

2021-2022



California State University, Fullerton Student Health Insurance Plan

www.anthem.com/studentadvantageca

Anthem Student Advantage

Keeping you at your personal best



Important notice

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

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**Welcome
to Anthem
Student
Advantage**



As your new school year begins, it's important to understand your health care benefits and how they work. Your Anthem Student Advantage plan will help guide you through that process with information about who is eligible, what is covered, how much it costs, and the best ways to access care.

What you need to know about Anthem Student Advantage



Who is eligible?

- › All registered International students or scholars enrolled on the main campus are required to purchase this insurance plan.
- › A person who is an immigrant, permanent resident alien or U.S. Citizen is not eligible for coverage.
- › Students must actively attend classes on campus for the first 45 consecutive days after the effective date, except for school-authorized breaks.
- › A once per lifetime medical withdrawal exception may be granted to students on school-approved medical leave during the first 31 days of coverage.
- › All refund requests must be sent to the University who will confirm non-student status with JCB, and submit the refund request on behalf of the student. Only

refunds submitted by the University before the refund deadline will be considered. Credit card refunds must be requested and processed within 120 days of the date of purchase and before the refund deadline. No refunds will be considered after the refund deadline. All refunds will be processed back to the original form of payment only, no exceptions. All refunds will be assessed a \$35 processing fee. Please allow 30 business days for us to receive and process the refund request, then an additional 3-5 business days to receive your refund from your financial institution. Pro-rated/partial refunds are not allowed. NOTE: You can check to see if your refund has been processed by logging in to your JCB account.

Coverage periods and rates



International degree

Session	Student	Spouse/ Domestic partner	Child	Two or more children
Annual (Yearly) 8/1/2021-7/31/2022	\$1,860	\$1,800	\$1,800	\$3,600
Fall 8/1/2021-12/31/2021	\$782	\$757	\$757	\$1,514
Spring/Summer 1/1/2022-7/31/2022	\$1,082	\$1,047	\$1,047	\$2,094

Semester abroad and exchange

Session	Student	Spouse/ Domestic partner	Child	Two or more children
Fall 8/1/2021-12/31/2021	\$782	\$757	\$757	\$1,514
Spring 1/1/2022-5/31/2022	\$770	\$745	\$745	\$1,490
Summer 6/1/2022-7/31/2022	\$312	\$302	\$302	\$604

OPT and Visiting Scholar

Session	Student	Spouse/ Domestic partner	Child	Two or more children
OPT 1 8/1/2021-10/31/2021	\$470	\$455	\$445	\$910
OPT 2 11/1/21-1/31/2022	\$470	\$455	\$445	\$910
OPT Mid-Term (Grad Only) 1/1/2022-3/31/2022	\$460	\$445	\$445	\$890
OPT (Grad Extension) 4/1/2022-6/30/2022	\$465	\$450	\$450	\$900

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



Keep in touch with your benefits information



Eligibility and enrollment questions

jcbins.com/

1-714-869-2961



Student Health Center

California State University, Fullerton

Student Wellness (SHCC-West)

800 N State College Blvd, Fullerton, CA 92831

1-657-278-2800

www.fullerton.edu/health/



Claims and coverage

1-800-888-2108

Anthem Blue Cross Life and Health Insurance Company

P.O. Box 60007, Los Angeles, CA 90060-0007

Easy access to care

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



Sydney Health app

With the Sydney Health¹ app through Anthem Student Advantage, you have instant access to:

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

Access the Sydney Health app

Go to the App StoreSM or Google PlayTM and search for the Sydney Health app to download it today.



Anthem Student Advantage CSUF website

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



ID Cards

To download your ID card, please access the Sydney app. You can also log onto www.anthem.com/ca to register and view your ID card.



24/7 NurseLine

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



Provider finder

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



LiveHealth Online

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

¹ Sydney Health is a service mark of CareMarket, Inc.

² Appointments subject to availability of a therapist. Psychologists or therapists using LiveHealth Online cannot prescribe medications. Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 1-800-784-2433 (National Suicide Prevention Lifeline) or 911 and ask for help. If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.



