillary partial denture (chairside) – once per six (6) months following D5211/D5213 with extractions; once per twelve (12) months following D5211/D5213 without extractions. Not a benefit within 12 months of a laboratory reline maxillary partial denture. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5741	Reline mandibular partial denture (chairside) – once per six (6) months following D5212/D5214 with extractions; once per twelve (12) months following D5212/D5214 without extractions. Not a benefit within 12 months of a laboratory reline mandibular partial denture. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5750	Reline complete maxillary denture (laboratory) – once per six (6) months following D5130/D5863 with extractions; once per twelve (12) months following D5110/D5863 without extractions. Not a benefit within 12

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
	months of a chairside reline maxillary denture. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5751	Reline complete mandibular denture (laboratory) – once per six (6) months following D5140/D5865 with extractions; once per twelve (12) months following D5120/D5865 without extractions. Not a benefit within 12 months of a chairside reline complete mandibular denture. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5760	Reline maxillary partial denture (laboratory) – once per six (6) months following D5213 with extractions; once per twelve (12) months following D5213 without extractions. Not a benefit within 12 months of a chairside reline maxillary partial denture with resin base. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5761	Reline mandibular partial denture (laboratory) – once per six (6) months following D5214 with extractions; once per twelve (12) months following D5214 without extractions. Not a benefit within 12 months of a chairside reline mandibular partial denture. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5850	Tissue conditioning, maxillary – two (2) times each appliance per thirty-six (36) months. Not a benefit same date of service as chairside or laboratory reline. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5851	Tissue conditioning, mandibular – two (2) times each appliance per thirty-six (36) months. Not a benefit same date of service as chairside or laboratory reline. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5862	Precision attachment, by report
D5863	Overdenture – complete maxillary
D5864	Overdenture – partial maxillary
D5865	Overdenture – complete mandibular
D5866	Overdenture – partial mandibular
D5899	Unspecified removable prosthodontic procedure, by report
D5911	Facial moulage (sectional)
D5912	Facial moulage (complete)
D5913	Nasal prosthesis
D5914	Auricular prosthesis
D5915	Orbital prosthesis
D5916	Ocular prosthesis
D5919	Facial prosthesis
D5922	Nasal septal prosthesis
D5923	Ocular prosthesis, interim
D5924	Cranial prosthesis
D5925	Facial augmentation implant prosthesis
D5926	Nasal prosthesis, replacement
D5927	Auricular prosthesis, replacement
D5928	Orbital prosthesis, replacement
D5929	Facial prosthesis, replacement
D5931	Obturator prosthesis, surgical
D5932	Obturator prosthesis, definitive
D5933	Obturator prosthesis, modification – two (2) times per twelve (12) months
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	Trismus appliance (not for TMD treatment)
D5951	Feeding aid - covered up to age 18
D5952	Speech aid prosthesis, pediatric - covered up to age 18
D5953	Speech aid prosthesis, adult – covered age 18 and older

