

Anthem Student Health Plan w/Child Dental

A Preferred Provider Organization (PPO) Plan



University of California, Berkeley

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**Anthem Blue Cross Life and Health Insurance Company
21555 Oxnard Street
Woodland Hills, CA 91367**

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SUMMARY OF BENEFITS

Anthem Student Health Plan w/Child Dental

A Preferred Provider Organization (PPO) Plan

A Platinum Plan

Actuarial Value: 89.32%

This SUMMARY OF BENEFITS sets forth the applicable Cost Shares for benefits available under this Plan. The term Cost Shares means the applicable Deductibles, Out of Pocket Maximums, Coinsurance and Copayments that You must pay for Covered Services You receive under this Plan. This SUMMARY OF BENEFITS does not list all specific services available under this Plan, their Cost Shares, or explain benefits, exclusions or limitations. For a complete explanation of the benefits available under this Plan and any limitations and exclusions, please read the entire Plan including the parts WHAT IS COVERED – MEDICAL, WHAT IS COVERED – PRESCRIPTION DRUGS, WHAT IS NOT COVERED (Exclusions) – MEDICAL, WHAT IS NOT COVERED (Exclusions) – PRESCRIPTION DRUGS, CLAIMS AND PAYMENTS and GETTING APPROVAL FOR BENEFITS.

All benefits are subject to the conditions, exclusions, limitations and terms of this Plan including any endorsements.

Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most Anthem will allow for a Covered Service. **When You use an Out of Network Provider, You may have to pay the difference between the Out of Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges.** This amount can be substantial. Please read the part CLAIMS AND PAYMENTS for more details.

Benefits for Emergency or urgent care are based on the Reasonable and Customary Value, which is the most Anthem will allow for Emergency care. Please read the part WHAT IS COVERED - MEDICAL for more details.

Only the covered charges that make up the Maximum Allowed Amount will apply toward the satisfaction of any Deductible. After You have satisfied any applicable Deductible, we will subtract your Co-Payment, if any, from the Maximum Allowed Amount remaining. If Your Co-Payment is a percentage (Coinsurance), we will apply the applicable percentage to the Maximum Allowed Amount remaining after any Deductible has been met.

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

Medical Deductible	All Providers
Individual	\$300 per Benefit Period
Family	\$900 per Benefit Period

For each Benefit Period You must first satisfy the applicable Medical Deductible for Covered Services. If only one (1) individual Insured is covered, the Insured must satisfy the individual Deductible before we begin to pay for Covered Services. If two (2) or more Insureds are covered, we will pay for Covered Services for an individual Insured that has satisfied the individual Deductible. Once the family Deductible is satisfied, we will pay for Covered Services for all other Insureds of the family. All Deductible amounts paid for Covered Services by each individual Insured in a family during a Benefit Period contribute to the family Deductible.

Unless stated otherwise, all amounts You pay for Covered Services during a Benefit Period will apply towards Your Medical Deductible, as applicable. Your Medical Deductible for Covered Services will apply towards Your Out of Pocket Maximum.

See "Deductibles" in CLAIMS AND PAYMENTS for a detailed description of how Your Deductible works.

There is a separate combined In Network and Out of Network Pediatric Dental Deductible. Please see "Pediatric Dental Deductible" below and in CLAIMS AND PAYMENTS for details.

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

Out of Pocket Maximum	In Network	Out of Network
Individual	\$3,200 per Benefit Period	\$6,500 per Benefit Period
Family	\$6,400 per Benefit Period	\$13,000 per Benefit Period

The Out of Pocket Maximums include all Deductibles, Coinsurance, and Copayments You pay during a Benefit Period for all Essential Health Benefits, medical services, pediatric vision, and Prescription Drug services together, except pediatric dental. It does not include charges over the Maximum Allowed Amount or amounts You pay for non-Covered Services. Pediatric dental services are subject to a separate Out of Pocket Maximum, which is shown below. The combined Out of Pocket Maximums for all services will not exceed the maximum amount permitted by law.

Once the applicable Out of Pocket Maximum is satisfied, You will not have to pay any additional Deductibles, Copayments or Coinsurance for the rest of the Benefit Period. If only one (1) individual Insured is covered, the Insured will have no further Copayments or Coinsurance after the applicable individual Out of Pocket Maximum is satisfied. If two (2) or more Insureds are covered, an individual Insured will have no further Copayments or Coinsurance once he or she has satisfied the applicable individual Out of Pocket Maximum. Once the applicable family Out of Pocket Maximum is satisfied, all other Insureds of the family will not be subject to further Copayments or Coinsurance for the Benefit Period. All Deductible, Copayments and Coinsurance amounts paid for Covered Services by each individual Insured in a family during a Benefit Period contribute to the applicable Out of Pocket Maximum.

Unless stated otherwise, all amounts You pay for Covered Services during a Benefit Period for the Medical Deductible, Coinsurance and Copayments apply to the Out of Pocket Maximum.

Charges over the Maximum Allowed Amount that are Your responsibility and amounts You pay for non-Covered Services do not apply to these Out of Pocket Maximums. Deductibles and Coinsurance are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

See "Out of Pocket Maximum" in CLAIMS AND PAYMENTS for a detailed description of how Your Out of Pocket Maximum works.

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

COINSURANCE AND COPAYMENTS

The following lists the Coinsurance and Copayment for benefits under this Agreement. The following does not list all services or the locations where a service may be received. If a service is available in another setting You may determine the applicable Cost Share by referring to that setting. For example, You might get Physical Therapy in a Physician's office, an outpatient Hospital Facility, or during an inpatient Hospital stay. For services in the office, look up "Office Visits." For services in the outpatient department of a Hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services."

Cost Sharing for services with Copayments is the lesser of the Copayment amount or Maximum Allowed Amount.

Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most Anthem will allow for a Covered Service, not the Provider's billed charges. When You use an Out of Network Provider, You may have to pay the difference between the Out of Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles and non-covered charges. This amount can be substantial. Please read the part CLAIMS AND PAYMENTS for more details.

When You need medical care, you must first go to the Student Health Center (SHC). Most non-emergency medical care must be initiated through the SHC for referral to be covered under this Plan. Please see the exceptions to this requirement in the INTRODUCTION to this booklet. This requirement applies only to the Insured Student; it does not apply to covered Dependents if they are eligible under this Plan. The SHC will diagnose and treat most illnesses, coordinate Your health care, and refer You when necessary to an In Network or Out of Network Provider. If You receive medical care without a referral from the SHC, Your expenses will not be covered unless they qualify as an exception. Services subject to Precertification (see below) do not need referral from the SHC.

Some services listed below require Precertification prior to receiving the service. If Precertification is not obtained, services will be subject to the Post Service Clinical Claims Review process and will be denied if they are determined to be not Medically Necessary and You may be financially responsible for the service, treatment or admission in whole or in part. See the part GETTING APPROVAL FOR BENEFITS for more information.

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

Benefit	You Pay	
	Coinsurance / Copayment	
	In Network	Out of Network
Acupuncture <ul style="list-style-type: none"> In Network care is not subject to the Deductible Student Health Center referral required 	\$15 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Chiropractic Care <ul style="list-style-type: none"> In Network care is not subject to the Deductible Student Health Center referral required 	\$15 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Ambulance Services (Ground, Air and Water) <ul style="list-style-type: none"> Precertification is required for ambulance services except in a Medical Emergency (see the part GETTING APPROVAL FOR BENEFITS for details) Ambulance services are not subject to the Deductible 	10% Coinsurance	Emergency: 10% Coinsurance plus all charges in excess of the Maximum Allowed Amount Non-Emergency: 40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Behavioral Health Treatment for Pervasive Developmental Disorder or Autism		
Inpatient services <ul style="list-style-type: none"> Precertification is required for inpatient services (see the part GETTING APPROVAL FOR BENEFITS for details) 	10% Coinsurance	\$500 Copayment plus 40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Outpatient services – Office visit <ul style="list-style-type: none"> In Network care is not subject to the Deductible Student Health Center referral required 	\$15 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

Benefit	You Pay	
	Coinsurance / Copayment	
	In Network	Out of Network
Outpatient services – All other outpatient items and services <ul style="list-style-type: none"> • Student Health Center referral required 	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Diagnostic Testing <ul style="list-style-type: none"> • Precertification is required for certain diagnostic procedures and tests (see the part GETTING APPROVAL FOR BENEFITS for details) • If You receive diagnostic testing, the Cost Share for those services is in addition to the applicable Office Visit (PCP or SCP), outpatient surgery services or urgent care Copayments 		
Diagnostic laboratory and pathology services	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Diagnostic imaging services and electronic diagnostic tests	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies <ul style="list-style-type: none"> • Hearing aids are covered, limited to one hearing aid per ear every three years • Student Health Center referral required 	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Emergency Care (Emergency Room) <ul style="list-style-type: none"> • Emergency room care is not subject to the Deductible • \$100 Copayment is waived if admitted into the Hospital from the Emergency room 	\$100 Copayment	\$100 Copayment

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

Benefit	You Pay	
	Coinsurance / Copayment	
	In Network	Out of Network
Fertility Preservation Services <ul style="list-style-type: none"> Coverage is limited to \$20,000 in your lifetime. 	\$250 Copayment plus 10% Coinsurance	\$250 Copayment plus 40% Coinsurance
Habilitation Services <ul style="list-style-type: none"> In Network care is not subject to the Deductible Student Health Center referral required 	\$15 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Home Care Services <ul style="list-style-type: none"> Precertification is required for home care services (see the part GETTING APPROVAL FOR BENEFITS for details) Coverage is limited to 100 visits per Benefit Period. This limit applies separately to rehabilitative services and habilitative services. A visit of four hours or less by a home health aide shall be considered as one home health visit. 	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Hospice Care <ul style="list-style-type: none"> Precertification is required for Hospice Care (see the part GETTING APPROVAL FOR BENEFITS for details) 	0% Coinsurance	0% Coinsurance plus all charges in excess of the Maximum Allowed Amount

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

Benefit	You Pay	
	Coinsurance / Copayment	
	In Network	Out of Network
Inpatient Facility Services <ul style="list-style-type: none"> • Precertification is required for inpatient Facility services except for Emergency admissions and inpatient Hospital stays for the delivery of a child or mastectomy surgery, including the length of Hospital stays associated with mastectomy and/or breast reconstruction surgery for breast cancer. For Emergency admissions, You, Your authorized representative or Physician must tell us within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time (see the part GETTING APPROVAL FOR BENEFITS for details) 		
Inpatient Facility care (Hospital)	10% Coinsurance	\$500 Copayment plus 40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Residential Treatment Center Facility	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Services received in the inpatient Facility	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Physicians that bill separately from Facility charges	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

Benefit	You Pay	
	Coinsurance / Copayment	
	In Network	Out of Network
Maternity Care		
Includes maternity services and abortion services		
Routine prenatal and postpartum care, including scheduled exams and other preventive care services such as breastfeeding support and counseling In Network care is not subject to the Deductible	0% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Inpatient Facility services for delivery of a newborn	10% Coinsurance	\$500 Copayment plus 40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Inpatient Facility services for an abortion (non-Emergency admissions for an abortion require precertification)	0% Coinsurance	\$500 Copayment plus 40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Outpatient Facility charge for an abortion (non-Emergency admissions for an abortion require precertification)	0% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Physician / Surgeon charges for an abortion (including but not limited to surgeon, anesthesiologist, pathologist, and radiologist)	0% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Mental Health and Substance Abuse (Chemical Dependency) Services		

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

Benefit	You Pay	
	Coinsurance / Copayment	
	In Network	Out of Network
Inpatient services <ul style="list-style-type: none"> Precertification is required for inpatient services (see the part GETTING APPROVAL FOR BENEFITS for details) 	10% Coinsurance	\$500 Copayment plus 40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Outpatient services – Office visit <ul style="list-style-type: none"> In Network care is not subject to the Deductible Student Health Center referral required 	\$15 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Outpatient services – All other outpatient items and services <ul style="list-style-type: none"> Student Health Center referral required 	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Office Visits <ul style="list-style-type: none"> Additional services received during an Office Visit may be subject to additional Coinsurance or Copayments For Preventive Care visits, please see Preventive Care below Student Health Center referral required 		
Primary Care Physician and Primary Care Provider (PCP) In Network care is not subject to the Deductible	\$15 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Specialty Care Physician and Specialty Care Provider (SCP) In Network care is not subject to the Deductible	\$15 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Retail health clinic visit In Network care is not subject to the Deductible	\$15 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Online care visit In Network care is not subject to the Deductible	\$15 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