Your summary of benefits



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

Medical

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible		
See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.	\$200 per insured person	Not applicable
Out-of-Pocket Limit		
When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.	\$4,000 per insured/ \$8,000 family	Not applicable
Preventive care/screening/immunization		
In-network preventive care is not subject to deductible, if your plan has a deductible.	No charge	Not covered
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	\$20 copay per visit deductible does not apply	Not covered
Specialist Care Visit	\$20 copay per visit deductible does not apply	Not covered
Prenatal Preventive Care	No charge	Not covered
Post-natal Office Visit	No charge	Not covered
Other Practitioner Visits:		
Retail Health Clinic Visit	\$20 copay per visit deductible does not apply	Not covered
On-line visit: Preferred On-line Visit Live Health Online is the preferred telehealth solution (www.livehealthonline.com). Includes Medical, Mental Health and Substance Use.	\$20 deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Chiropractic/Manipulation Therapy <i>Coverage is limited to 50 visits per year. Applies to In-Network. Visit limits are combined both across outpatient and other professional visits.</i>	10% coinsurance after deductible is met	Not covered
Acupuncture	\$20 copay per visit after deductible is met	Not covered
Other Services in an Office:		
Allergy Testing	\$20 copay per visit after deductible is met	Not covered
Chemo/Radiation Therapy	10% coinsurance after deductible is met	Not covered
Hemodialysis	10% coinsurance after deductible is met	Not covered
Drugs Administered in the Office <i>For the drug itself dispensed in the office through infusion/injection</i>	10% coinsurance after deductible is met	Not covered
Diagnostic Services		
Lab:		
Office	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Freestanding Lab/Reference Lab	10% coinsurance per service after deductible is met	Not covered
X-Ray:		
Office	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Advanced Diagnostic Imaging (for example, MRI/PET/CA scans):		
Office	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Emergency and Urgent Care		
Urgent Care (Office Setting)	\$20 copay per visit deductible does not apply	Not covered
Emergency Room Facility Services <i>Emergency Room copay is waived if directly admitted to the hospital.</i>	\$175 copay per visit and 10% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	10% coinsurance after deductible is met	Covered as In-Network
Emergency Ambulance Transportation	10% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	\$20 copay per visit deductible does not apply	Not covered
Facility visit: Facility Fees	10% coinsurance after deductible is met	Not covered
Doctor Services	10% coinsurance after deductible is met	Not covered
Outpatient Surgery		
Facility fees: Hospital	10% coinsurance after deductible is met	Not covered
Doctor and Other Services Hospital	10% coinsurance after deductible is met	Not covered
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board)	10% coinsurance after deductible is met	Not covered
Doctor and other services	10% coinsurance after deductible is met	Not covered
Recovery & Rehabilitation		
Home Health Care <i>Coverage is unlimited per year.</i>	10% coinsurance after deductible is met	Not covered
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office	10% coinsurance per visit deductible does not apply	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Habilitation services (for example, physical/speech/occupational therapy):		
Office	10% coinsurance per visit deductible does not apply	Not covered
Outpatient hospital	10% coinsurance after deductible is met	Not covered
Cardiac rehabilitation		
Office	10% coinsurance per visit deductible does not apply	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Skilled Nursing Care (in a facility) <i>Coverage is limited to 100 days per benefit period. Limit is combined In- Network and Non-Network. Limit is combined across a skilled nursing facility and inpatient rehabilitation facility (includes services in an outpatient day rehabilitation program).</i>	10% coinsurance after deductible is met	Not covered
Hospice	10% coinsurance after deductible is met	Not covered
Durable Medical Equipment	10% coinsurance after deductible is met	Not covered