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D5954	Palatal augmentation prosthesis
D5955	Palatal lift prosthesis, definitive
D5958	Palatal lift prosthesis, interim
D5959	Palatal lift prosthesis, modification – two (2) times per twelve (12) months
D5960	Speech aid prosthesis, modification – two (2) times per twelve (12) months
D5982	Surgical stent
D5983	Radiation carrier
D5984	Radiation shield
D5985	Radiation cone locator
D5986	Fluoride gel carrier
D5987	Commissure splint
D5988	Surgical splint
D5991	Vesiculobullous disease medicament carrier
D5999	Unspecified maxillofacial prosthesis, by report
D6010	Surgical placement of implant body: endosteal implant
D6011	Second stage implant surgery
D6013	Surgical placement of mini implant
D6040	Surgical placement: eposteal implant
D6050	Surgical placement: transosteal implant
D6052	Semi-precision attachment abutment
D6055	Connecting bar – implant supported or abutment supported
D6056	Prefabricated abutment – includes modification and placement
D6057	Custom fabricated abutment – includes placement
D6058	Abutment supported porcelain/ceramic crown
D6059	Abutment supported porcelain fused to metal crown (high noble metal)
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061	Abutment supported porcelain fused to metal crown (noble metal)
D6062	Abutment supported cast metal crown (high noble metal)
D6063	Abutment supported cast metal crown (predominantly base metal)
D6064	Abutment supported cast metal crown (noble metal)
D6065	Implant supported porcelain/ceramic crown
D6066	Implant supported crown (porcelain fused to high noble alloys)
D6067	Implant supported crown (high noble alloys)
D6068	Abutment supported retainer for porcelain/ceramic FPD
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072	Abutment supported retainer for cast metal FPD (high noble metal)
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)
D6074	Abutment supported retainer for cast metal FPD (noble metal)
D6075	Implant supported retainer for ceramic FPD
D6076	Implant supported retainer for porcelain FPD (fused to high noble alloys)
D6077	Implant supported retainer for metal FPD (high noble alloys)
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure
D6082	Implant supported crown – porcelain fused to predominantly base alloys
D6083	Implant supported crown – porcelain fused to noble alloys
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D6085	Provisional implant crown
D6086	Implant supported crown – predominantly base alloys
D6087	Implant supported crown – noble alloys
D6088	Implant supported crown – titanium and titanium alloys
D6090	Repair implant supported prosthesis, by report
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment
D6092	Re-cement or re-bond implant/abutment supported crown - covered twelve (12) months after initial placement of crown by same provider
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture - covered twelve (12) months after initial placement of crown by same provider
D6094	Abutment supported crown - (titanium) and titanium alloys
D6095	Repair implant abutment, by report
D6096	Remove broken retaining screw
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys
D6098	Implant supported retainer – porcelain fused to predominantly base alloys
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys
D6100	Implant removal, by report
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys
D6121	Implant supported retainer for metal FPD – predominantly base alloys
D6122	Implant supported retainer for metal FPD – noble alloys
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys
D6190	Radiographic/surgical implant index, by report
D6194	Abutment supported retainer crown for FPD (titanium) and titanium alloys
D6199	Unspecified implant procedure, by report
D6211	Pontic - cast predominantly base metal - once per tooth per sixty (60) months; age 13 and older; only in conjunction with D5211/ D5212/ D5213/ D5214 and same date of service as D6721/ D6740/ D6751/ D6781/ D6783/ D6791
D6241	Pontic - porcelain fused to predominantly base metal – once per tooth per sixty (60) months; age 13 and older; only in conjunction with D5211/ D5212/ D5213/ D5214 and same date of service as D6721/ D6740/ D6751/ D6781/ D6783/ D6791
D6245	Pontic - porcelain/ceramic – once per tooth per sixty (60) months; age 13 and older; only in conjunction with D5211/ D5212/ D5213/ D5214 and same date of service as D6721/ D6740/ D6751/ D6781/ D6783/ D6791
D6251	Pontic - resin with predominantly base metal – once per tooth per sixty (60) months; age 13 and older; only in conjunction with D5211/ D5212/ D5213/ D5214 and same date of service as D6721/ D6740/ D6751/ D6781/ D6783/ D6791
D6721	Retainer crown - resin with predominantly base metal - once per tooth per sixty (60) months; age 13 and older; in conjunction with D5211/ D5212/ D5213/ D5214
D6740	Retainer crown - porcelain/ceramic - once per tooth per sixty (60) months; age 13 and older; in conjunction with D5211/ D5212/ D5213/ D5214
D6751	Retainer crown - porcelain fused to predominantly base metal – once per tooth per sixty (60) months; age 13 and older; in conjunction with D5211/ D5212/ D5213/ D5214

