



# Custom Premier PPO (350/1050-20/90/70)

In addition to dollar and percentage copays, members are responsible for deductibles, as described below.

Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Members are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

### Subject to Utilization Review

Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.

### Explanation of Maximum Allowed Amount

**Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance. PPO Providers—The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount. Non-PPO Providers—For non-emergency care, reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. Members are responsible for the difference between the provider's usual charges & the maximum allowed amount.** For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.

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

<b>Calendar year deductible for all providers</b>	\$350/member; \$1,050/family
<b>Copay for non-Anthem Blue Cross PPO hospital or residential treatment center or ambulatory surgical center</b>	\$500/admission ( <i>waived for emergency admission</i> )
<b>Copay for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained</b>	\$500/admission ( <i>waived for emergency admission</i> )
<b>Copay for emergency room services</b>	\$100/visit ( <i>waived if admitted directly from ER</i> )
<b>Annual Out-of-Pocket Maximums</b> ( <i>no cross application</i> )	
PPO Providers & Other Health Care Providers	\$683/Individual \$1,366/Two-Party (employee + 1) \$2,049/Family (3 or more)
Non-PPO Providers	\$1,636/Individual \$3,272/Two-Party (employee + 1) \$4,908/Family (3 or more)

The following do not apply to out-of-pocket maximums: non-covered expenses. After an annual out-of-pocket maximum is met for medical and prescription drugs during a calendar year, the individual member or family will no longer be required to pay a copay or coinsurance for medical and prescription drug covered expenses for the remainder of that year. The member remains responsible for non-covered expenses.

<b>Lifetime Maximum</b>	Unlimited	
<b>Covered Services</b>	<b>PPO: Per Member Copay</b>	<b>Non-PPO: Per Member Copay</b>
<b>Hospital Medical Services</b> ( <i>subject to utilization review for inpatient services; waived for emergency admissions</i> )		
➤ Semi-private room, meals & special diets, & ancillary services	10%	30% <sup>1</sup>
➤ Outpatient medical care, surgical services & supplies ( <i>hospital care other than emergency room care</i> )	10%	30% <sup>1</sup>
<b>Ambulatory Surgical Centers</b>		
➤ Outpatient surgery, services & supplies	10%	30%
<b>Hemodialysis</b>		
➤ Outpatient hemodialysis services & supplies	10%	30%
<b>Skilled Nursing Facility</b> ( <i>subject to utilization review</i> )		
➤ Semi-private room, services & supplies	10%	30%
<b>Hospice Care</b>		
➤ Inpatient or outpatient services for members with up to one year life expectancy; family bereavement services		10% <sup>2</sup>

<sup>1</sup> For California facilities, a discount will be applied if the facility has a contract with Anthem Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher costs for members.

<sup>2</sup> These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
<b>Home Health Care</b> (subject to utilization review)		
➤ Services & supplies from a home health agency (limited to 100 visits/ calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)	10%	30%
<b>Home Infusion Therapy</b> (subject to utilization review)		
➤ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	30%
<b>Physician Medical Services</b>		
➤ Office & home visits (includes retail health clinic)	\$20/visit <sup>1</sup> (deductible waived)	30%
➤ Preferred Online visits (includes Mental/Behavioral Health and Substance Abuse)	\$20/visit (deductible waived)	30%
➤ Hospital & skilled nursing facility visits	10%	30%
➤ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	30%
➤ Drugs administered by a medical provider (certain drugs are subject to utilization review)	10%	30%
<b>Diagnostic X-ray &amp; Lab</b>		
➤ MRI, CT scan, PET scan & nuclear cardiac scan (subject to utilization review)	10%	30%
➤ Other diagnostic x-ray & lab	10%	30%
<b>Preventive Care services</b>		
Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay/exam (deductible waived)	30%
<b>Physical Therapy, Physical Medicine &amp; Occupational Therapy, including Chiropractic Services</b>	10%	30%
<b>Speech Therapy</b>		
➤ Outpatient speech therapy following injury or organic disease	10%	30%
<b>Acupuncture</b>		
➤ Services for the treatment of disease, illness or injury	10% <sup>2</sup>	30% <sup>2</sup>
<b>Temporomandibular Joint Disorders</b>		
➤ Splint therapy & surgical treatment	10%	30%
<b>Pregnancy &amp; Maternity Care</b>		
➤ Physician office visits	\$20/visit <sup>1</sup> (deductible waived)	30%
➤ Prescription drug for abortion (mifepristone)	10%	30%
Normal delivery, cesarean section, complications of pregnancy & abortion		
➤ Inpatient physician services	10%	30%
➤ Hospital & ancillary services	10%	30% <sup>4</sup>
<b>Organ &amp; Tissue Transplants</b> (subject to utilization review; specified transplants covered only when performed at Centers of Medical Excellence [CME] and Blue Distinction Centers for Specialty Care [BDCSC] for California; Blue Distinction Centers for Specialty Care [BDCSC] for out of California)		
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants		10%
➤ Transplant travel expense for an authorized, specified transplant at a CME (recipient & companion transportation limited to 6 trips/episode & \$250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & \$100/day for 21 days/trip, other expenses limited to \$25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode & \$250 for round-trip coach airfare, hotel limited to \$100/day for 7 days, other expenses limited to \$25/day for 7 days)		No copay (deductible waived)