Benefit	You Pay	
	Coinsurance / Copayment	
	In Network	Out of Network
Telehealth In Network care is not subject to the Deductible	\$15 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Other Eligible Providers If You obtain services from Other Eligible Providers, Your responsibility will be 20% Coinsurance plus all charges in excess of the Maximum Allowed Amount. Student Health Center referral required.		
Outpatient Surgery Services <ul style="list-style-type: none"> Precertification is required for surgical procedures (see the part GETTING APPROVAL FOR BENEFITS for details). Additional services received in an outpatient surgery Facility may be subject to additional Coinsurance or Copayments 		
Facility charge	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Services received in the outpatient Facility	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Physician / Surgeon charges (including but not limited to surgeon, anesthesiologist, pathologist, and radiologist)	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Preventive Care <ul style="list-style-type: none"> In Network Preventive care is not subject to the Deductible Student Health Center referral required 	0% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Rehabilitation Services <ul style="list-style-type: none"> In Network care is not subject to the Deductible Student Health Center referral required 	\$15 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

Benefit	You Pay	
	Coinsurance / Copayment	
	In Network	Out of Network
Skilled Nursing Facility <ul style="list-style-type: none"> Precertification is required for a Skilled Nursing Facility (see the part GETTING APPROVAL FOR BENEFITS for details) Coverage is limited to 100 days per Benefit Period. 	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Sterilization Procedures for Men <ul style="list-style-type: none"> Student Health Center referral required 	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Travel Benefits for Specified Services <ul style="list-style-type: none"> All travel expenses must be approved in advance See the sections "Center of Medical Excellence (CME) for Transplants and Bariatric Surgery" and "Transgender Services" in the part WHAT IS COVERED – MEDICAL for details Travel benefits are not subject to the Deductible or to any Copayments or Coinsurance The dollar amounts shown below represent the maximum payment Anthem will make for travel expenses for these services only 		
Bariatric surgery	\$3,000 per surgery	
Transplants	\$10,000 per transplant	
Transgender services	\$10,000 per surgery or series of surgeries	

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

Benefit	You Pay	
	Coinsurance / Copayment	
	In Network	Out of Network
Urgent Care <ul style="list-style-type: none"> In Network care is not subject to the Deductible Additional services received in an urgent care may be subject to additional Coinsurance or Copayments 	\$50 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Vision – Pediatric Vision Services <ul style="list-style-type: none"> Insureds are covered until the last day of the month in which the individual turns nineteen (19) years of age Vision – Pediatric Vision Services are not subject to the Deductible 		
Routine Eye Exam Once every Benefit Period	\$0 Copayment	\$0 Copayment plus all charges in excess of the Maximum Allowed Amount
Comprehensive Low Vision Exam Once every five (5) Benefit Periods	\$0 Copayment	Not covered
Low Vision Follow up Visits Up to four (4) visits in any five (5) Benefit Periods	\$0 Copayment	Not covered
Optical/Non-optical Aids One (1) per Benefit Period	\$0 Copayment	Not covered
Standard Plastic or Glass Lenses* <ul style="list-style-type: none"> Once every Benefit Period The following lens options are included at no extra cost when received In Network: fashion and gradient tinting; oversized and glass-grey #3 prescription sunglass lenses; blended segment lenses; intermediate vision lenses; standard, premium, select and ultra progressive lenses; photochromic glass lenses, plastic photosensitive lenses; polarized lenses, standard, premium and ultra anti-reflective coating; high index lenses, polycarbonate lenses, scratch-resistant coating. 		

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

Benefit	You Pay	
	Coinsurance / Copayment	
	In Network	Out of Network
Single Vision	\$0 Copayment	\$0 Copayment plus all charges in excess of the Maximum Allowed Amount
Bifocal	\$0 Copayment	\$0 Copayment plus all charges in excess of the Maximum Allowed Amount
Trifocal	\$0 Copayment	\$0 Copayment plus all charges in excess of the Maximum Allowed Amount
Progressive	\$0 Copayment	\$0 Copayment plus all charges in excess of the Maximum Allowed Amount
Lenticular	\$0 Copayment	\$0 Copayment plus all charges in excess of the Maximum Allowed Amount
Frames* (formulary) <ul style="list-style-type: none"> Once every Benefit Period This Plan offers a selection of covered frames 	\$0 Copayment	\$0 Copayment plus all charges in excess of the Maximum Allowed Amount
Contact Lenses (formulary)* <ul style="list-style-type: none"> A one (1) Year supply is covered every Benefit Period This Plan offers a selection of covered contact lenses Fitting, evaluation, and follow-up care for both elective and non-elective contact lenses are included in the contact lens benefit 		
Elective (conventional and disposable) These are contact lenses chosen for comfort or appearance	\$0 Copayment	\$0 Copayment plus all charges in excess of the Maximum Allowed Amount

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

Benefit	You Pay	
	Coinsurance / Copayment	
	In Network	Out of Network
Non-elective These are contact lenses that are prescribed to You for a medical condition, such as for Aniridia or Aphakia	\$0 Copayment	\$0 Copayment plus all charges in excess of the Maximum Allowed Amount
*If You receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until You satisfy the benefit frequency listed in this SUMMARY OF BENEFITS.		

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

PRESCRIPTION DRUG BENEFITS

Prescription Drug benefits accumulate toward the applicable Out of Pocket Maximum. You must pay the applicable Deductible before Your benefits begin.

Your Benefit Program limits Prescription Drug coverage to those Drugs listed on our Prescription Drug List, or Formulary. The Formulary is a list of Drugs that includes a select number of medications in therapeutic categories and classes.

The Formulary may be accessed online

at http://fm.formularynavigator.com/FBO/143/Traditional_ABC_4_Tier_Student_Health_Plan.pdf, and shows which tier each drug is in.

Each Prescription Drug will be subject to a Copayment/Coinsurance as described below. If Your Prescription Drug order includes more than one Prescription Drug, a separate Copayment/Coinsurance will apply to each Prescription Drug.

IMPORTANT NOTE:

Benefits for Covered Services are based on the Prescription Drug Maximum Allowed Amount, which is the most Anthem will allow for a Covered Service. When You use an Out of Network Provider, You may have to pay the difference between the Out of Network Provider's billed charge and the Prescription Drug Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the parts CLAIMS AND PAYMENTS and WHAT IS COVERED – PRESCRIPTION DRUGS for more details.

PREVENTIVE PRESCRIPTION DRUGS:

Your Prescription Drug benefits include certain preventive drugs, medications, and other items that may be covered as Preventive Care services. In order to be covered as a Preventive Care service, these items must be prescribed by a Physician and obtained from an In Network Provider. This includes items that can be obtained over-the-counter for which a Physician's prescription is not required by law. When these items are covered as preventive care services, the Calendar Year Deductible, if any, will not apply and no Co-payment or Coinsurance will apply. In addition, any separate Deductible that applies to prescription drugs will not apply.

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

See the parts WHAT IS COVERED – PRESCRIPTION DRUGS and WHAT IS NOT COVERED (Exclusions) – PRESCRIPTION DRUGS for descriptions of Covered Services, limitations and exclusions. In cases where Your Physician prescribes a medication that is not on the Prescription Drug List, it may be necessary to obtain Prior Authorization in order for the Prescription to be a covered benefit. Physicians and Insureds are informed of the Prior Authorization process through the Insured's Plan, Anthem's web site, www.anthem.com/ca and the Provider's manual.

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

Benefit	You Pay	
	Coinsurance / Copayment	
	In Network	Out of Network
Prescription Drug Deductible		
Individual	Prescription Drugs are not subject to any Deductibles in this Plan	Prescription Drugs are not subject to any Deductibles in this Plan
Family	Prescription Drugs are not subject to any Deductibles in this Plan	Prescription Drugs are not subject to any Deductibles in this Plan
Retail Pharmacies – 30 day supply		
Tier 1 • Low cost and preferred Drugs (includes diabetic supplies)	\$10.00 Copayment	\$10 Copayment plus 40% Coinsurance up to a maximum of \$250 plus all charges in excess of the Prescription Drug Maximum Allowed Amount
Tier 2 • Preferred drugs with a higher Copayment	\$35.00 Copayment	\$35 Copayment plus 40% Coinsurance up to a maximum of \$250 plus all charges in excess of the Prescription Drug Maximum Allowed Amount
Tier 3 Non-preferred and high cost Drugs	\$50.00 Copayment	\$50 Copayment plus 40% Coinsurance up to a maximum of \$250 plus all charges in excess of the Prescription Drug Maximum Allowed Amount

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

Benefit	You Pay	
	Coinsurance / Copayment	
	In Network	Out of Network
Tier 4 <ul style="list-style-type: none"> High cost Drugs including Specialty Drugs 	20% Coinsurance up to a maximum of \$250	20% Coinsurance up to a maximum of \$250 plus all charges in excess of the Prescription Drug Maximum Allowed Amount
Home Delivery Pharmacy	Not Covered	

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

PEDIATRIC DENTAL SERVICES

Pediatric dental benefits do not accumulate toward Medical Out of Pocket Maximum. Insureds are covered until the last day of the month in which the individual turns nineteen (19) years of age.

For each Benefit Period, You must first satisfy the individual or family Pediatric Dental Deductible before we begin to pay for Covered Services. If only one (1) individual Insured is covered, the Insured must satisfy the individual Deductible before we begin to pay for Covered Services. If two (2) or more Insureds are covered, we will pay for Covered Services for an individual Insured that has satisfied the individual Deductible. Once the family Deductible is satisfied, we will pay for Covered Services for all other Insureds in the family. All Deductible amounts paid for Covered Services by each individual Insured in a family during a Benefit Period contribute to the family Deductible.

Benefit	You Pay	
	Coinsurance / Copayment	
	In Network	Out of Network
Pediatric Dental Deductible per Benefit Period		
In Network and Out of Network Deductibles combined		
Individual		\$60
Family		\$180
Pediatric Dental Services		
Diagnostic and Preventive Services	0% Coinsurance	0% Coinsurance
Basic Restorative Services	30% Coinsurance	30% Coinsurance
Endodontic, Periodontal, and Oral Surgery	30% Coinsurance	30% Coinsurance
Major Restorative and Prosthodontic Services	30% Coinsurance	30% Coinsurance
Medically Necessary Orthodontic Care	30% Coinsurance	30% Coinsurance

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

Pediatric Dental Out of Pocket Maximum	In Network	Out of Network
Individual	\$1,000 per Benefit Period	No limit
Family	\$2,000 per Benefit Period	No limit

The Out of Pocket Maximums include all Deductibles, Coinsurance, and Copayments You pay during a Benefit Period for pediatric dental services. It does not include charges over the Maximum Allowed Amount or amounts You pay for non-Covered Services. All other Essential Health Benefits, medical services, pediatric vision, and Prescription Drug services are subject to a separate Out of Pocket Maximum, which is shown above. The combined Out of Pocket Maximums for all services will not exceed the maximum amount permitted by law.

Once the applicable Out of Pocket Maximum is satisfied for In Network Providers, You will not have to pay any additional Deductibles, Copayments or Coinsurance for the rest of the Benefit Period for services received from In Network Providers. If only one (1) individual Insured is covered, the Insured will have no further Copayments or Coinsurance after the applicable individual Out of Pocket Maximum is satisfied. If two (2) or more Insureds are covered, an individual Insured will have no further Copayments or Coinsurance once they have satisfied the applicable individual Out of Pocket Maximum. Once the applicable family Out of Pocket Maximum is satisfied, all other Insureds of the family will not be subject to further Copayments or Coinsurance for the Benefit Period. All Deductible, Copayments and Coinsurance amounts paid for Covered Services by each individual Insured in a family during a Benefit Period contribute to the applicable Out of Pocket Maximum.

Please note that this Plan has no Out of Pocket Maximum for the costs of services received from Out of Network Providers. You will continue to be responsible for all Cost Shares for services received from Out of Network Providers even after the In Network Out of Pocket Maximum is satisfied.

Unless stated otherwise, all amounts You pay for Covered Services during a Benefit Period for the Pediatric Dental Deductible, Coinsurance, and Copayments apply to the Out of Pocket Maximum.

Charges over the Maximum Allowed Amount that are Your responsibility and amounts You pay for non-Covered Services do not apply to these Out of Pocket Maximums. Deductibles and Coinsurance are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

See "Out of Pocket Maximum" in CLAIMS AND PAYMENTS for a detailed description of how Your Out of Pocket Maximum works.