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D6781	Retainer crown - 3/4 cast predominantly base metal – once per tooth per sixty (60) months; age 13 and older; in conjunction with D5211/ D5212/ D5213/ D5214
D6783	Retainer crown - 3/4 porcelain/ceramic – once per tooth per sixty (60) months; age 13 and older; in conjunction with D5211/ D5212/ D5213/ D5214
D6784	Retainer crown - 3/4 titanium and titanium alloys – once per tooth per sixty (60) months; age 13 and older; in conjunction with D5211/ D5212/ D5213/ D5214
D6791	Retainer crown - full cast predominantly base metal – once per tooth per sixty (60) months; age 13 and older; in conjunction with D5211/ D5212/ D5213/ D5214
D6930	Re-cement or re-bond fixed partial denture - covered twelve (12) months after initial placement of crown by same provider
D6980	Fixed partial denture repair necessitated by restorative material failure - covered twelve (12) months after initial placement or repair of crown by same provider
D6999	Unspecified fixed prosthodontic procedure, by report
D7111	Extraction, coronal remnants - deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated. Surgical removal of 3rd molars is covered only when symptoms of pathology exist.
D7220	Removal of impacted tooth - soft tissue. Surgical removal of 3rd molars is covered only when symptoms of pathology exist.
D7230	Removal of impacted tooth - partially bony. Surgical removal of 3rd molars is covered only when symptoms of pathology exist.
D7240	Removal of impacted tooth - completely bony. Surgical removal of 3rd molars is covered only when symptoms of pathology exist.
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications. Surgical removal of 3rd molars is covered only when symptoms of pathology exist.
D7250	Removal of residual tooth roots (cutting procedure). Surgical removal of 3rd molars is covered only when symptoms of pathology exist.
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth is covered; once per arch regardless of the number of teeth involved; for permanent anterior tooth only.
D7280	Exposure of an unerupted tooth
D7283	Placement of device to facilitate eruption of impacted tooth - covered with orthodontia
D7285	Incisional biopsy of oral tissue-hard (bone, tooth) – once per arch per date of service, regardless of the areas involved
D7286	Incisional biopsy of oral tissue-soft – three (3) times per date of service for the removal of the specimen only
D7290	Surgical repositioning of teeth – once per arch per lifetime; with active orthodontia treatment
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report – once per arch per lifetime; with active orthodontia treatment
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant - covered following six (6) months of any extraction in the same quadrant for the same provider
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant covered following six (6) months of any extraction in the same quadrant for the same provider
D7340	Vestibuloplasty - ridge extension (secondary epithelialization) – once per arch per 60 months
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) – once per arch per lifetime with orthodontia
D7410	Excision of benign lesion up to 1.25 cm