<sup>1</sup> The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

<sup>2</sup> Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

<sup>3</sup> For California facilities, a discount will be applied if the facility has a contract with Anthem Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher costs for members.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
<b>Bariatric Surgery</b> <i>(subject to utilization review; covered only when performed at a Blue Distinction Center for Specialty Care [BDCSC])</i>		
➤ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	10%	
➤ Bariatric travel expense when member's home is 50 miles or more from the nearest bariatric COE <i>(member's transportation to &amp; from COE limited to \$130/person/trip for 3 trips [pre-surgical visit, initial surgery &amp; one follow-up visit]; one companion's transportation to &amp; from COE limited to \$130/person/trip for 2 trips [initial surgery &amp; one follow-up visit]; hotel for member &amp; one companion limited to one room double occupancy &amp; \$100/day for 2 days/trip, or as medically necessary, for pre-surgical &amp; follow-up visit; hotel for one companion limited to one room double occupancy &amp; \$100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to \$25/day/person for 4 days/trip)</i>	No copay <i>(deductible waived)</i>	
<b>Diabetes Education Programs</b> <i>(requires physician supervision)</i>		
➤ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	\$20/visit <i>(deductible waived)</i>	30%
<b>Prosthetic Devices</b>		
➤ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts for members with diabetes	10%	30%
<b>Durable Medical Equipment</b>		
➤ Rental or purchase of DME including hearing aids, dialysis equipment & supplies <i>(hearing aids benefit is available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)</i>	10%	30%
<b>Related Outpatient Medical Services &amp; Supplies</b>		
➤ Ground transportation, services & disposable supplies	No copay first \$50 of expenses <i>(deductible waived)</i> ; thereafter 20% <sup>1</sup> <i>(subject to deductible)</i>	
➤ Air ambulance transportation, services & disposable supplies	No copay first \$200 of expenses <i>(deductible waived)</i> ; thereafter 20% <sup>1</sup> <i>(subject to deductible)</i>	
➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20% <sup>1</sup>	
➤ Autologous blood <i>(self-donated blood collection, testing, processing &amp; storage for planned surgery)</i>	20% <sup>1</sup>	
<b>Accidental injury benefit</b> <i>(if expenses incurred within 90 days of accidental injury)</i>	No copay first \$500 of expenses <i>(deductible waived)</i>	
	10%	30%

<sup>1</sup> These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
<b>Emergency Care</b>		
➤ Emergency room services & supplies ( <i>\$100 copay waived if admitted</i> )	10%	10%
➤ Inpatient hospital services	10%	10%
➤ Ambulatory surgical center services & supplies	10%	10%
➤ Physician services	10%	10%
<b>Mental/Behavioral Health and Substance Abuse</b>		
➤ Inpatient facility care ( <i>subject to utilization review; waived for emergency admissions</i> )	No copay ( <i>deductible waived</i> )	30%
➤ Inpatient physician visits	No copay ( <i>deductible waived</i> )	30%
➤ Outpatient facility care	No copay ( <i>deductible waived</i> )	30%
➤ Physician office visits	No copay ( <i>deductible waived</i> )	30%

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

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

# Premier Plan Exclusions and Limitations

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

**Experimental or Investigative.** Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Evidence of Coverage (EOC).

**Services Received Outside of the United States.** Services rendered by providers located outside the United States, unless the services are for an emergency, emergency ambulance or urgent care. **Incarceration.** For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation. **Not Covered.** Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the EOC.

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

**Work-Related.** Any injury, condition or disease arising out of employment for which benefits or payments are covered by any worker's compensation law or similar law. If we provide benefits for such injuries, conditions or diseases we shall be entitled to establish a lien or other recovery under section 4903 of the California Labor Code or any other applicable law, as specified in the EOC/Certificate.

**Government Treatment.** Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the member is not required to pay for them or they are given to the insured person for free.