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

<p>REPATRIATION OF REMAINS EXPENSE INSURANCE Repatriation of remains expense benefits do not accumulate toward Medical Out of Pocket Maximum</p>
<p>Benefits are payable under this Plan if You die from any cause while in the United States. We will pay expenses incurred, up to the Maximum Amount of Insurance, to prepare and transport Your remains from the United States back to the country of Your permanent legal residence.</p>

Maximum Amount of Insurance	\$25,000
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Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

<p>MEDICAL EVACUATION EXPENSE INSURANCE</p> <p>Medical evacuation expense benefits do not accumulate toward Medical Out of Pocket Maximum</p>
<p>Benefits are payable under this Plan if You have an accident or become ill while in the United States and require medical evacuation back to the country of Your permanent legal residence. We will pay expenses incurred, up to the Maximum Amount of Insurance, for Your medical evacuation from the United States back to the country of Your permanent legal residence.</p>

Maximum Amount of Insurance	\$50,000
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Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

Anthem Student Health Plan w/Child Dental

INTRODUCTION

THE ENTIRE CERTIFICATE SETS FORTH, IN DETAIL THE RIGHTS AND OBLIGATIONS OF BOTH YOU AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY. IT IS, THEREFORE, IMPORTANT THAT YOU READ THE ENTIRE CERTIFICATE CAREFULLY. PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS SHOULD READ THOSE SECTIONS THAT APPLY TO THEM.

Throughout this booklet, You will find key terms that will appear with the first letter of each word capitalized. When You see these capitalized words, You should refer to the part DEFINITIONS where the meanings of these terms or words are defined. Some key terms may be defined within a specific benefit description.

IN THIS CERTIFICATE, "WE," "US", "OUR", AND "ANTHEM" SHALL MEAN ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY. "YOU" AND "YOUR" MEAN THE INSURED STUDENT AND ANY ELIGIBLE DEPENDENTS WHO ARE COVERED UNDER THIS PLAN. WHEN WE USE THE WORD "INSURED", WE MEAN YOU AND ANY ELIGIBLE DEPENDENTS WHO ARE COVERED UNDER THIS PLAN.

When you need medical care, you must first go to the Student Health Center (SHC), which is called University Health Services or UHS (AKA the Tang Center). This requirement applies only to the Insured Student; it does not apply to any eligible Dependents who are covered under this Plan. The Tang Center coordinates your care, facilitates referrals, and acts as your health care advocate. All care with the exception of medical emergencies and some other specific services (see below for exception details) must be coordinated through Tang. You can access care at Tang through in person appointments, the advice nurse, the appointment office, or the Urgent Care center to coordinate your care. If You receive medical care without a referral, Your expenses will not be covered, except under the following conditions:

1. Medical emergencies or urgently needed care,
2. Obstetrical or gynecological care provided by an In Network Provider who specializes in obstetrics or gynecology, and
3. Services needed outside the U.S.

CHOICE OF IN NETWORK PROVIDER OR OUT OF NETWORK PROVIDER

You have the right to choose an In Network Provider or Out of Network Provider. Choosing an Out of Network Provider may impact Your personal financial costs. Refer to the SUMMARY OF BENEFITS to review Copayment and Coinsurance differences between these types of Providers since Your responsibility is often significantly higher when You use an Out of Network Provider.

Note: The total reimbursement allowed under this Plan for Covered Services is determined in part by whether you choose an In Network Provider or Out of Network Provider. Your financial responsibility for Covered Services may likewise vary. Because In Network Providers agree to accept the Maximum Allowed Amount as payment in full for their Covered Services, they will not bill you for amounts they charge that exceed the Maximum Allowed Amount. Because Out of Network Providers have not signed any contract with us, they have made no such agreement and may bill you for amounts that exceed the Maximum Allowed Amount (please see the section How Your Coverage Works for an explanation of Maximum Allowed Amount). In addition, this Plan generally provides a lower benefit for Covered Services from Out of Network Providers, which also means your financial responsibility may be greater when you choose an Out of Network Provider. You can access a directory of In Network Providers from our website at <http://www.anthem.com/ca/health-insurance/provider-directory/searchcriteria?planstate=CA&plantype=PPOSTUD&planname=Blue+Cross+PPO+Prudent+Buyer+-+Student+Health>, and as explained below.

Added note: Anthem covers only Emergency or urgent care services obtained outside our Service Area.

If You have a Grievance or complaint regarding Your ability to access needed health care in a timely manner, you may contact us to discuss Your concern or obtain a Grievance form. You may also contact the California Department of Insurance for assistance. Please see the section COMPLAINTS AND GRIEVANCES for more information.

How to Find a Provider in the Network

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

- See our directory of In Network Providers at www.anthem.com/ca, which lists the Physicians, Providers and Facilities that participate in our network.
- Call customer service at the telephone number listed on Your Identification Card or access our website at <http://www.anthem.com/ca/health-insurance/provider-directory/searchcriteria?planstate=CA&plantype=PPOSTUD&planname=Blue+Cross+PPO+Prudent+Buyer+-+Student+Health> for a list of Physicians, Providers and Facilities that participate in our network, based on specialty and geographic area.
- Check with Your Physician or Provider.

If You need help choosing a Physician who is right for You, call customer service at the number listed on Your Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with Your needs.

Note: We have several Provider networks, and a Provider that is In Network for one Plan may not be In Network for another. Be sure to call customer service to find out which network this Plan uses.

Some Hospitals and other Providers do not provide one or more of the following services that may be covered under the Plan and that You or Your family member might need:

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

You should obtain more information before You enroll or select a network Provider. Call Your prospective doctor or clinic, or call us at the customer service telephone number listed on Your ID Card to ensure that You can obtain the health care services that You need.

Providers are independent contractors. Anthem is not responsible for any claim for damages or injuries suffered by the Insured while receiving care from any Provider.

You have the right to receive a copy of the Notice of Privacy Practices. You may obtain a copy by calling our customer service department at the telephone number listed on Your ID Card or by accessing our website at www.anthem.com/ca.

How to Get Language Assistance

Anthem offers a Language Assistance Program to assist Insureds with limited English proficiency understand the health coverage of this Plan at no additional cost, and in a timely manner. This program includes oral interpretation services and written translation for certain written materials vital to understanding Your health coverage.

To request language assistance, please contact Customer Service by calling the phone number on Your Identification Card, to update Your language preference to receive future translated documents or to request interpretation assistance. Anthem also sends/receives TDD/TTY messages by using the National Relay Service through **711**. A special operator will get in touch with us to help with Your needs. For more information about the Language Assistance Program visit www.anthem.com/ca.

Written materials available for translation include Grievance and appeal letters, consent forms, claim denial letters, and explanations of benefits. These materials are available in the top 15 languages as determined by the California State Department of Health Care Services. Oral interpretation services are also available in these languages.

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

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

For information on how to file a complaint concerning language assistance or discrimination, please see COMPLAINTS AND GRIEVANCES later in this certificate.

TIMELY ACCESS TO CARE

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

- Urgent Care appointments for services that do not require prior authorization: within forty-eight (48) hours of the request for an appointment;
- Urgent Care appointments for services that require prior authorization: within ninety-six (96) hours of the request for an appointment;
- Non-Urgent appointments for primary care: within ten (10) business days of the request for an appointment;
- Non-Urgent appointments with specialists: within fifteen (15) business days of the request for an appointment;

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

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

If you need the services of an interpreter, the services will be coordinated with scheduled appointments and will not result in a delay of an appointment with an In Network Provider.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

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

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate quantitative treatment limitations (day or visit limits) on Mental Health and Substance Abuse benefits with day or visit limits on medical and surgical benefits. In general, health plans offering Mental Health and Substance

Abuse benefits cannot set day or visit limits on Mental Health or Substance Abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on Mental Health and Substance Abuse benefits offered under the plan.

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

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

YOUR ELIGIBILITY

This part explains enrollment, when coverage begins, who is eligible for coverage, and events that may cause eligibility to change, for example, birth, adoption, marriage, divorce, Domestic Partnership or dissolution of Domestic Partnership.

Who is Eligible for Coverage

Students

All full-time students are eligible for coverage under this Plan. A full-time student is one who carries at least 12 units per term, or approved to be below 12 units. Full-time student status is determined on the Add/Drop Deadline Date for the current term. A student may only decline coverage under this Plan if he or she presents proof of comparable coverage to the Policyholder's business office on or before the first day of the current term.

Note: A student may waive coverage under this plan only if he or she provides proof within the deadline that he or she has other adequate health coverage that meets the University's requirements for coverage. See WAIVER OF COVERAGE below for more information.

Dependents

To be eligible for coverage to enroll as a Dependent, You must be enrolled by the Student using the online enrollment process provided through the University and meet all Dependent eligibility criteria. The following may be enrolled as Dependents of the Student:

1. The Student's legal spouse. A spouse does not include any person who is covered as a Student or Domestic Partner.
2. The Student's Domestic Partner, provided the Student and Domestic Partner have completed and filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, and the Domestic Partnership has not terminated. The Domestic Partner does not include any person who is covered as a Student or spouse. For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse and a Domestic Partner's child, Adopted Child or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

3. The Student's or the Student's spouse's or Domestic Partner's children, including stepchildren, Newborn and Adopted Children and any child for whom the Student has assumed a parent-child relationship under age twenty six (26).
4. Children under age twenty-six (26) for whom the Student or the Student's spouse or Student's Domestic Partner is a legal guardian.

Children over the age of 26 may be eligible for coverage as a dependent if they are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, and chiefly dependent upon the Student for support and maintenance. To qualify as an overage Dependent, the Dependent's disability must start before the end of the period he or she would become ineligible for coverage.

Eligibility will be continued past the age limit of twenty-six (26) as an Overage Dependent for those Dependents who are already enrolled and who cannot work to support themselves by reason of intellectual or physical disability. To qualify as an Overage Dependent, the Dependent's disability must start before the end of the period he or she would become ineligible for coverage.

Anthem shall determine whether the Dependent meets those criteria before the Dependent attains the limiting age.

1. Ninety (90) days before the Dependent reaches the age limit of twenty-six (26), Anthem will issue a request for proof that the Dependent continues to meet the criteria for continued coverage.
2. The Student must submit written proof of such dependency within sixty (60) days of receiving the request.
3. Before the date the Dependent reaches the age limit of twenty-six (26), Anthem will determine whether the Dependent meets the criteria for continued coverage.
4. Two (2) years after receipt of the initial proof, we may require proof no more than annually of the continuing handicap and dependency.

A new Student who enrolls in the Plan may also enroll an Overage Dependent who cannot work to support himself or herself by reason of intellectual or physical disability if the Dependent meets the criteria listed above as determined by Anthem. Anthem may request a new Student to provide information regarding a Dependent with a continued physically or mentally disabling injury, illness or condition at the time of enrollment and not more than annually thereafter for proof that the Dependent meets the criteria for continued coverage. The Student must submit written proof of such dependency within sixty (60) days of receiving the request.

We may require the Student to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Newborn and Adopted Child Coverage

Newborn and adopted child(ren) of the Student or the Student's spouse or Domestic Partner will be covered for an initial period of thirty-one (31) days from the date of birth or adoption. Coverage for Newborn and adopted child(ren) will continue beyond the thirty-one (31) days, provided the Student submits a membership change form to the Policyholder to add the child under the Student's Plan. Failure to submit the membership change form to the Policyholder during this thirty-one (31) day period will result in no coverage for the Newborn or Adopted Child beyond the first thirty-one (31) days.

A child will be considered adopted from the earlier of:

1. the moment of placement for adoption; or
2. the date of an entry of an order granting custody of the child to You.

The child will continue to be considered adopted unless the child is removed from Your home prior to issuance of a legal decree of adoption.

NEWBORN AND ADOPTED CHILDREN OF THE STUDENT'S, STUDENT'S SPOUSE'S OR STUDENT'S DOMESTIC PARTNER'S DEPENDENT CHILDREN ARE NOT COVERED UNDER THIS PLAN.

Adding a Child due to Award of Guardianship

If a Student or the Student's spouse or Domestic Partner files an application for an appointment of guardianship for a child, the Student must add the child to the Plan within sixty (60) days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Individuals not eligible for Dependent coverage

- Spouses of Dependent children are not eligible for coverage under this Plan.
- Children, including Newborns and Adopted Children, of Dependent children are not eligible for coverage under this Plan unless that child meets other coverage criteria established under State law.
- Temporary custody is not sufficient to establish eligibility under this Plan.
- Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Plan unless required by the laws of this State.

Qualified Medical Child Support Order

If You are required by a Qualified Medical Child Support Order or court order, as defined by applicable State or federal law, to enroll Your child under this Plan, and the child is otherwise eligible for the coverage, we will permit Your child to enroll under this Plan, and we will provide the benefits of this Plan in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any Dependent Age Limit listed in the SUMMARY OF BENEFITS and above in "Who Is Eligible for Coverage – Dependents". Any claims covered under this Plan will be allowed to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to us directly.