Pharmacy

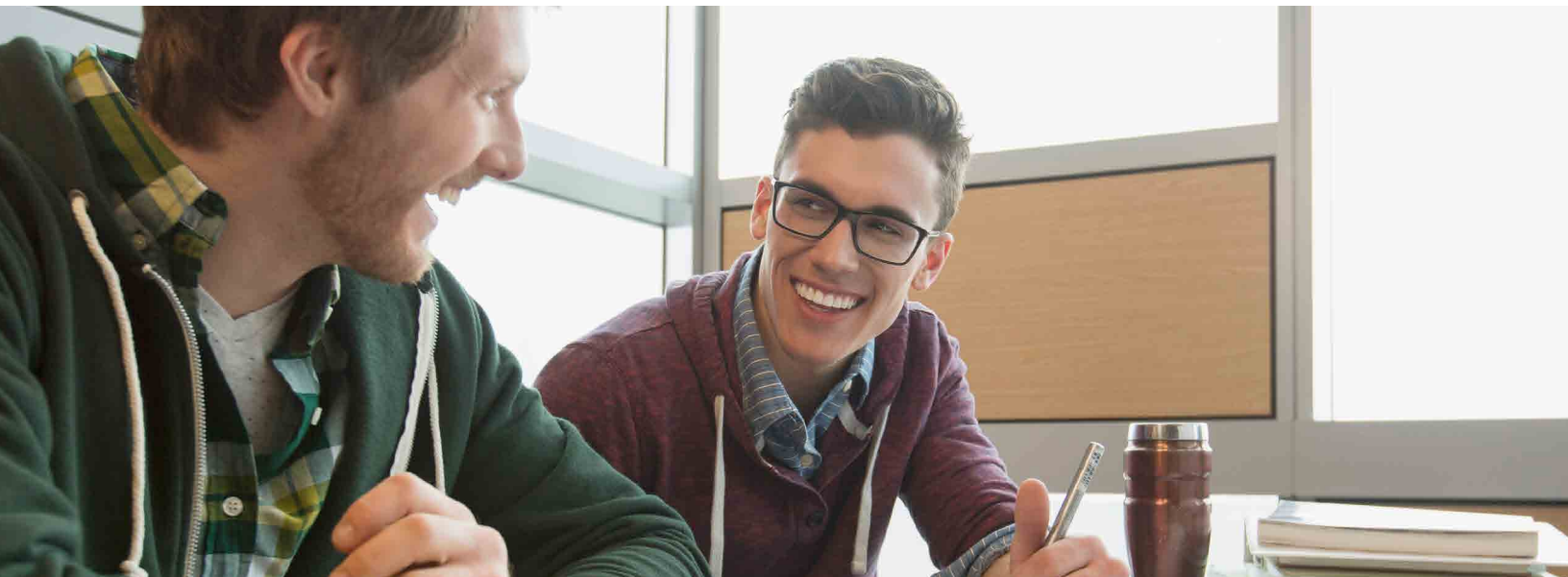
Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	None	Not applicable
Pharmacy Out of Pocket	Combined with medical out of pocket	Not applicable
Prescription Drug Coverage <i>This Plan uses a Traditional Drug List. Drugs not on this list are not covered.</i>		
Tier1 - Typically Generic <i>Covers up to a 30 day supply (retail pharmacy). No coverage for non-formulary drugs.</i>	\$15 copay per prescription (retail)	Not covered
Tier2 - Typically Preferred Brand <i>Covers up to a 30 day supply (retail pharmacy). No coverage for non-formulary drugs.</i>	\$35 copay per prescription (retail)	Not covered
Tier3 - Typically Non-Preferred Brand <i>Covers up to a 30 day supply (retail pharmacy). No coverage for non-formulary drugs.</i>	\$60 copay per prescription (retail)	Not covered

Pediatric Vision *Limited to covered persons under the age of 19.*

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail.

Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	\$0	\$0
Vision exam <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.</i>	No charge	Not covered
Frames <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Not covered
Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Not covered
Elective contact lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Not covered
Elective disposable contact lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Not covered
Non-Elective Contact Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Not covered
Adult Vision (age 19 and older)	See "Preventive Care" benefit	Not covered
Adult Vision Coverage <i>Limited to certain vision screenings required by Federal law and covered under the "Preventive Care" benefit.</i>	See "Preventive Care" benefit	Not covered





Pediatric Dental *Limited to covered persons under the age of 19.*

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's dental services count towards your out of pocket limit.</p>		
Children's Dental Essential Health Benefits (up to age 19)		
Diagnostic and preventive <i>Includes cleanings, exams, x-rays, sealants, fluoride.</i>	No charge	Not covered
Basic services <i>Includes fillings and simple extractions</i>	20% coinsurance after deductible is met	Not covered
Major services/Prosthodontic	50% coinsurance after deductible is met	Not covered
Endodontic, Periodontics, Oral Surgery	50% coinsurance after deductible is met	Not covered
Medically Necessary Orthodontia	50% coinsurance after deductible is met	Not covered
Deductible	Not applicable	Not applicable
Adult Dental	Not covered	Not covered

Benefits that go with you



You can count on medical coverage anywhere worldwide with GeoBlue.¹ Easily access international doctors by phone or video and use our 24/7 help center for emergency health questions. Anthem Student Advantage and GeoBlue provides the right support and services when you need them the most.



Visit <https://www.geobluestudents.com> to learn more.

GeoBlue benefits for the 2021-2022 school year

Use of benefits must be coordinated and approved by GeoBlue.

International telemedicine services²

Global TeleMD™ Confidential access to international doctors by telephone or video call.