**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.* **Voluntary Payment.** Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

**Private Contracts.** Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

**Inpatient Diagnostic Tests.** Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

**Mental Health Conditions.** Academic or educational testing, counseling, and remediation. Mental or nervous disorders and alcohol or drug dependence, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC. This exclusion does not apply to the *medically necessary services to treat severe mental disorders* or serious emotional disturbances of a child as required by state law.

**Orthodontia.** Braces, other orthodontic appliances or orthodontic services.

**Dental Services or Supplies.** Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

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

**Optometric Services or Supplies.** Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, eyeglasses or contact lenses, except as specified as covered in the EOC.

**Outpatient Occupational Therapy.** Outpatient occupational therapy, except by a home health agency, hospice, or infusion therapy provider, except as specified as covered in the EOC.

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

**Cosmetic Surgery.** Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

**Weight loss.** Services, programs, or supplies for losing weight or the treatment of obesity. We will cover this kind of care if we find that the member is morbidly obese.

**Sterilization Reversal.**

**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.

**Infertility Treatment.** Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

**Surrogacy.** Any services or supplies given for a surrogate pregnancy (i.e., the bearing of a child by another woman for an infertile couple), unless the member is the surrogate mother.

**Gene Therapy.** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit,

benefits may be available under the "Gene Therapy Services" benefit. Please see that section for details.

**Foot Orthotics.** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes. **Air Conditioners.** Air purifiers, air conditioners or humidifiers.

**Custodial Care or Rest Cures.** Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

**Exercise Equipment.** Exercise equipment, or any charges for fitness programs. This includes charges like those from a physical fitness instructor, health club or gym, even if doctor advises the member to change one's lifestyle.

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

**Educational Services.** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

**Nutrition.** Food or nutritional supplements except for special food products and formulas that are part of a special diet prescribed by a doctor for the treatment of phenylketonuria. This exclusion does not apply to the *medically necessary services to treat severe mental disorders* or serious emotional disturbances of a child as required by state law.

**Telephone and Facsimile Machine Consultations.** Consultations provided by telephone or facsimile machine. This exclusion does not apply to the *medically necessary services to treat severe mental disorders* or serious emotional disturbances of a child as required by state law.

**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.

**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 as specified in the EOC. This exclusion does not apply to the *medically necessary services to treat severe mental disorders* or serious emotional disturbances of a child as required by state law. **Acupuncture.** Acupuncture treatment, as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

**Eye Surgery for Refractive Defects.** Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

**Physical Therapy or Physical Medicine.** Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the EOC.

**Drugs Given to you by a Doctor.** The following exclusions apply to drugs you receive from a doctor:

• Delivery Charges. Charges for the delivery of prescription drugs.

• 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](http://www.anthem.com).

If you or your doctor believes you need to use a different prescription drug, please have your doctor or pharmacist get in touch with us. We will cover the other prescription drug only if we agree that it is medically necessary and appropriate over the clinically equivalent drug. We will review benefits for the prescription drug from time to time to make sure the drug is still medically necessary.

• Compound Drugs. Compound drugs unless all of the ingredients are FDA-approved in the form in which they are used in the compound drug and as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a prescription to dispense, and the compound drug 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.

• Drugs Contrary to Approved Medical and Professional Standards. Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

• Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the plan or us.

• 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.

• Drugs Prescribed by Providers Lacking Qualifications, Registrations and/or Certifications. Prescription drugs prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications as determined by us.

• Drugs That Do Not Need a Prescription. Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law), except for injectable

insulin. This exclusion does not apply to over-the-counter drugs that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a doctor.

- Lost or Stolen Drugs. Refills of lost or stolen drugs.
- Non-Approved Drugs. Drugs not approved by the FDA.

**Outpatient Prescription Drugs and Medications.** Outpatient prescription drugs or medications and insulin, except as specified as covered in the Certificate. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

**Specialty Pharmacy Drugs.** Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. **Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.**

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

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

**Private Duty Nursing.** 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.

**Residential accommodations.** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

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

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

**Wigs.**

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

**Coordination Of Benefits** — The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

**Medicare.** For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in "General Provisions." If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when you should enroll and when you are allowed to delay enrollment without penalties.

**Services Received from Providers on a Federal or State Exclusion List.** 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 an emergency medical condition.

**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.

**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.

**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.

**Autopsies.** Autopsies and post-mortem testing.

**Dental Devices for Snoring.** Oral appliances for snoring.

**Hospital Services Billed Separately.** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.

**Growth Hormone Treatment.** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

**Hyperhidrosis Treatment.** Medical and surgical treatment of excessive sweating (hyperhidrosis).

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

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