Enrollment

Students are automatically enrolled if they are eligible. To enroll Dependents, the Student must add the Dependents to the Plan using the online enrollment process provided through the University within 31 days from the eligibility date. Notification of enrollment must be received by Wells Fargo Insurance Services within 90 days. Wells Fargo is the broker for Your Student Health Insurance Plan and helps coordinate the enrollment process. If any of these steps are not followed, coverage may be denied.

Effective Dates

The effective date of coverage is subject to the timely payment of premium on your behalf. The date you become covered is determined as follows:

1. **Students.** Full-time Students are covered on the first day of the current term.
2. **Dependents - Timely Enrollment.** If you enroll your Dependents for coverage before, on, or within 31 days after your eligibility date, then their coverage will begin on the later of (i) the date the Student's coverage begins, or (ii) the first day of the month after the Dependent becomes eligible. If you become eligible before the Policy takes effect, coverage begins on the effective date of the Policy, provided you properly complete the online enrollment process.
3. **Dependents - Late Enrollment.** If you fail to enroll within 31 days after your eligibility date, you must wait until the next term to enroll.

Special Enrollment

A special enrollment period is a period during which the Insured or an enrollee who experiences certain qualifying events or changes in eligibility may enroll in the Plan, without waiting for the next term.

Length of special enrollment periods: Unless specifically stated otherwise, the Insured or enrollee has sixty (60) calendar days from the date of a qualifying event to enroll.

Qualifying Events:

- Involuntary loss of Minimum Essential Coverage (loss of Minimum Essential Coverage includes loss of eligibility of coverage as a result of legal separation, divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment. Loss of eligibility does not include a loss due to the failure of the employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan)
- Gain a Dependent or become a Dependent through marriage, Domestic Partnership, birth, adoption, placement for adoption or appointment of Domestic Partnership
- Mandated to be covered as a Dependent pursuant to a valid state or federal court order
- Release from incarceration
- Health coverage issuer substantially violated material provision of health coverage contract
- Access to new health benefit plans due to permanent move
- Loss of services from contracting Provider under another health benefit plan, as defined in Sections 10965 of the Insurance Code or 1399.845 of the Health and Safety Code, for a condition described in Health and Safety Code § 1373.96(c) (an acute condition, serious chronic condition, pregnancy, terminal illness, care of Newborn between birth and 36 months of age, or performance of a surgery or other procedure that has been recommended and documented by the Provider) and that Provider is no longer participating in the health benefit plan
- Member of the Reserve Forces of the U.S. military returning from active duty or member of the California National Guard returning from active duty under Title 32 of the U.S. Code.

Effective Dates for special enrollment periods:

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption; and
2. In the case of marriage, Domestic Partnership or in the case where an Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after You complete the online enrollment process.

You must elect coverage and complete the online enrollment process within sixty (60) days.

Effective Dates for special enrollment due to loss of Minimum Essential Coverage apply when the loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1. Legal separation, dissolution of Domestic Partnership or divorce;
2. Cessation of Dependent status, such as attaining the maximum age;
3. Death of an employee;
4. Termination of employment;
5. Reduction in the number of hours of employment; or
6. Any loss of eligibility for coverage after a period that is measured by reference to any of the following:
 - a. Individual who no longer resides, lives or works in the Plan's Service Area,
 - b. A situation in which the Plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
 - c. Termination of employer contributions, and
 - d. Exhaustion of COBRA benefits.

Eligible Students who involuntarily lose coverage under another group insurance plan are also eligible to purchase coverage under this Plan the day after prior coverage ends if the enrollment request is received by Wells Fargo Insurance Services within 30 days from the loss of prior coverage.

There is no special enrollment for loss of Minimum Essential Coverage when the loss includes termination or loss due to:

1. Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2. Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

WAIVER OF COVERAGE (APPLICABLE TO STUDENTS ONLY)

You may waive coverage under the University's Student Health Insurance Plan if you provide proof that you have other adequate health coverage which meets the University's minimum requirements for coverage. You must complete a waiver form and submit it to the University.

The University will determine whether your alternative health care coverage meets the minimum requirements.

Each semester or term, you must complete and submit a waiver form by the deadline date in order to waive coverage.

Notice of Changes

The Policyholder is responsible to notify us of any changes that will affect the eligibility of any Student or that of Dependents for services or benefits under this Plan. We must be notified of any changes as soon as possible but no later than within sixty (60) days of the event. This includes changes in address, marriage, divorce, dissolution of Domestic Partnership, death, change of Dependent disability or dependency status. Failure to notify us of persons no longer eligible for services will not obligate us to pay for such services. Acceptance of premium for persons no longer eligible for services will not obligate us to pay for such services.

Anthem must be notified if any Insured becomes eligible for Medicare.

All notifications must be in writing and on approved forms. Such notifications must include all information required to effect the necessary changes.

Contact customer service at the telephone number listed on Your ID Card or send Your request to us at:

Anthem Blue Cross Life and Health Insurance Company

21555 Oxnard Street

Woodland Hills, California 91367

Statements and Forms

Students or applicants (including applicants to be covered as a Dependent) for coverage shall complete and submit to the Policyholder or Anthem any forms or statements that may be requested or required. Students or applicants for membership represent to the best of their knowledge and belief that all information contained in such questionnaires, forms, or statements submitted to the Policyholder or Anthem are true, correct, and complete. Students and applicants for membership understand that all rights to benefits under this Plan are subject to the condition that all such information is true, correct and complete. Any act or practice that constitutes fraud or an intentional misrepresentation of material fact by the Insured may result in termination or rescission of coverage.

Termination

This section describes how coverage for Insureds can be canceled.

Termination of the Insured

Your coverage ends, without notice from us, as provided below:

1. If the Policy terminates, your coverage ends at the same time. The Policy may be cancelled or changed without notice to you.
2. If the Policyholder no longer provides coverage for the class of Insureds to which you belong, your coverage ends on the effective date of that change. If this Policy is amended to delete coverage for Dependents a Dependent's coverage ends on the effective date of that change.
3. Coverage for Dependents ends when the Student's coverage ends.
4. Coverage ends at the end of the period for which premium has been paid to us on your behalf when the required premium for the next period is not paid.
5. If you voluntarily cancel coverage at any time, coverage ends on the premium due date coinciding with or following the date of voluntary cancellation, as provided by written notice to us.
6. If you no longer meet the eligibility requirements set forth in this Plan, your coverage ends as of the premium due date coinciding with or following the date you cease to meet such requirements.

Exception

Medical withdrawal or school authorized breaks. If you are an Insured Student and the premiums have been paid to us on your behalf, your coverage may continue for one semester during a medical withdrawal or school breaks approved by the Policyholder.

IMPORTANT: All of Your coverage will be terminated as of the date of Termination, whether or not a specific condition was incurred prior to the Termination date. Covered Services are eligible for payment only if Your coverage is in effect at the time such services are provided.

Loss of Eligibility

Coverage ends when You or Your Dependents no longer meet the eligibility requirements for coverage under this Plan. You must timely furnish any information requested regarding Your eligibility and the eligibility of Your Dependents, including but not limited to, marriage, divorce, dissolution of Domestic Partnership, death, change of Dependent disability or dependent status. Failure to give timely notification of a loss of eligibility will not obligate us to provide benefits for ineligible persons, even if we have accepted premiums or paid benefits.

Cancellation

Once coverage is canceled, the Insured cannot reenroll until the next term unless there is an event that qualifies for a special enrollment prior to the next term.

Removal of Insureds

A Student may cancel the enrollment of any Insured from the Plan. If this happens, no benefits will be provided after the Insured's termination date.

Reinstatement of Coverage for Members of the Military

Insureds who are members of the United States Military Reserve and National Guard who terminate their coverage in this Plan as a result of being ordered to active duty on or after January 1, 2007, may have their coverage reinstated. Please contact customer service at the telephone number listed on Your ID Card for information on how to apply for reinstatement of coverage following active duty as a reservist.

Services Received After Coverage Ends

We will not cover services You receive after Your coverage ends with us. This is also stated in the part WHAT IS NOT COVERED (Exclusions) – MEDICAL and WHAT IS NOT COVERED (Exclusions) – PRESCRIPTION DRUGS.

Continuation of Benefits After Termination

If an Insured is confined as an inpatient in a hospital on the date of discontinuance of the Plan or the Policy, benefits may be continued for treatment of illness or injury for which the Insured is hospitalized. No benefits are provided for services treating any other illness, injury or condition. The Insured's benefits will be extended for a period of 30 days provided that the Insured is confined as an inpatient in a hospital, under a Physician's care, and the services are medically necessary. Any benefits payable under this Plan will not exceed any benefit maximums listed herein. The cost of the Continuation of Benefits After Termination is one month's premium.

HOW YOUR COVERAGE WORKS

This Plan provides a wide range of coverage for health care services. The information contained in this part is designed to explain how to access Your benefits. Anthem will cover up to the maximum described below for a Covered Service or supply. Review the SUMMARY OF BENEFITS, the parts WHAT IS COVERED – MEDICAL and WHAT IS COVERED – PRESCRIPTION DRUGS for information on Deductibles, Out of Pocket Maximums, Copayments/Coinsurance and any per day, Year or visit limits which may be applied to a particular benefit.

This is a Preferred Provider Organization (PPO) Plan. We provide access to a network of Hospitals and Providers who contract with Anthem to facilitate services to our Insureds and who provide services at pre-negotiated discounted rates. Benefits for In Network Providers are based on a Maximum Allowed Amount. In Network Providers have an agreement in effect with Anthem and have agreed to accept the Maximum Allowed Amount as payment in full. An In Network Provider may, after notice from us, be subject to a reduced Maximum Allowed Amount in the event the In Network Provider fails to make routine referrals to In Network Providers, except as otherwise allowed (such as for Medical Emergency Services). Out of Network Providers do not have an agreement with Anthem. Your personal financial costs when using Out of Network Providers may be considerably higher than when You use In Network Hospitals or In Network Providers. Further, for certain services there may be no benefit provided when using an Out of Network Provider. You will be responsible for any amount not paid by Anthem when using the services of an Out of Network Provider. If you receive services from an In Network Hospital or Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out of Network Provider, you will pay the Out of Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In Network Provider. Please see the INSURED COST SHARE section for more information. Please read the SUMMARY OF BENEFITS and the benefit sections under the part WHAT IS COVERED – MEDICAL carefully to determine these differences. For assistance locating In Network Providers, You may contact us at the telephone number listed on Your ID Card or access our website at www.anthem.com/ca.

Reminder! When You need medical treatment or services, You must first go to the Student Health Center (SHC). Please see the exceptions to this requirement in the INTRODUCTION to this booklet, above. The SHC will diagnose and treat most illnesses, coordinate all Your health care, and refer You, when necessary, to an In Network Provider who participates in our Prudent Buyer Plan network. Referrals are made at the sole and absolute discretion of the SHC.

CHOICE OF IN NETWORK PROVIDER OR OUT OF NETWORK PROVIDER

You have the right to choose an In Network Provider or Out of Network Provider as stated above. Choosing an Out of Network Provider may impact Your personal financial costs. Refer to the SUMMARY OF BENEFITS and the part WHAT IS COVERED - MEDICAL to review Copayment and Coinsurance differences between these types of Providers since Your responsibility is often significantly higher when You use an Out of Network Provider.

Some Hospitals and other Providers do not provide one or more of the following services that may be covered under this Plan and that You or Your family member might need:

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

You should obtain more information before You enroll or select a network Provider. Call Your prospective doctor or clinic, or call Anthem at the telephone number listed on Your ID Card or by accessing our website at www.anthem.com/ca to ensure that You can obtain the health care services that You need.

In Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers (SCPs)), other professional Providers, Hospitals, and other Facilities who contract with us to care for You. Referrals are never needed to visit an In Network Specialist including behavioral health Providers.

To see a Physician, call their office:

- Tell them You are an Anthem Insured,
- Have Your Identification Card handy. The Physician's office may ask You for Your ID number.
- Tell them the reason for Your visit.

When You go to the office, be sure to bring Your Identification Card with You.

Maximum Allowed Amount

The Maximum Allowed Amount is the total reimbursement allowed under this Plan for Covered Services You receive from In Network Providers, Out of Network Providers and Other Eligible Providers. It is our payment towards the services billed by Your Provider combined with any Deductible, Copayment or Coinsurance owed by You. In some cases, You may be required to pay the entire Maximum Allowed Amount. For instance, if You have not met Your Deductible under the Plan, then You could be responsible for paying the entire Maximum Allowed Amount for Covered Services. In addition, if these services are received from an Out of Network Provider or Other Eligible Provider, You may be billed by the Provider for the difference between their charges and our Maximum Allowed Amount. In many situations, this difference could be significant. If you receive services from an In Network Hospital or Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out of Network Provider, you will pay the Out of Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In Network Provider. Please see INSURED COST SHARE below for more information.