Coverage outside the U.S., excluding student's home country.

Medical Expenses Maximum benefit up to \$250,000 per coverage year, no deductibles or copays. Consult coverage certificate for benefit limitations and exclusions.³

Coverage worldwide except within 100 miles of primary residence for U.S. students. Coverage worldwide, excluding home country for international students.

Emergency medical evacuation	Unlimited
Repatriation of remains	Unlimited
Emergency family travel arrangements	Maximum benefit up to \$5,000 per coverage year
Political emergency and natural disaster evacuation (Available only when traveling outside the United States) ⁴	Covered 100% up to \$100,000 per person. Subject to a combined \$5,000,000 limit per any one covered event for all people covered under the plan.
Accidental death and dismemberment	Maximum benefit up to \$10,000 per coverage year



¹ GeoBlue is the trade name of Worldwide Insurance Services, LLC (Worldwide Services Insurance Agency, LLC in California and New York), an independent licensee of the Blue Cross and Blue Shield Association. GeoBlue is the administrator of coverage provided under insurance policies issued by 4 Ever Life International Limited, Bermuda, an independent licensee of the Blue Cross Blue Shield Association. Coverage is not available in all states. Some restrictions apply.

² Telemedicine services are provided by Teladoc Health, directly to members. GeoBlue assumes no liability and accepts no responsibility for information provided by Teladoc Health and the performance of the services by Teladoc Health. Support and information provided through this service does not confirm that any related treatment or additional support is covered under a member's health plan.

³ These medical expenses are limited and are subject to limitations and exclusions. See full certificate of insurance for a full description of services and coverage of what is and isn't covered.

⁴ The Political, Military and Natural Disaster Evacuation Services (PEND) are provided through Crisis24, an independent third party, non-affiliated service provider. Crisis24 does not supply Blue Cross or Blue Shield products or other benefits, and is therefore solely responsible for PEND and other collateral services it provides. GeoBlue makes no warranty, express or implied, and accepts no responsibility resulting from the provision or use of Crisis24 PEND or other Crisis24 services.



Designed with you in mind

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

Notes

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

- › If Medically Necessary Prescription Drugs cannot be obtained from the Student Health Center, they may be obtained from an In Network retail Pharmacy. You will pay no more than the same cost sharing that you would pay for those same Drugs obtained from the Student Health Center.
- › This plan includes custom benefits that may supersede some of the information included in the Limitations and Exclusions list provided here. Please see your EOC for full details on your covered benefits.

Exclusions

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

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

What Is Not Covered – 2021/2022

1. Administrative Charges.

- a) Charges to complete claim forms,
- b) Charges to get medical records or reports,
- c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include fees for educational brochures or calling you to give you test results.

2. Aids for Non-verbal Communication.

Devices and computers to assist in communication and speech except for speech aid devices and tracheoesophageal voice devices approved by Anthem.

3. Alternative / Complementary Medicine.

Services or supplies for alternative or complementary medicine. This includes the following. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

- a) Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body
- b) Aquatic therapy and other water therapy except for other water therapy services that are part of a physical therapy treatment plan and covered under the "Therapy Services" section of this Booklet,
- c) Holistic medicine,
- d) Homeopathic medicine,
- e) Hypnosis,
- f) Aroma therapy,
- g) Massage and massage therapy, except for other massage therapy services that are part of a physical therapy treatment plan and covered under the "Therapy Services" section of this Booklet,
- h) Reiki therapy,
- i) Herbal, vitamin or dietary products or therapies,
- j) Naturopathy,
- k) Thermography,
- l) Orthomolecular therapy,
- m) Contact reflex analysis,
- n) Bioenergetic synchronization technique (BEST),
- o) Iridology-study of the iris,
- p) Auditory integration therapy (AIT),
- q) Colonic irrigation,
- r) Magnetic innervation therapy,
- s) Electromagnetic therapy,
- t) Neurofeedback / Biofeedback.

4. Autopsies.

Autopsies and post-mortem testing.

5. Before Effective Date or After Termination Date.

Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

6. Certain Providers.

Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

7. Charges Not Supported by Medical Records.

Charges for services not described in your medical records.

8. Charges Over the Maximum Allowed Amount.

Charges over the Maximum Allowed Amount for Covered Services.

