Exclusions and Limitations

- **Not Medically Necessary**. Services or supplies that are not medically necessary, as defined.
- **Unlisted Services.** Services not specifically listed in this booklet as covered services.
- **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 Certificate.
- **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 Certificate.
- **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*.
- **Excess Amounts**. Any amounts in excess of covered expense or any medical benefit 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.
- **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 or as required by federal law, as described in the EOC. If you do not enroll in Medicare Part B, we will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.

- **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 member 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; and5. Two-thirds of its patients must have conditions directly related to the hospital's research.
- **Waived Cost-Shares Out-of-Network Provider.** For any service for which you are responsible under the terms of this plan to pay a co-payment or deductible, and the co-payment or deductible is waived by an out-of-network provider.
- **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 or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the Certificate. 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**. For dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:
    - Extraction, restoration, and replacement of teeth; 2. Services to improve dental clinical outcomes.
    - This exclusion does not apply to the following:
    - Services which we are required by law to cover; 2. Services specified as covered in this booklet;
    - Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.

Exclusions and Limitations

- **Hearing Aids or Tests.** Hearing aids and routine hearing tests, except as specified as covered in the Certificate.
- **Optometric Services or Supplies**. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the Certificate. Eyeglasses or contact lenses, except as specified as covered in the Certificate.
- **Outpatient Occupational Therapy.** Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the Certificate.
- **Outpatient Speech Therapy**. Outpatient speech therapy, except as specified as covered in the Certificate.
- **Cosmetic Surgery.** Cosmetic surgery or other services performed to alter or reshape normal (including aged) structures or tissues of the body to improve appearance
- **Commercial Weight Loss Programs**. Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan. This exclusion includes, but is not limited to, 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 described in the Certificate.
- **Sterilization Reversal.**
- **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, except as specified as covered in the Certificate.
- **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.
- **Surrogate Mother Services.** For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- **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 Certificate.
- **Clinical Trials** - Services and supplies in connection with clinical trials, except as specified as covered in the Certificate or EOC.
- **Health Club Memberships**. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas, except as specified as covered in the Certificate.
- **Personal Items**. Any supplies for comfort, hygiene or beautification.
- **Education or Counseling**. Educational services or nutritional counseling, except as specified as covered in the Certificate. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa. Additionally, 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.
- **Food or Dietary Supplements**. Nutritional and/or dietary supplements, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist. 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.
- **Gene Therapy.** Gene therapy as well as any drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
- **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

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disturbances of a child as required by state law.

- **Routine Physicals and Immunizations.** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law 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, except as specified as covered in the Certificate. Acupressure or massage to control pain, treat illness or promote

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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 Eye glasses 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 Certificate.
- Drugs Given to you by a Medical Provider. The following exclusions apply to drugs you receive from a medical provider:
    - 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.

If you or your physician believes you need to use a different prescription drug, please have your physician 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 physician.
    - 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 Certificate.
- **Diabetic Supplies**. Prescription and non-prescription diabetic supplies except as specified as covered in the Certificate.
- **Private Duty Nursing**. Private duty nursing services.
- **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.
    - Wilderness camps.

  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.
- **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.
- **Medical Equipment, Devices and Supplies.** This plan does not cover the

Exclusions and Limitations

following:

- 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.
- Enhancements to standard equipment and devices that is not medically necessary.
- Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is medically necessary in your situation.
- This exclusion does not apply to the medically necessary treatment as specifically stated as covered in the EOC/Certificate.

- **Varicose Vein Treatment**. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.
- **Wigs.**
- **Third Party Liability:** Anthem Blue Cross Life and Health Insurance Company are 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.

Prescription Drug Exclusions & Limitations

- Hypodermic syringes &/or needles: except when dispensed for use with insulin & other self-injectable drugs or medications.
- Drugs & medications used to induce spontaneous & non- spontaneousabortions.
- Drugs & medications dispensed or administered in an outpatient setting, including outpatient hospital facilities and physicians' offices.
- Professional charges in connection with administering, injecting or dispensing drugs.
- Drugs & medications that may be obtained without a physician's written prescription, except insulin or niacin for cholesterol lowering and certain over-the- counter drugs approved by the Pharmacy and Therapeutics Process to be included in the prescription drug formulary.

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- Drugs & medications dispensed by or while confined in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility.
- Durable medical equipment, devices, appliances & supplies, even if prescribed by a physician, except contraceptive diaphragms, as specified as covered in the EOC/Certificate.
- Services or supplies for which the member is not charged.
- Oxygen.
- Cosmetics & health or beauty aids. However, health aids that are medically necessary and meet the requirements as specified as covered in the EOC/Certificate.
- Drugs labeled "Caution, Limited by Federal Law to Investigational Use," or experimental drugs.
- Drugs or medications prescribed for experimental indications.
- Any expense for a drug or medication incurred in excess of the prescription drug maximum allowed amount.
- Drugs which have not been approved for general use by the Food and Drug Administration. This does not apply to drugs that are medically necessary for a covered condition.
- Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of drug for medically necessary treatment of a medical condition other than one that is cosmetic.
- Drugs used primarily to treat infertility (including, but not limited to, Clomid, Pergonal and Metrodin), unless medically necessary for another covered condition.
- Anorexiants and drugs used for weight loss, except when used to treat morbid obesity (e.g., diet pills & appetite suppressants).
- Drugs obtained outside the U.S, unless they are furnished in connection with urgent care or an emergency.
- Allergy desensitization products or allergy serum.
- Infusion drugs, except drugs that are self-administered subcutaneously.
- Herbal supplements, nutritional and dietary supplements, except as described in this plan or that we must cover by law. This exclusion includes, but is not limited to, 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.
- Formulas and special foods for the treatment of phenylketonuria (PKU).
- Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin even if written as a *prescription,*. This does not apply if an over-the-counter equivalent was tried and was ineffective.
- Onychomycosis (toenail fungus) drugs except to treat members who are immuno-compromised or diabetic.
- Prescription drugs that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material, thus treating a disease or abnormal medical condition.
- All compound prescription drugs when a commercially available dosage form of a medically necessary medication is not available, all the ingredients of the compound drug are FDA approved in the form in which they are used in the compound medication and as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a prescription to dispense and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
- 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

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from a retail pharmacy that member should have obtained from the specialty pharmacy program.

- Prescription drugs that are considered multi-source brand drugs. This exclusion only applies to the Essential Drug Formulary plans.
- Off label prescription drugs
- Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records..
- Certain prescription drugs may not be covered if you could use a clinically equivalent drug, unless required by law. "Clinically equivalent" means drugs that for most members, will give you similar results for a disease or condition. If you have questions about whether a certain drug is covered and which drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com. If you or your physician believes you need to use a different prescription drug, please have your physician 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. This exclusion only applies to the Traditional Drug Formulary plans.
- Drugs which are over any quantity or age limits set by the plan or us.
- Prescription drugs prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications.
- Drugs prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law or self.
- 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*.

- Services we conclude are not medically necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- Third Party Liability Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Please refer to the Certificate or EOC for details and complete list of exclusions and limitations. Exclusion does not apply to the medically necessary treatment as specifically stated as covered in the EOC/Certificate.