In no event do we cover any charge in excess of our Maximum Allowed Amount for any Covered Service or supply.

We have provided two examples below, which illustrate how the Maximum Allowed Amount works. These examples are for illustration purposes only and do not reflect actual benefit amounts under this Plan.

Example 1: The Plan has the Insured Coinsurance Cost Share of 30% for In Network Provider services after the Deductible has been met. The Insured receives services from an In Network surgeon. The charge is \$2,000. The Maximum Allowed Amount under the Plan for the surgery is \$1,000. After the Deductible has been satisfied, Anthem pays 70% when an In Network surgeon is used. This is \$700. The Insured's Coinsurance responsibility is 30%, which is \$300. The In Network surgeon accepts the total of \$1,000 as reimbursement for the surgery even though he or she billed \$2,000.

Example 2: The Plan has the Insured Coinsurance Cost Share of 50% for Out of Network Provider services after the Deductible has been met. The Insured receives services from an Out of Network surgeon. The charge is \$2,000. The Maximum Allowed Amount under the Plan for the surgery is \$1,000. After the Deductible has been satisfied, Anthem pays 50% when an Out of Network surgeon is used. This is \$500. The Insured's Coinsurance responsibility is also 50%, which is \$500. In addition, the Out of Network surgeon could bill the Insured the difference between \$2,000 and

\$1,000, so the Insured's total out-of-pocket charge would be \$500 plus an additional \$1,000, for a total Insured responsibility of \$1,500.

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

Provider Status

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

In Network Providers: For Covered Services performed by an In Network Provider, the Maximum Allowed Amount is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because In Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have a Deductible, Copayment, or Coinsurance.

Out of Network Providers and Other Eligible Providers: Providers who have not signed any contract with us and are not in any of our networks are Out of Network Providers. Other Eligible Providers are providers that do not enter into agreements with us (blood banks, certified registered nurse anesthetists). For Covered Services You receive from an Out of Network Provider or Other Eligible Provider, the Maximum Allowed Amount will be based on the applicable Anthem Out of Network Provider or Other Eligible Provider rate or fee schedule for this Plan, an amount negotiated by us or a third party vendor which has been agreed to by the Out of Network Provider or Other Eligible Provider, an amount based on or derived from the total charges billed by the Out of Network Provider or Other Eligible Provider, an amount based on information provided by a third party vendor, or an amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the

Maximum Allowed Amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually.

Out of Network Providers and Other Eligible Providers may send You a bill and collect the amount of the Out of Network Provider's or Other Eligible Provider's charge that exceeds the Maximum Allowed Amount under this Plan. You may be responsible for paying the difference between the Maximum Allowed Amount and the amount the Out of Network Provider charges. This amount can be significant. If you receive services from an In Network Hospital or Facility at which, or as a result of which, you receive non-Emergency Covered Services from Out of Network Providers, you will pay no more than the same cost sharing that you would pay for those same non-Emergency Covered Services received from an In Network Provider, and you will not have to pay the Out of Network Provider more than the In Network cost sharing for such non-Emergency Covered Services. Please see INSURED COST SHARE for more information. **Customer service is available to assist You in determining the Maximum Allowed Amount for a particular Covered Service from an Out of Network Provider or Other Eligible Provider.**

Please see the part WHAT IS COVERED - MEDICAL for additional information.

Reminder: If You utilize an In Network Provider, the Provider will send us a claim on Your behalf. If You utilize an Out of Network Provider, the Provider may or may not file a claim on Your behalf.

Insured Cost Share

For certain Covered Services, You may be required to pay all or a part of the Maximum Allowed Amount as Your Cost Share amount (Deductible, Copayment, and/or Coinsurance). Your Cost Share amount and Out of Pocket Maximums may be different depending on whether You received Covered Services from an In Network Provider, Out of Network Provider or Other Eligible Provider. Specifically, You may be required to pay higher cost-sharing amounts or may have limits on Your benefits when using Out of Network Providers or Other Eligible Providers. See the SUMMARY OF BENEFITS and the part WHAT IS COVERED – MEDICAL for Your Cost Share responsibilities and limitations, or call us at the telephone number listed on Your ID Card to learn how the Plan's benefits or Cost Share amounts may vary by the type of Provider You use.

Anthem will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by Your Provider for non-Covered Services, regardless of whether such services are performed by an In

Network Provider, Out of Network Provider or Other Eligible Provider. Non-Covered Services include services specifically excluded from coverage by the terms of this Plan including services received but are not Medically Necessary and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits. The responsibility for services that are denied because they are not Medically Necessary is dependent upon a Provider's status. Network Providers are prohibited by their contract with us from billing or collecting from You for any services that are provided but denied because they are not Medically Necessary unless they obtain a written agreement from You wherein You agree to pay for such services. Out of Network Providers do not have a contract with us and You will be responsible for the total amount billed by an Out of Network Provider for services that are denied because they are not Medically Necessary.

In some instances, You may only be asked to pay the In Network Provider Cost Share percentage when You use an Out of Network Provider. For example, if You receive covered non-Emergency Services at an In Network Hospital or Facility at which, or as a result of which, you receive Covered Services from an Out of Network Provider such as a radiologist, anesthesiologist or pathologist, You will pay the In Network Provider Cost Share percentage of the Maximum Allowed Amount for those Covered Services, and You will not be liable for the difference between the Maximum Allowed Amount and the Out of Network Provider's charge. Such In Network Provider Cost Share percentage will apply to the In Network Provider deductible (if any) and the In Network Provider out-of-pocket amount. This paragraph does not apply, however, if the Out of Network Provider has your written consent, satisfying the following criteria:

- (1) At least 24 hours in advance of care, you consent in writing to receive services from the identified Out of Network Provider.
- (2) The consent shall be obtained by the Out of Network Provider in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent shall not be obtained by the facility or any representative of the facility. The consent shall not be obtained at the time of admission or at any time when the member is being prepared for surgery or any other procedure.
- (3) At the time consent is provided the Out of Network Provider shall give you a written estimate of your total out-of-pocket cost of care. The written estimate shall be based on the professional's billed charges for the service to be provided. The Out of Network Provider shall not attempt to collect more than the estimated amount without receiving separate written consent from you or your authorized representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given that would require the provider to change the estimate.

(4) The consent shall advise you that you may elect to seek care from an In Network Provider or may contact Anthem in order to arrange to receive the health service from an In Network Provider for lower out-of-pocket costs.

(5) The consent and estimate shall be provided to you in the language spoken by you, if the language is a Medi-Cal threshold language, as defined in state law (subdivision (d) of Section 128552 of the Health and Safety Code).

(6) The consent shall also advise you that any costs incurred as a result of your use of the Out of Network Provider benefit shall be in addition to In Network Provider cost-sharing amounts and may not count toward the annual out-of-pocket maximum for In Network Provider benefits or a deductible, if any, for In Network Provider benefits.

Authorized Referrals

In some circumstances, we may authorize In Network Provider Cost Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out of Network Provider. In such circumstance, You or Your Physician must contact us in advance of obtaining the Covered Service. It is Your responsibility to ensure that we have been contacted. If we certify an In Network Provider Cost Share amount to apply to a Covered Service received from an Out of Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Out of Network Provider's charge. In certain situations, however, if you receive non-Emergency covered services at an In Network Hospital or Facility at which, or as a result of which, you receive services from an Out of Network Provider, you will pay no more than the cost sharing that you would pay for the same covered services received from an In Network Provider. Please see INSURED COST SHARE for more information. Please contact us at the telephone number listed on Your ID Card for Authorized Referral information or to request authorization.

Reminder: Carry Your identification ("ID") card

Your Anthem ID card identifies You and contains important health care coverage information. Carrying Your ID card at all times will ensure You always have access to this coverage information when You need it. Make sure You show Your ID card to Your doctor, Hospital, pharmacist, or other health care Provider so they know You are covered with Anthem.

As a reminder, refer to the section Emergency Care to understand the differences between obtaining out-of-area Emergency Services within the State of California and for services outside California. Only Emergency Services outside California will utilize the Inter-Plan Arrangements.

Inter-Plan Arrangements

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You access healthcare services outside the geographic area We serve (the "Anthem Service Area"), the claim for those services may be processed through one (1) of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of the Anthem Service Area, You will receive it from one (1) of two (2) kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how We pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

Claim types not eligible to be processed through Inter-Plan Arrangements, as described above, are Prescription Drugs that You obtain from a Pharmacy and most dental or vision benefits.

A. BlueCard® Program

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

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

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected

average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments, and/or other credits or charges.

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

B. Special Cases: Value-Based Programs

BlueCard Program

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

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

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

D. Non-participating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

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

2. Exceptions

In certain situations, We may use other pricing methods, such as billed charges or the pricing We would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount We will pay for services provided by nonparticipating Providers. In these

situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment We make for the Covered Services as set forth in this paragraph.

E. Blue Cross Blue Shield Global Core Program

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

When You are traveling abroad and need medical care, You can call the Blue Cross Blue Shield Global Core Service Center any time. They are available twenty-four (24) hours a day, seven (7) days a week. The toll free number is **1-800-810-2583**. Or You can call them collect at **1-804-673-1177**.

If You need inpatient Hospital care, You or someone on Your behalf, should contact us for Precertification. Keep in mind, if You need Emergency medical care, go to the nearest Hospital. There is no need to call before You receive care. Please refer to the GETTING APPROVAL FOR BENEFITS section.

How Claims are Paid with Blue Cross Blue Shield Global Core

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

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

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

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

Additional information on Blue Cross Blue Shield Global Core claims:

- You are responsible, at your expense, for obtaining an English language translation of foreign country Provider claims and medical records.
- The exchange rate utilized for:
 - Inpatient Hospital care is based on the date of admission.
 - Outpatient and professional services are based on the date of service.

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

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

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

CLAIMS AND PAYMENTS

A claim is incurred on the date the service is provided to You. This is important because You must be enrolled and eligible to receive benefits on the date the service is provided. A claim must be submitted in order for us to record the services and consider them for benefits. We will record claims in our records in the order in which Your claims are processed, not necessarily in the order in which You receive the service or supply.

We only provide benefits for Covered Services that are Medically Necessary. Benefits and benefit limits are described in WHAT IS COVERED – MEDICAL and in the SUMMARY OF BENEFITS.

Copayments and Coinsurance are Cost Shares and are outlined in the SUMMARY OF BENEFITS. A Copayment is a fixed dollar amount you must pay for the service you receive, and may apply per day or per visit. Coinsurance is a specified percentage of the Maximum Allowed Amount for Covered Services you receive. Some services could require payment of both a Copayment and Coinsurance.

When Covered Services are provided by an Out of Network Provider, You may be responsible for the difference between the Provider's billed charges and the Maximum Allowed Amount. This is not Coinsurance and will not apply to Your Out of Network Out of Pocket Maximums.

These amounts are Your financial responsibility. Copayments are normally paid at the time services are performed. While Your Deductible and/or Coinsurance financial responsibility may also be collected by the Provider at the time services are performed, the Provider may choose to bill You for these services after the claim has been submitted to us. Cost sharing for services with Copayments is the lesser of the Copayment amount or Maximum Allowed Amount.

Described below are the Deductibles, Coinsurance and the Out of Pocket Maximums.

Note: If You replace Your health care coverage from another health insurance carrier with this Plan, we will not apply those Deductibles or Out of Pocket amounts to this Plan.

Deductibles

Please refer to the SUMMARY OF BENEFITS for services that do not apply to the Deductible.

Each Benefit Period, You must satisfy Your Deductibles before we will pay benefits for Covered Services. Your Deductibles may include an In Network medical Deductible, an Out of Network medical Deductible, an In Network Prescription Drug Deductible, an Out of Network Prescription Drug Deductible for Covered Services and a combined In and Out of Network Pediatric Dental Deductible.

Pediatric Dental Deductible

Your Pediatric Dental Deductible is a combination of Covered Services for both In and Out of Network Providers. Your Pediatric Dental Deductible amount is determined by the number of family members enrolled in this Plan. If only one (1) person is enrolled, then only the Individual Pediatric Dental Deductible applies. If more than one (1) person is enrolled, then both Individual Pediatric Dental Deductible and Family Pediatric Dental Deductible are applicable as follows:

- Pediatric Individual Deductible for one (1) Insured
 - Once the total allowable charges applying to the Individual Pediatric Dental Deductible have been met, no further Pediatric Dental Deductible for the Insured will be required for the remainder of that Benefit Period.
- Pediatric Family Deductible for two (2) or more Insureds
 - Once the total allowable charges applying to the Individual Pediatric Dental Deductible have been met by one (1) Insured, no further Pediatric Dental Deductible for that Insured will be required for the remainder of that Benefit Period. The Insured's Individual Pediatric Dental Deductible will contribute towards meeting the Family Pediatric Dental Deductible.
 - All other Insured family members will be subject to the remainder of the Family Pediatric Dental Deductible until either the Insured's Individual Pediatric Dental Deductible is met or the Family Pediatric Dental Deductible is satisfied, whichever occurs first. Pediatric Dental Deductibles paid for Covered Services by each individual Insured in a family during a Benefit Period will contribute to the remainder of the family's Pediatric Dental Deductible.