9. Clinical Trial Non-Covered Services.

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

10. Compound Drugs.

Compound Drugs unless all of the ingredients are FDA-approved in the form in which they are used in the Compound Drug and as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

11. Cosmetic Services.

Treatments, services, Prescription Drugs, equipment, or supplies given for Cosmetic Services. Cosmetic Services are meant to preserve, change, or improve how you look. This exclusion does not apply to Reconstructive Surgery for breast symmetry after a mastectomy, surgery to correct birth defects and birth abnormalities, services provided for the treatment of Gender Dysphoria, or any surgery to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomology or creating a normal appearance.

12. Court Ordered Testing.

Court ordered testing or care unless Medically Necessary.

13. Custodial Care.

Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

14. Delivery Charges.

Charges for delivery of Prescription Drugs.

15. Dental Services

- a) Dental care for Members age 19 and older, except for what is provided for in the "What's Covered" section under Dental Services (All Members/All Ages).
- b) Dental services not listed as covered in this Booklet.
- c) Dental services which a Member would be entitled to receive for a nominal charge or without charge if this coverage were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Member receives a bill or direct charge for dental services under any governmental program, then this Exclusion shall not apply. Benefits under this Plan will not be reduced or denied because dental services are rendered to a Student who is eligible for or receiving medical assistance.
- d) Procedures which are not generally accepted standards of dental practice within the organized dental community in California.

- e) Dental services or health care services not specifically listed in the “What’s Covered” section of this EOC (including any Hospital charges or Prescription Drug charges and dental services or supplies that do not have an American Dental Association Procedure Code, unless covered by the medical benefits of this Plan).
 - f) Dental services completed prior to the date the Member became eligible for coverage or received after the coverage under this Plan has ended.
 - g) Analgesia, analgesia agents, medicines and Drugs for surgical or non-surgical care.
 - h) Local anesthetic when billed separately from a Covered Service, as this is a part of the final service, such as for restoration services (fillings, crowns).
 - i) Dental services performed other than by a licensed dentist, licensed Physician, his or her employees.
 - j) Dental care services you received for which you are not legally obligated to pay or dental care services you received for which there would be no charge to you in the absence of insurance.
 - k) Covered Services received from a person who lives in the Member’s home or who is related to the Member by blood, marriage or adoption.
 - l) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
 - m) Dental services provided by dentists solely for the purpose of improving the appearance of the tooth when the tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist. This includes tooth whitening agents, bonding and veneers or restorations (such as fillings) placed for preventive purposes.
 - n) Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (filling, crown) has not been placed.
 - o) Athletic mouth guards, enamel microabrasion and odontoplasty.
 - p) Bacteriologic tests.
 - q) Cytology sample collection.
 - r) Separate services billed when they are an inherent component of another Covered Service.
 - s) Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case
 - t) Additional, elective or enhanced prosthodontic procedures including connector bars, stress breakers and precision attachments.
 - u) Provisional splinting, temporary procedures or interim stabilization
 - v) Adjunctive diagnostic tests.
 - w) Cone beam images.
 - x) Anatomical crown exposure.
 - y) Temporary anchorage devices.
 - z) Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials, and the procedures used to prepare and place materials in the canals (tooth roots).
 - aa) Incomplete endodontic treatment and bleaching of discolored teeth.
 - bb) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
 - cc) Services or supplies that are not Medically Necessary.
- 16. Drugs Contrary to Approved Medical and Professional Standards.**
Drugs given to you or prescribed in a way that is against generally accepted standards of medical practice or inconsistent with FDA approvals (except covered off-label use).
- 17. Drugs Over Quantity or Age Limits.**
Drugs which are over any quantity or age limits set by the Plan unless Medically necessary and approved through an exception request (please see the “Prior Authorization” provision in the section “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy).
- 18. Drugs Over the Quantity Prescribed or Refills After One Year.**
Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- 19. Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications.**
Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications.
- 20. Drugs That Do Not Need a Prescription.**
Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to drugs and other products that are available over-the-counter and do not legally require a Prescription, but are recommended by the USPSTF or the Health Resources and Services Administration for certain individuals as preventive care services, when prescribed by a licensed Provider.
- 21. Educational Services.**
Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law, or to educational and counseling services related to screening for or the treatment of asthma, diabetes, HIV, tobacco use prevention and cessation, family planning and contraceptive management, breastfeeding, nutritional counseling, or educational services in the treatment of mental health or substance abuse.
- 22. Experimental or Investigational Services.**
Services or supplies that we find are Experimental / Investigational, except as specifically stated under Clinical Trials in the section “What’s Covered.” This Exclusion applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

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

If a Member has a life-threatening or seriously debilitating condition and Anthem determines that requested treatment is not a Covered Service because it is Experimental or Investigational, the Member may request an Independent Medical Review. See the “Grievance and External Review Procedures” section for further details.
- 23. Eye Exercises.**
Orthoptics and vision therapy.
- 24. Eye Surgery.**
Eye surgery to fix errors of refraction, such as near-sightedness. This includes LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
- 25. Eyeglasses and Contact Lenses.**
Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.