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7465	Destruction of lesion(s) by physical or chemical method, by report
D7471	Removal of lateral exostosis (maxilla or mandible) - once per quadrant per lifetime
D7472	Removal of torus palatinus – once per quadrant per lifetime
D7473	Removal of torus mandibularis – once per quadrant per lifetime
D7485	Reduction of osseous tuberosity – once per quadrant per lifetime
D7490	Radical resection of maxilla or mandible
D7510	Incision and drainage of abscess - intraoral soft tissue – once per quadrant per same date of service
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) – once per quadrant per same date of service
D7520	Incision and drainage of abscess - extraoral soft tissue – once per quadrant per same date of service
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces) – once per quadrant per same date of service
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue covered once per date of service
D7540	Removal of reaction producing foreign bodies, musculoskeletal system covered once per date of service
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone – once per quadrant per date of service; only after 30 days following an extraction
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	Maxilla - open reduction (teeth immobilized, if present)
D7620	Maxilla - closed reduction (teeth immobilized, if present)
D7630	Mandible - open reduction (teeth immobilized, if present)
D7640	Mandible - closed reduction (teeth immobilized, if present)
D7650	Malar and/or zygomatic arch - open reduction
D7660	Malar and/or zygomatic arch - closed reduction
D7670	Alveolus - closed reduction, may include stabilization of teeth
D7671	Alveolus - open reduction, may include stabilization of teeth
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7710	Maxilla - open reduction
D7720	Maxilla - closed reduction
D7730	Mandible - open reduction
D7740	Mandible - closed reduction
D7750	Malar and/or zygomatic arch - open reduction
D7760	Malar and/or zygomatic arch - closed reduction
D7770	Alveolus - open reduction stabilization of teeth
D7771	Alveolus, closed reduction stabilization of teeth
D7780	Facial bones - complicated reduction with fixation and multiple approaches
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D7840	Condylectomy
D7850	Surgical discectomy, with/without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrotomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7871	Non-arthroscopic lysis and lavage
D7872	Arthroscopy - diagnosis, with or without biopsy
D7873	Arthroscopy: lavage and lysis of adhesions
D7874	Arthroscopy: disc repositioning and stabilization
D7875	Arthroscopy: synovectomy
D7876	Arthroscopy: discectomy
D7877	Arthroscopy: debridement
D7880	Occlusal orthotic device, by report
D7881	Occlusal orthotic device adjustment
D7899	Unspecified TMD therapy, by report
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
D7920	Skin graft (identify defect covered, location and type of graft)
D7922	Placement of intrasocket dressing to aid in hemostasis or clot stabilization, per site
D7940	Osteoplasty - for orthognathic deformities
D7941	Osteotomy - mandibular rami
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy - segmented or subapical
D7945	Osteotomy - body of mandible
D7946	LeFort I (maxilla - total)
D7947	LeFort I (maxilla - segmented)
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft
D7949	LeFort II or LeFort III - with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach
D7952	Sinus augmentation via a vertical approach
D7955	Repair of maxillofacial soft and/or hard tissue defect
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure - once per arch
D7963	Frenuloplasty
D7970	Excision of hyperplastic tissue - per arch – once per arch
D7971	Excision of pericoronal gingiva
D7972	Surgical reduction of fibrous tuberosity – once per quadrant per day
D7979	Non-surgical Sialolithotomy
D7980	Sialolithotomy
D7981	Excision of salivary gland, by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D7991	Coronoidectomy
D7995	Synthetic graft - mandible or facial bones, by report
D7997	Appliance removal (not by dentist who placed appliance), includes removal of arch bar – once per arch per day
D7999	Unspecified oral surgery procedure, by report
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8210	Removable appliance therapy – once per lifetime; age six (6) – twelve (12)
D8220	Fixed appliance therapy – once per lifetime; age six (6) – twelve (12)
D8660	Pre-orthodontic treatment examination to monitor growth and development – once every three (3) months
D8670	Periodic orthodontic treatment visit – four (4) visits per year (paid quarterly)
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s) – one (1) appliance per arch per course of treatment
D8681	Removable orthodontic retainer adjustment
D8696	Repair of orthodontic appliance – maxillary
D8697	Repair of orthodontic appliance – mandibular
D8698	Re-cement or re-bond fixed retainer – maxillary
D8699	Re-cement or re-bond fixed retainer – mandibular
D8701	Repair of fixed retained, includes reattachment - maxillary
D8702	Repair of fixed retainer, includes reattachment – mandibular
D8703	Replacement of lost or broken retainer – maxillary
D8704	Replacement of lost or broken retainer – mandibular
D8999	Unspecified orthodontic procedure, by report
D9110	Palliative (emergency) treatment of dental pain - minor procedure – once per day
D9120	Fixed partial denture sectioning
D9210	Local anesthesia not in conjunction with operative or surgical procedures – once per day
D9211	Regional block anesthesia is included in the fee for other procedures and is not payable separately
D9212	Trigeminal division block anesthesia is included in the fee for other procedures and is not payable separately
D9215	Local anesthesia in conjunction with operative or surgical procedures is covered one (1) time per day per provider
D9222	Deep sedation/analgesia - first fifteen (15) minutes
D9223	Deep sedation/general anesthesia – each fifteen (15) minute increment
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis - Covered for patients under age 13 when they are uncooperative.. Not covered on the same date of service as deep sedation/general anesthesia (D9220 and D9221), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248) and when all associated procedures on the same date of service by the same provider are denied.
D9239	Intravenous moderate (conscious) sedation/anesthesia - first fifteen (15) minutes is covered once per date of service
D9243	Intravenous moderate (conscious) sedation/analgesia – each fifteen (15) minute increment is covered once per date of service
D9248	Non-intravenous conscious sedation is covered for patients under age 13 when they are uncooperative
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician
D9311	Consultation with a medical health care professional
D9410	House/extended care facility call – once per day
D9420	Hospital or ambulatory surgical center call - units are in hours
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed once per day, per provider
D9440	Office visit - after regularly scheduled hours – once per day, per provider
D9610	Therapeutic parenteral drug, single administration – four (4) times per day

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D9612	Therapeutic parenteral drugs, two or more administrations, different medications - alternates to D9610, which equals four (4) times per day
D9910	Application of desensitizing medicament – once per twelve (12) months per provider
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report – one (1) treatment per day per provider; within thirty (30) days of extraction
D9950	Occlusion analysis - mounted case – once per twelve (12) months for analysis for temporomandibular joint disorder; age 13 and older
D9951	Occlusal adjustment - limited – once per twelve (12) months, per quadrant, per provider and for natural teeth only; age 13 and older
D9952	Occlusal adjustment - complete – once per twelve (12) months following occlusion analysis mounted case for temporomandibular joint dysfunction disorders only; age 13 and older
D9997	Dental case management – patients with special health care needs
D9999	Unspecified adjunctive procedure, by report

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

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.

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)**

Amharic
ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ። (TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(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)**

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (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)

German
Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Ilokano
Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (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)

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)

Samoan
E iai lou ‘aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se totogi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha 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)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (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's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't 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 isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services 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, Richmond, VA 23279 or by email to compliance.coordinator@anthem.com. Or you can 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.