The Pediatric Dental Deductible amounts are listed in the SUMMARY OF BENEFITS.

Medical Deductible

Your Medical Deductible is a Deductible amount that applies to covered expense for covered services for both In and Out of Network Providers for medical services. Before we will make payment for certain Covered Services, You must first satisfy the Medical Deductible.

Your Deductible amount is determined by the number of family members enrolled. If only one (1) person is enrolled, then only the Individual Deductible applies. If more than one (1) person is enrolled, then both the Individual Deductible and the Family Deductible are applicable as follows:

- **Individual Deductible for one (1) Insured**
 - Once the total allowable charges applying to the Individual Deductible have been met, no further Deductible for the Insured will be required for the remainder of that Benefit Period.
- **Family Deductible for two (2) or more Insureds**
 - Once the total allowable charges applying to the Individual Deductible have been met by one (1) Insured, no further Deductible for that Insured will be required for the remainder of that Benefit Period. The Insured's Individual Deductible will contribute towards meeting the Family Deductible.
 - All other Insured family members will be subject to the remainder of the Family Deductible until either the Insured's Individual Deductible is met or the Family Deductible is satisfied, whichever occurs first. Deductibles paid for Covered Services by each individual Insured in a family during a Benefit Period will contribute to the remainder of the family's Deductible.

The Deductible amounts are listed in the SUMMARY OF BENEFITS.

The automatic enrollment of Newborn or Adopted Children may cause the applicable Deductible to automatically change from an Individual Deductible to a Family Deductible. Additional information on Newborn or Adopted Children is explained in the part YOUR ELIGIBILITY.

During each Benefit Period, each Insured is responsible for Covered Services incurred up to the Deductible amounts. These Deductibles are not prorated for a partial Benefit Period. Only Covered Services will apply toward the Deductibles. A claim must be submitted in order for us to record Your eligible covered Deductible expense. We will record Your Deductibles in our files in the order in which Your claims are processed, not necessarily in the order in which You receive the service or supply.

If You submit a claim for services which have a maximum payment limit and the applicable Deductible is not satisfied, we will apply only the allowed per visit or per day amount, whichever applies, toward Your Deductible.

Your Deductibles for Covered Services will apply towards Your Out of Pocket Maximums.

Coinsurance and Copayments

After Your Deductible has been satisfied, You will be required to pay Coinsurance or Copayments for services received while You are covered under this Plan. Coinsurance is the percentage amount of the Maximum Allowed Amount that You are responsible for as stated in the SUMMARY OF BENEFITS.

When Covered Services are provided by an Out of Network Provider, You may be responsible for the difference between the Provider's billed charges and the Maximum Allowed Amount. This is not Coinsurance and will not apply to Your Out of Pocket Maximum.

Out of Pocket Maximums

The Out of Pocket Maximums include all Deductibles, Coinsurance and Copayments You pay during a Benefit Period for all Essential Health Benefits. It does not include charges over the Maximum Allowed Amount, Precertification penalties or amounts You pay for non-Covered Services.

The Out of Pocket Maximums for pediatric dental services accumulate separately from the Medical and Prescription Drug Out of Pocket Maximums for all other Essential Health Benefits (medical services, pediatric vision, and Prescription Drug services). The Out of Pocket Maximums for these two sets of services are listed in the SUMMARY OF BENEFITS. The combined Out of Pocket Maximums for all services will not exceed the maximum amount permitted by law.

Pediatric Dental Out of Pocket Maximums

Your Pediatric Dental Out of Pocket Maximum is a combination of Covered Services for both In and Out of Network Providers. Your Out of Pocket Maximum is determined by the number of Insureds enrolled. If only one (1) Insured is enrolled, then only the Individual Out of Pocket Maximum applies. If more than one (1) Insured is enrolled, then both the Individual Out of Pocket Maximum and the Family Out of Pocket Maximum are applicable.

- **Individual Out of Pocket Maximum for one (1) Insured**
 - Once the total allowable charges applying to the Individual Out of Pocket Maximum have been met, Anthem will provide 100% of the Maximum Allowed Amount for Covered Services for the remainder of that Benefit Period.

- **Family Out of Pocket Maximum for two (2) or more Insureds**
 - Once the total allowable charges applying to the Family Out of Pocket Maximum have been met for one (1) Insured, Anthem will provide benefits at 100% of the Maximum Allowed Amount for Covered Services for that Insured for the remainder of that Benefit Period. The Insured's Individual Out of Pocket Maximum will contribute towards meeting the Family Out of Pocket Maximum.
 - All other Insured family members will be subject to the remainder of the Out of Pocket Maximum until either the Insured's Individual Out of Pocket Maximum is met or the Family Out of Pocket Maximum is satisfied, whichever occurs first. All Cost Shares paid for Covered Services by each additional individual Insured in a family during a Benefit Period will contribute to the remainder of the Family Out of Pocket Maximum. Once the total allowable charges applying to the Family Out of Pocket Maximum have been met, Anthem will provide benefits at 100% of the Maximum Allowed Amount for Covered Services for all Insured family members for the remainder of that Benefit Period.

Medical and Prescription Drug Out of Pocket Maximums

The Medical and Prescription Drug Out of Pocket Maximum is a dollar amount that combines the Cost Shares You pay for covered medical services and Prescription Drugs. This Plan has separate In Network and Out of Network Out of Pocket Maximums for medical services and Prescription Drugs, meaning it has two separate Out of Pocket Maximums for these services. The In Network and Out of Network Out of Pocket Maximums for medical services and Prescription Drugs are separate and do not apply toward each other. Cost Shares paid for Out of Network Emergency care, including Emergency medical transportation (ambulance) and Emergency Hospital care, will apply to the In Network Out of Pocket Maximum. In addition, in certain situations, Cost Shares paid for Out of Network non-Emergency care, when you receive Covered Services from an Out of Network Provider such as a radiologist, anesthesiologist or pathologist at a Network Hospital, will apply to the In Network Out of Pocket Maximum.

The information provided in this section applies to both the In Network and Out of Network Out of Pocket Maximums.

Your Out of Pocket Maximum is determined by the number of Insureds enrolled. If only one (1) Insured is enrolled, then only the Individual Out of Pocket Maximum applies. If more than one (1) Insured is enrolled, then both the Individual Out of Pocket Maximum and the Family Out of Pocket Maximum are applicable.

- **Individual Out of Pocket Maximum for one (1) Insured**

- Once the total allowable charges applying to the Individual Out of Pocket Maximum have been met, Anthem will provide 100% of the Maximum Allowed Amount for Covered Services for the remainder of that Benefit Period.
- **Family Out of Pocket Maximum for two (2) or more Insureds**
 - Once the total allowable charges applying to the Individual Out of Pocket Maximum have been met for one (1) Insured, Anthem will provide benefits at 100% of the Maximum Allowed Amount for Covered Services for that Insured for the remainder of that Benefit Period. The Insured's Individual Out of Pocket Maximum will contribute towards the Family Out of Pocket Maximum.
 - All other Insured family members will be subject to the remainder of the Out of Pocket Maximum until the Family Out of Pocket Maximum is satisfied. All Cost Shares paid for Covered Services by each additional individual Insured in a family during a Benefit Period will contribute to the remainder of the Family Out of Pocket Maximum. Once the total allowable charges applying to the Family Out of Pocket Maximum have been met, Anthem will provide benefits at 100% of the Maximum Allowed Amount for Covered Services for all Insured family members for the remainder of that Benefit Period. But each Insured will pay no more than the amount of the Individual Out of Pocket Maximum.

The In Network and Out of Network Out of Pocket Maximum amounts are listed in the SUMMARY OF BENEFITS.

The automatic enrollment of a Newborn or Adopted Children may cause the applicable Out of Pocket Maximum to automatically change from the Individual Out of Pocket Maximum to a Family Out of Pocket Maximum. Additional information on Newborn or Adopted Children is explained in the part YOUR ELIGIBILITY.

WHAT IS COVERED – MEDICAL

This part describes the Covered Services available under this Plan. Covered Services are subject to all the terms and conditions listed in this Plan, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, exclusions and Medical Necessity requirements. Please read the SUMMARY OF BENEFITS for details on the amounts You must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read HOW YOUR COVERAGE WORKS for more information on the Plan's rules. Read WHAT IS NOT COVERED (Exclusions) – MEDICAL for important details on excluded services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find.

Note: Several sections may apply to Your claims. For example, if You have surgery, benefits for Your Hospital stay will be described under "Surgery" and "Inpatient Facility Services." Benefits for Your Physician's services will be described under "Office Visits." As a result, You should read all sections that might apply to Your claims.

You should also know that many Covered Services can be received in several settings, including a Physician's office, urgent care services, Outpatient Facility Services, or Inpatient Facility Services. Benefits will often vary depending on where You choose to get Covered Services, and this can result in a change in the amount You need to pay. Please see the SUMMARY OF BENEFITS for more details on how benefits vary in each setting.

For a list of services and supplies that are not covered by this Plan, and important details on excluded services, please refer to WHAT IS NOT COVERED (Exclusions) – MEDICAL and WHAT IS NOT COVERED – PRESCRIPTION DRUGS.

THIS PLAN ONLY COVERS SERVICES AND SUPPLIES THAT ARE MEDICALLY NECESSARY. ANTHEM RESERVES THE RIGHT TO REVIEW SERVICES AND/OR SUPPLIES TO DETERMINE IF THEY ARE MEDICALLY NECESSARY PRIOR TO THOSE SERVICES BEING RENDERED (PRECERTIFICATION), WHILE SERVICES ARE BEING RENDERED (CONTINUED STAY REVIEW), OR AFTER SERVICES HAVE BEEN PROVIDED (RETROSPECTIVE REVIEW). PLEASE REFER TO THE DEFINITIONS FOR A DEFINITION OF MEDICALLY NECESSARY. ADDITIONAL INFORMATION ON THE REVIEW PROCESS IS AVAILABLE IN THE PART TITLED GETTING APPROVAL FOR BENEFITS OR YOU MAY CALL CUSTOMER SERVICE.

You must satisfy the In Network or Out of Network medical Deductible before we will make payment for services You receive, except for certain services as stated in the sections below. Additionally, the medical Deductible is explained in the SUMMARY OF BENEFITS.

Any limits on the number of visits or days covered are stated under the specific benefit and also listed in the SUMMARY OF BENEFITS. These benefits are subject to all other provisions of this Plan as well, which may also limit benefits or result in benefits not being payable.

Eligibility for coverage cannot be based on health status-related factors: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability, or any other health status-related factor determined appropriate by the United States Secretary of Health and Human Services. This Plan does not discriminate against an individual based on any of the following factors: age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

Acupuncture

Please see "Therapy Services" later in this part.

Allergy Services

Please see "Office Visits" and "Office Visits – Additional Services in an Office Setting" later in this part.

Ambulance Services (Ground, Air and Water)

Precertification is required for all non-Emergency ambulance transportation (see the part GETTING APPROVAL FOR BENEFITS for details).

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a State licensed vehicle that is designed, equipped and used only to transport the sick and/or injured and staffed by Emergency Medical Technicians (EMT), paramedics or other certified medical professionals. Ambulance services include medical and mental health Medically Necessary non-emergency ambulance transportation, including psychiatric transportation for safety issues. This includes ground, water, fixed wing and rotary wing air transportation. Ambulance Services do not include transportation by car, taxi, bus, gurney van, wheelchair van and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Provider.
- For ground ambulance, You are taken:
 - From Your home, scene of an accident or Medical Emergency to a Hospital;
 - Between Hospitals, including when we require You to move from an Out of Network Hospital to an In Network Hospital; or
 - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, You are taken:
 - From the scene of an accident or Medical Emergency to a Hospital;
 - Between Hospitals, including when we require You to move from an Out of Network Hospital to an In Network Hospital
 - Between a Hospital and an approved Facility.

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

Emergency Response Ambulance Services

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if You are not taken to a Facility. If requested through a 911 call, ambulance charges are covered if it is reasonably believed that a Medical Emergency existed even if You are not transported to a Hospital. Payment of benefits for ambulance services may be made directly to the Provider of service unless proof of payment is received by us prior to the benefits being paid.