26. Family Members.

Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

27. Foot Care.

Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including:

- a) Cleaning and soaking the feet.
- b) Applying skin creams to care for skin tone.
- c) Other services that are given when there is not an illness, injury or symptom involving the foot.

28. Foot Orthotics.

Foot orthotics, orthopedic shoes or footwear or support items except as covered under Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical Surgical Supplies or used for a systemic illness affecting the lower limbs, such as severe diabetes.

29. Foot Surgery.

Surgical treatment of flat feet; subluxation of the foot; tarsalgia; metatarsalgia; hyperkeratoses. This Exclusion does not apply to Medically Necessary reconstructive surgery to correct congenital defects, developmental abnormalities, trauma, infection, tumors, or other disease as stated in the "Surgery" provision in the section "What's Covered".

30. Government Treatment.

Any services you actually received that were provided by a local, state, or federal government agency, or by a public school system or school district, except when payment under this Plan is expressly required by federal or state law. This Exclusion does not apply to Medically Necessary services you receive from the Student Health Center, if such services are otherwise covered by this Plan. We will not cover payment for these services if you are not required to pay for them or they are given to you for free. You are not required to seek any such services prior to receiving Medically Necessary health care services that are covered by this Plan.

31. Growth Hormone Treatment.

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

32. Health Club Memberships and Fitness Services.

Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, such as a gym, even if ordered by a Doctor. This Exclusion also applies to health spas. This Exclusion does not apply to Medically Necessary therapy services as specified under the "Therapy Services" provision in the section "What's Covered" when rendered by a licensed health care Provider.

33. Hearing Aids.

Hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

34. Home Care.

- a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
- b) Food, housing, homemaker services and home delivered meals.

This Exclusion does not apply to Medically Necessary services to treat

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

35. Hospital Services Billed Separately.

Services rendered by Hospital resident Doctors or interns that are billed separately by the Doctor or intern that are also billed by the Hospital. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions that are normally billed by that institution, and charges included in other duplicate billings.

36. Illegal Occupation.

Any claim to which a contributing cause was your commission of or attempt to commit a felony or to which a contributing cause was your being engaged in an illegal occupation.

37. Infertility Treatment.

Testing or treatment related to infertility. This does not apply to medically necessary fertility preservation services to prevent iatrogenic infertility as specified in the section "What's Covered".

38. Inpatient Diagnostic Tests.

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

39. In-vitro Fertilization.

Services or supplies for in-vitro fertilization (IVF) for purposes of pre-implant genetic diagnosis (PGD) of embryos, regardless of whether they are provided in connection with infertility treatment.

40. Lifestyle Programs.

Programs to alter one's lifestyle which may include diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us, or to educational and counseling services related to screening for or the treatment of asthma, diabetes, HIV, tobacco use prevention and cessation, family planning and contraceptive management, breastfeeding, nutritional counseling, or educational services in the treatment of mental health or substance abuse.

41. Lost or Stolen Drugs.

Refills of lost or stolen Drugs.

42. Maintenance Therapy.

Rehabilitative treatment or care that is provided when no further gains or improvements in your current level of function are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to habilitative services.

43. Medical Equipment, Devices and Supplies.

- a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
- b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
- c) Non-Medically Necessary enhancements to standard equipment and devices.
- d) Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.

- e) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the “What’s Covered” section.

44. Medicare.

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

45. Missed or Cancelled Appointments.

Charges for missed or cancelled appointments.

46. Non-Approved Drugs.

Drugs not approved by the FDA.

47. Non-Medically Necessary Services.

Any services or supplies that are not Medically Necessary as defined. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

48. Nutritional or Dietary Supplements.

Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

49. Off Label Use.

Off label use, unless we must cover it by law or if we approve it.

50. Oral Surgery.

Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.