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

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

Ground Ambulance

Services are subject to Medical Necessity review by Anthem. All scheduled ground ambulance service for non-Emergency transports, not including acute Facility to acute Facility transport, requires Precertification.

Air and Water Ambulance

Air Ambulance Services are subject to Medical Necessity review by Anthem. We retain the right to select the Air Ambulance Provider. This includes fixed wing, rotary wing or water transportation. Air ambulance services for non-Emergency Hospital to Hospital transports require Precertification.

Important Notes on Air Ambulance Benefits

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

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

Hospital to Hospital Transport

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

Fixed Wing Air Ambulance

Fixed wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing air ambulance may be necessary because Your condition requires rapid transport to a treatment Facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate Facility. Transport by fixed wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance Provider.

Rotary Wing Air Ambulance

Rotary wing air ambulance is furnished when the Insured's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by rotary wing air ambulance may be necessary because the Insured's condition requires rapid transport to a treatment Facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate Facility. Transport by rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance Provider.

Autism

Benefits for Covered Services for the treatment of Autism are provided on the same basis as any other medical condition. Please see "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" later in this part.

Bariatric Surgery

Please see "Center of Medical Excellence (CME) for Transplants and Bariatric Surgery" later in this part.

Behavioral Health Treatment for Pervasive Developmental Disorder or Autism

Precertification is required for all inpatient Facility and residential treatment admissions related to Behavioral Health Treatment for Pervasive Developmental Disorder or Autism (see the part GETTING APPROVAL FOR BENEFITS for details).

Benefits for Covered Services and supplies provided for Behavioral Health Treatment for Pervasive Developmental Disorder or Autism are subject to the same cost-sharing provisions and quantitative treatment limitations that are no more restrictive than the predominant financial requirements and quantitative treatment limitations that apply to substantially all medical and surgical benefits in the same classification or sub-classification. These benefits are subject to all other terms, conditions, limitations and exclusions, including WHAT IS COVERED – MEDICAL.

Our Provider network will be limited to certain Qualified Autism Service Providers who may supervise and employ Qualified Autism Service Professionals or Paraprofessionals who provide and administer Behavioral Health Treatment for a Provider that has contracted with Anthem.

For purposes of this section **Behavioral Health Treatment** means professional services and treatment programs, including Applied Behavior Analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder or Autism and that meet all of the following criteria:

- The treatment is prescribed by a licensed Physician or is developed by a licensed psychologist.
- The treatment is provided under a treatment plan prescribed by a Qualified Autism Service Provider and is administered by one of the following:
 - A Qualified Autism Service Provider.
 - A Qualified Autism Service Professional supervised by the Qualified Autism Service Provider.
 - A Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or a Qualified Autism Service Professional.

- The treatment plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six (6) months by the Qualified Autism Service Provider and modified whenever appropriate, and shall be consistent with applicable State law that imposes requirements on the provision of Behavioral Health Treatment services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:
 - Describes the patient's behavioral health impairments to be treated.
 - Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.
 - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or Autism.
 - Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate.
- The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to Anthem upon request.

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

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

For purposes of this section **Pervasive Developmental Disorder or autism** is as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

For purposes of this section **Qualified Autism Service Provider** is either of the following:

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

For purposes of this section **Qualified Autism Service Professional** is a Provider who meets all of the following requirements:

- Provides Behavioral Health Treatment, which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider,
- Is supervised by a Qualified Autism Service Provider,
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Is a behavioral service Provider who meets the education and experience qualifications defined in the state regulations for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program, or who meets equivalent criteria in the state in which he or she practices if not providing services in California and
- Has training and experience in providing services for Pervasive Developmental Disorder or Autism pursuant to applicable State law.

For purposes of this section **Qualified Autism Service Paraprofessional** is an unlicensed and uncertified individual who meets all of the following requirements:

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

Conditions of Services

- Coverage is not provided for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program.
- The treatment plan shall be made available to Anthem upon request.
- Coverage is limited to Behavioral Health Treatment.

Cardiac Rehabilitation Therapy

Please see "Therapy Services" later in this part.

Center of Medical Excellence (CME) for Transplants and Bariatric Surgery

Precertification is required for all services related to Human Organ and Tissue Transplants and Bariatric Surgery (see the part GETTING APPROVAL FOR BENEFITS for details).

Anthem is providing access to the following separate Center of Medical Excellence (CME) networks. The Facilities included in each of these CME networks are selected to provide the following specified medical services:

- **Transplant Facilities.** Transplant Facilities have been organized to provide services for the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. This may include harvesting the organ, tissue or bone marrow and for treatment of complications. These procedures are covered only when performed at a CME.
- **Bariatric Facilities.** Hospital Facilities have been organized to provide services for bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss programs. These procedures are covered only when performed at a CME.

Note: An In Network Provider is not necessarily a CME Facility. Information on CME Facilities can be obtained by calling the telephone number listed on Your ID Card.

Bariatric Surgery (requires Precertification): Services and supplies will be provided in connection with Medically Necessary surgery for weight loss, only for morbid obesity and only when performed at a CME Facility. You or Your Physician must obtain Precertification for all bariatric surgical procedures. **Precertification can be obtained by calling the toll free telephone number listed on your ID Card.** When You or Your Physician calls for the required Precertification, we will advise You that such services must be performed at a CME Facility.

Note: Charges for these bariatric surgical procedures and related services are covered only when the bariatric surgical procedures and related services are performed at a CME Facility.

Bariatric Travel Expense: The following travel expense benefits will be provided in connection with a covered bariatric surgical procedure only when the Insured's home is fifty (50) miles or more from the nearest bariatric CME. All travel expenses must be approved by Anthem in advance. Our maximum payment will not exceed **\$3,000** per surgery for the following travel expenses incurred by the Insured and/or one companion:

- Transportation for the Insured and/or one companion to and from the CME.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Tobacco, alcohol, drug and meal expenses are excluded from coverage.

Customer service will confirm if the bariatric travel benefit is provided in connection with access to the selected bariatric CME. Details regarding reimbursement can be obtained by calling customer service toll free at the number listed on your ID Card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Transplants (requires Precertification): You or Your Physician must obtain Precertification for all services including, but not limited to preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart lung, kidney, pancreas, simultaneous pancreas-kidney, bone marrow/stem cell and similar procedures. Specified transplants must be performed at a Center of Medical Excellence (CME). Charges for services provided for or in connection with a specified transplant performed at a Facility other than a CME will not be considered covered expense. **Precertification can be obtained by calling the toll free number for pre-service review listed on Your ID Card.**

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

Note: Charges for these specified transplants and related services are covered only when the transplant and related services are performed at a CME.

The following **services and supplies** are provided to You in connection with a covered non-investigative organ or tissue transplant, if You are;

- the recipient or
- the donor

If You are the recipient, an organ or tissue donor who is not an enrolled Insured is also eligible for services as described. If You are the donor, and the recipient is not covered by Anthem, no benefits are available under this Plan. Benefits are reduced by any amounts paid or payable by that donor's own coverage.

Transplant Travel Expense. Certain travel expenses incurred by the Insured, up to a maximum \$10,000 Anthem payment per transplant will be covered for the recipient or donor in connection with an approved, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a designated CME qualified to provide services, provided the expenses are authorized by us in advance. All travel expenses are limited up to the maximum set forth in the Internal Revenue Code at the time services are rendered and must be approved by Anthem in advance. Travel expenses include the following for the recipient (and one companion) or the donor:

- Ground transportation to and from the CME when the designated CME is 75 miles or more from the recipient's or donor's place of residence.

- Coach airfare to and from the CME when the designated CME is 300 miles or more from the recipient's or donor's place of residence.
- Lodging, limited to one room, double occupancy.
- Meals, tobacco, alcohol, Drug expenses and other non-food items are excluded.

Note: When the Insured recipient is under 18 years of age, this benefit will apply to the recipient and two companions or caregivers.

When You request reimbursement of covered travel expenses, You must submit a completed travel reimbursement form and itemized, legible copies of all applicable receipts. Credit card slips are not acceptable. Covered travel expenses are not subject to Deductibles or Copayments/Coinsurance. Please call customer service at the telephone number listed on Your ID Card for further information and/or to obtain the travel reimbursement form.

Travel expenses that are not covered include, but are not limited to: meals, alcohol, tobacco, or any other non-food items; child care; mileage within the city where the CME is located, rental cars, buses, taxis or shuttle services; frequent flyer miles, coupons, vouchers or travel tickets; prepayments or deposits; services for a condition that is not directly related, or a direct result of, the transplant; telephone calls; laundry; postage; entertainment; travel expenses for a donor companion/caregiver; or return visits for the donor for a treatment of a condition found during the evaluation.

Unrelated Donor Searches

- For unrelated donor searches for covered bone marrow/stem cell transplants, payment will not exceed \$30,000 per transplant.

Each Year thousands of people's lives are saved by organ transplants. The success rate of transplants is rising, but more donations are needed. This is a unique opportunity to give the gift of life. Anyone who is 18 years of age or older and of sound mind may become a donor when he or she dies. Minors may become donors with a parent or guardian's consent. Organ and tissue donation may be used for transplants and research. Today, it is possible to transplant about 25 different organs and tissues. Your decision to become a donor could someday save or prolong the life of someone You know, even a close friend or family member. If You decide to become a donor, talk it over with Your family. Let Your Physician know Your intentions as well. Obtain a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with Your driver's license or identification card.

Chemotherapy

Please see "Therapy Services" later in this part.

Chiropractic Services

Chiropractic manipulations and/or adjustments as part of a course of chiropractic treatment including but not limited to manipulating the muscle and connective tissue.

Clinical Trials

Benefits include coverage for services given to You as a participant in an approved Clinical Trial if the services are Covered Services under this Plan. An "approved Clinical Trial" means a phase I, phase II, phase III, or phase IV Clinical Trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

- g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review. The peer review requirement shall not be applicable to cancer Clinical Trials provided by i-iii below:
- i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. The Department of Energy.
2. Studies or investigations done as part of an Investigational new Drug application reviewed by the Food and Drug Administration;
 3. Studies or investigations done for Drug trials which are exempt from the Investigational new Drug application.

You may be required to use an In Network Provider to utilize or maximize Your benefits.

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

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

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

Dental Services

Preparing the Mouth for Medical Treatments

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

- Evaluation
- Orthognathic (jawbone) surgery

- Dental X-rays
- Extractions, including surgical extractions
- Fluoride treatment
- Anesthesia

Admissions for dental care up to three (3) days of inpatient Hospital services when a Hospital stay is Medically Necessary.

Treatment of Accidental Injury

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

Benefits are available for the services of a Physician treating an Accidental Injury to Your natural teeth when You receive treatment within one (1) Year following the injury or within one (1) Year following Your Effective Date, whichever is later. Treatment excludes orthodontia.

Dental Anesthesia

General anesthesia and associated Facility charges for dental procedures in a Hospital or Ambulatory Surgery Center are covered if the Insured is:

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

General anesthesia and associated Facility charges for dental procedures are covered under the above conditions even if the dental procedure itself is not covered.

Cleft Palate

Medically Necessary dental or orthodontic services are covered if they are integral to Reconstructive Surgery for cleft palate procedures. Cleft palate is a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Important: If You decide to receive Dental Services that are not covered under this Plan, an In Network Provider who is a dentist may charge You his or her usual and customary rate for those services. Prior to providing You with Dental Services that are not a Covered Service, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about the Dental Services that are covered under this Plan, please call customer service at the telephone number listed on Your ID Card.

Dental Services – Pediatric

Your Dental Benefits. Dental care treatment decisions are made by You and Your dentist. We cover treatment based on what benefits You have, not whether the care is Medically or Dentally Necessary. The only exception is when You get orthodontic care — We do review those services to make sure they're appropriate.

Pretreatment Estimates. When You need major dental care, like crowns, root canals, dentures/bridges, oral surgery or braces — it's best to go over a care or treatment plan with Your dentist beforehand. It should include a "pretreatment estimate" so You know what it will cost.

You or Your dentist can send Us the pretreatment estimate to get an idea of how much of the cost Your benefits will cover. Then You can work with Your dentist to make financial arrangements, before You start treatment.

Pediatric Dental Essential Health Benefits. The following dental care services are covered for Insureds until the end of the month in which they turn nineteen (19). All Covered Services are subject to the terms, limitations and exclusions of this Plan. See the SUMMARY OF BENEFITS for any applicable Deductible, Coinsurance, Copayment, and benefit limitation information. See APPENDIX II, at the end of this Booklet, for the CDT codes listing all coverage and limitations of Your pediatric dental care services.