51. Personal Care, Convenience and Mobile/Wearable Devices.

- a) Items for personal comfort, convenience, protection, cleanliness or beautification such as air conditioners, humidifiers, air or water purifiers, sports helmets, raised toilet seats, and shower chairs.
- b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads, disposable sheaths and supplies).
- c) Home workout or therapy equipment, including treadmills and home gyms.
- d) Pools, whirlpools, spas, or hydrotherapy equipment.
- e) Hypo-allergenic pillows, mattresses, or waterbeds.
- f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
- g) Consumer wearable / personal mobile devices such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

52. Private Contracts.

Services or supplies provided pursuant to a private contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of

Title XVIII of the Social Security Act.

53. Private Duty Nursing.

Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the “Home Care Services” benefit.

54. Prosthetics.

Prosthetics for sports or cosmetic purposes.

55. Residential Accommodations.

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

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

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

56. Routine Physicals and Immunizations.

Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes, which are not required by law under the “Preventive Care” benefit. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law, or to immunizations required or recommended for travel to countries outside the United States.

57. Sanctioned or Excluded Providers.

Any service, Drug, Drug regimen, treatment, or supply, furnished, ordered, or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to Emergency Care.

58. Services You Receive for Which You Have No Legal Obligation to Pay.

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

59. Stand-By Charges.

Stand-by charges of a Doctor or other Provider.

60. Sterilization.

Services to reverse an elective sterilization.

61. Surrogate Mother Services.

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

62. Temporomandibular Joint Treatment.

Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

63. Travel Costs.

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

64. Vein Treatment.

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

65. Vision Services.

- a) Vision care for Members age 19 and older, unless covered by the medical benefits of this Plan.
- b) Safety glasses and accompanying frames.
- c) Two pairs of glasses in lieu of bifocals.
- d) Plano lenses (lenses that have no refractive power)
- e) Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
- f) Vision services or supplies not specifically listed as covered in this Booklet.
- g) Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed in this Booklet.
- h) Blended or oversize lenses or sunglasses, unless specifically listed in this Booklet.
- i) Services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
- j) For Members through age 18, no benefit is available for frames or contact lenses purchased outside of our formulary.
- k) Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.

66. Waived Cost-Shares Out-of-Network.

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

67. Weight Loss Programs.

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

This Exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to Medically Necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as stated in the "Bariatric Surgery" provision of "What's Covered."

68. Wilderness or other outdoor camps and/or programs.

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

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

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

1. Administration Charges.

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

2. Charges Not Supported by Medical Records.

Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.

3. Clinical Trial Non-Covered Services.

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

4. Compound Drugs.

Compound Drugs unless all of the ingredients are FDA-approved in the form in which they are used in the Compound Drug and as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

5. Contrary to Approved Medical and Professional Standards.

Drugs given to you or prescribed in a way that is against generally accepted standards of medical practice or inconsistent with FDA approvals (except covered off-label use).

6. Delivery Charges.

Charges for delivery of Prescription Drugs.

7. Drugs Given at the Provider's Office / Facility.

Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit - they are Covered Services.

8. Drugs Not on the Prescription Drug List (a formulary).

Drugs not on the Prescription Drug List except if authorized through prior authorization. If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to the "Prescription Drug List" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception. You can get a copy of the list by calling us or visiting our website at www.anthem.com/ca.

9. Drugs Over Quantity or Age Limits.

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

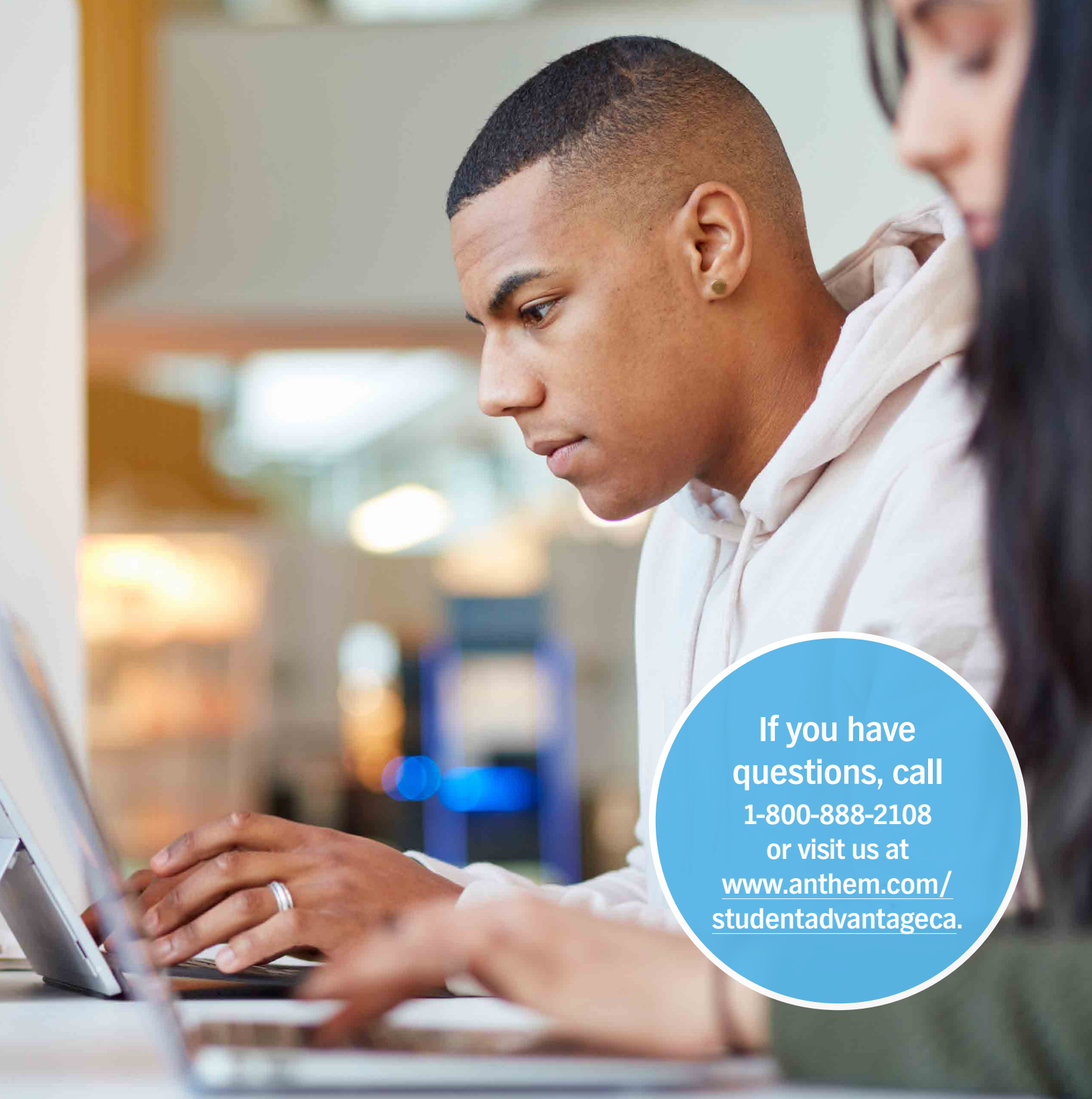
10. Drugs Over the Quantity Prescribed or Refills After One Year.

Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.

11. Drugs Prescribed for Cosmetic Purposes.

12. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications.**
Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications.
13. **Drugs that Do Not Need a Prescription.**
Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to drugs and other products that are available over-the-counter and do not legally require a Prescription, but are recommended by the USPSTF or the Health Resources and Services Administration for certain individuals as preventive care services, when prescribed by a licensed Provider.
14. **Family Members.**
Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
15. **Growth Hormone Treatment.**
Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
16. **Infertility Drugs.**
Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT).
17. **Items Covered as Durable Medical Equipment (DME).**
Therapeutic DME, devices and supplies except as described in this Booklet or that we must cover by law, including peak flow meters, spacers, and blood glucose monitors, and other diabetes supplies. See the "Diabetes Equipment, Education, and Supplies" section for more information. Items not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.
18. **Items Covered Under the "Allergy Services" Benefit.**
Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.
19. **Lost or Stolen Drugs.**
Refills of lost or stolen Drugs.
20. **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider.**
Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
21. **Non-Approved Drugs.**
Drugs not approved by the FDA. If Anthem determines that the requested drug is not covered because it is Investigational or prescribed for Experimental indications, the Member may request an Independent Medical Review. See the "Grievance and External Review Procedures" section for further details.
22. **Non-Medically Necessary Services.**
Any services or supplies that are not Medically Necessary as defined. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
23. **Nutritional or Dietary Supplements.**
Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.
24. **Off Label Use.**
Off label use, unless we must cover the use by law or if we, or the PBM, approve it.
25. **Over-the-Counter Items.**
Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product may not be covered, even if written as a Prescription. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.

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



If you have
questions, call
1-800-888-2108
or visit us at
[www.anthem.com/
studentadvantageca.](http://www.anthem.com/studentadvantageca)

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