Diagnostic and Preventive Services

Oral exams

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

- Comprehensive periodontal evaluation for new or established patient

Radiographs (x-rays)

- Complete full mouth series (including bitewings) are covered once per thirty-six (36) months, per provider.
- Periapicals (first radiographic image and each additional radiographic image) are covered twenty (20) films per twelve (12) months, per provider.
- Intraoral – occlusal radiographic images are covered two (2) times per six (6) months per provider, except when documented as essential for a follow-up/post-operative exam (such as after oral surgery).
- Extraoral 2D radiographic images are covered once per day
- Extraoral posterior radiograph images are covered four (4) films per day
- Bitewings (single film) are covered once per date of service
- Bitewings (two films) are covered once per six (6) months, per provider.
- Bitewings (three films) are covered once per six (6) months, per provider.
 - Bitewings (four films) are covered once per six (6) months, per provider **Note:** Bitewings are covered if it has been six (6) months since Complete Full Mouth Series (including bitewings) were taken by the same provider.
- Vertical bitewings seven (7) to eight (8) radiographic images are covered.
- Posterior-Anterior or Lateral Skull and Facial Bone Survey Radiographic image.
- Sialography
- Temporomandibular joint arthrogram, including injection covered three (3) times per day
- Tomographic survey covered twice (2) per twelve (12) months, per provider
- Panoramic film is covered one (1) per thirty-six (36) months per provider (except when documented as essential for a follow-up/post-operative exam).

Consultation with a medical health examiner

Pulp vitality tests

Diagnostic casts are covered as part of orthodontic care.

Dental cleaning (prophylaxis). Procedure to remove plaque, tartar (calculus), and stain from teeth. If You have periodontal maintenance (see Basic Restorative Services later in this section), that will count as an instance towards the dental cleaning benefit frequency. Covered one (1) time per six (6) months. **Fluoride treatment** (topical application or fluoride varnish) is covered one (1) time per six (6) months.

Nutritional counseling

Tobacco counseling for the control and prevention of oral disease

Oral hygiene instructions

Dental sealant treatments are covered for first, second and third molars only. Covered one (1) time per tooth per thirty-six (36) months per provider. The original provider is responsible for any repair or replacement during the thirty-six (36) month period.

Preventive resin restoration is covered for the first, second and third molars only for an active cavity in a pit or fissure of a tooth. Covered one (1) time per tooth per thirty-six (36) months per provider. The original provider is responsible for any repair or replacement during the thirty-six (36) month period.

Sealant repair(s) are covered for the first, second and third molars only. Covered one (1) time per tooth per thirty-six (36) months per provider only on the occlusal surfaces that are free of decay and/or restorations. The original provider is responsible for any repair or replacement during the thirty-six (36) month period.

Caries risk assessment and documentation (low, medium or high)

Other oral pathology procedures (by report)

Space maintainers (fixed and removable). Unilateral space maintainers are covered one (1) time per quadrant. Bilateral space maintainers are covered one (1) time per arch.

Re-cement space maintainers is covered once per provider per applicable quadrant or arch.

Removal of space maintainer is covered only when performed by a Provider that did not initially place the appliance.

Distal shoe space maintainer – fixed – unilateral

Unspecified diagnostic procedure(s) (by report)

Basic Restorative Services

Emergency treatment (also called palliative treatment) is covered for the temporary relief of pain or infection. Covered one (1) time per day per provider.

Fillings (restorations). Amalgam (silver colored) and composite (tooth-colored) fillings are covered under this Plan. Fillings on primary teeth are covered one (1) time per tooth per twelve (12) months. Fillings on permanent teeth are covered one (1) time per tooth per thirty-six (36) months.

Periodontal maintenance is covered four (4) times per twelve (12) months and only twenty-four (24) months after scaling and root planing. If You have a dental cleaning (see Diagnostic and Preventive Services), it will count as an instance toward the periodontal maintenance benefit frequency.

Basic extractions

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

Reattachment of tooth fragment – incisal edge or cusp

Pins and pin build-up is covered when given with a restoration service, such as a filling.

Sedative fillings are covered one (1) time per six (6) months, per provider.

Interim therapeutic restoration – primary dentition

Restorative foundation for an indirect restoration

Miscellaneous services

- Consultation provided by dentist or physician other than requesting dentist or physician
- House calls are covered one (1) time per day.
- Hospital or ambulatory surgical center call
- Office visits are covered one (1) time per day, per provider.
- Therapeutic drug injections are covered four (4) times per day.
- Application of desensitizing medicament covered one (1) time per twelve (12) months per provider.
- Treatment of complications (post-surgical) or unusual circumstances are covered one (1) time per day per provider and only within thirty (30) days of an extraction.
- Local anesthesia in and not in conjunction with operative or surgical procedures is covered one (1) time per day per provider.
- Regional block anesthesia is included in the fee for other procedures and is not payable separately
- Trigeminal division block anesthesia is included in the fee for other procedures and is not payable separately.

Endodontic Services

Endodontic therapy. The following will be covered one (1) time per tooth. Covered on permanent teeth only:

- Root canal therapy
- Root canal retreatment are covered twelve (12) months after the initial root canal therapy when given by the same Provider as the root canal therapy

Root canal obstruction

Internal root repair of perforation defects is to be performed in conjunction with endodontic procedures and not separately.

Other endodontic treatments. Unless otherwise noted below, the following services are covered one (1) time per primary tooth.

- Apexification first visit is covered one (1) time per permanent tooth.
- Apexification – interim medication replacement is covered one (1) time per permanent tooth.
- Apicoectomy, anterior, bicuspid, and molar(s) are covered ninety (90) days after a root canal therapy on a permanent tooth by the same Provider or twenty-four (24) months after apicoectomy/periradicular surgery on a permanent tooth by the same Provider.
- Therapeutic pulpotomy
- Gross pulpal debridement

- Partial pulpotomy for apexogenesis
- Pulpal therapy – anterior or posterior tooth (excluding final restoration)
- Unspecified endodontic procedure, by report

Pulp cap – direct and indirect (excluding final restoration)

Apicoectomy, each additional root

Periradicular surgery without apicoectomy

Retrograde filling – per root

Surgical procedure for isolation of tooth with rubber dam

Periodontal Services

Periodontal scaling and root planing. One (1) to three (3) teeth or four (4) or more teeth are covered one (1) time per quadrant per twenty-four (24) months. Covered for Insureds age thirteen (13) and older.

Biologic materials to aid tissue regeneration

Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation

Full mouth debridement

Chemotherapeutic agents

Unscheduled dressing change, by someone other than treating dentist is covered one (1) time, per provider within thirty (30) days of gingivectomy/gingivoplasty, or osseous surgery.

Complex Surgical Periodontal Care

- **Gingivectomy/gingivoplasty** for one (1) to three (3) contiguous teeth or tooth bounded spaces per quadrant or four (4) or more continuous teeth or tooth bounded spaces is covered one (1) time per quadrant per thirty-six (36) months on Insureds age thirteen (13) and older
- **Apically positioned flap**
- **Crown lengthening**
- **Osseous surgery** for one (1) to three (3) contiguous teeth or tooth bounded spaces per quadrant or four (4) or more continuous teeth or tooth bounded spaces is covered one (1) time per quadrant per thirty-six (36) months on Insureds age thirteen (13) and older

Unspecified periodontal service, by report, is covered for Insureds age thirteen (13) and older.

Oral Surgery Services

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

Complex surgical extractions. Surgical removal of third (3rd) molars are covered only when symptoms of pathology exists.

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth – soft tissue, partially bony, completely bony, and completely bony with unusual surgical complications
- Surgical removal of residual tooth roots

Other oral surgery procedures are covered. Oral surgeries include, but are not limited to:

- Biopsy of oral tissue (hard) are covered one (1) time per arch per date of service, regardless of the areas involved.
- Biopsy of oral tissue (soft) are covered three (3) times per date of service for the removal of the specimen only.
- Excision and removal of lesions, cysts and tumors
- Frenulectomy (frenectomy or frenotomy) is covered one (1) time per arch per day.
- Incision and drainage of abscesses is covered one (1) time per quadrant same date of service.
- Removal of foreign body and removal of reaction producing foreign bodies- each is covered once per date of service.
- Removal of lateral exostosis (maxilla and mandible) is covered once per quadrant for the buccal and or facial exostosis only.
- Removal of palatal torus is covered once in lifetime.
- Removal of mandibular torus is covered one (1) time per quadrant.
- Radical resection of maxilla or mandible
- Oroantral fistula closure
- Sinus perforation – primary closure
- Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth is covered once per arch regardless of the number of teeth involved for permanent anterior teeth only.
- Placement of device to facilitate eruption of impacted tooth
- Sinus augmentation
- Surgical reduction tuberosity is covered one (1) time per quadrant
- Sequestrectomy for osteomyelitis is covered one (1) time per quadrant per date of service and only after thirty (30) days has passed since an extraction.

Intravenous conscious sedation, IV sedation and general anesthesia are covered when given with a covered complex surgical service. The service must be given in a dentist's office by the dentist or an employee of the dentist

that is certified in their profession to give anesthesia services. Non-intravenous conscious sedation may be used for Insureds under thirteen (13) when they are uncooperative.

Local anesthesia.

- Covered in conjunction with operative or surgical procedures (such as filling, crowns, or oral surgery) but is not payable separately.
- Covered one (1) time per date of service when not in conjunction with operative or surgical procedures (such as a filling, crown or oral surgery) to perform a different diagnosis or as an injection to eliminate or control a disease or abnormal state.

Nitrous oxide is covered for Insureds under thirteen (13) when they are uncooperative. Covered for Insureds age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the Insured from responding to the provider's attempts to perform treatment. Not covered on the same date of service as deep sedation/general anesthesia (D9220 and D9221), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248) and when all associated procedures on the same date of service by the same provider are denied. Covered only when given in a dental office by a Provider that is acting within the scope of their license.

Major Restorative Services

Permanent crowns are covered one (1) time per sixty (60) months for Insureds age thirteen (13) and older. The following crowns are covered under this Plan:

- Resin (lap procedure)
- $\frac{3}{4}$ resin-based composite (indirect)
- Resin with predominantly base metal
- Porcelain with ceramic substrate
- Porcelain fused to predominately base metal
- $\frac{3}{4}$ cast predominately base metal
- $\frac{3}{4}$ porcelain/ceramic
- Full cast predominately base metal

Recement inlay, onlay or partial coverage restoration are covered one (1) time per twelve (12) months per provider.

Recement cast or prefabricated post and core

Recement crown is covered twelve (12) months after initial placement of crown. Covered only when given by the same Provider that placed the crown.

Core buildup including any pins

Restorative cast post and core buildup is covered one (1) time per tooth.

Additional cast post and core buildup, same tooth

Prefabricated post and core (in addition to crown) are covered one (1) time per tooth.

Post removal not in conjunction with endo

Each prefabricated additional post, same tooth

Additional procedure to construct new crown under existing partial dental framework

Prefabricated crowns

- Porcelain/ceramic on primary tooth is covered one (1) time per twelve (12) months
- Stainless steel crown on primary tooth is covered one (1) time per twelve (12) months
- Stainless steel crown on permanent tooth is covered one (1) time per thirty-six (36) months
- Resin on primary tooth is covered one (1) time per twelve (12) months and resin on permanent tooth is covered one (1) time per thirty-six (36) months
- Stainless steel with resin window is covered one (1) time per twelve (12) months for primary tooth and one (1) time per thirty-six (36) months for permanent tooth

Note: Prefabricated crowns for permanent teeth are not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.

Crown repair is covered every twelve (12) months after initial placement or repair of the crown by the same Provider.

Unspecified restorative procedure

Occlusal guards are covered one (1) per twelve (12) months for Insureds ages thirteen (13) and up with temporomandibular joint disorders.

Occlusion Analysis, mounted case – once per twelve (12) months for analysis for temporomandibular joint disorder.

Occlusal Adjustment (limited and complete) – limited occlusal adjustment is covered once (1) per twelve (12) months per quadrant per provider for Insureds age thirteen (13) and up and for natural teeth only. Complete occlusal adjustment is covered once in a 12-month period following occlusion analysis mounted case for temporomandibular joint dysfunction disorders only.

Prosthodontic Services – Removable

Complete and partial dentures are covered one (1) time per sixty (60) months for the replacement of extracted permanent teeth. If You have an existing denture or partial, a replacement is only covered if at least sixty (60) months has passed and it cannot be repaired or adjusted. Types of partial dentures covered are resin base and cast

metal with resin base. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

Immediate dentures (upper and lower) are covered one (1) time per arch per lifetime. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

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

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

Overdenture (complete and partial)

Relines. Chairside or laboratory relines are covered one (1) time per twelve (12) months following placement of a complete or partial denture without extractions. Covered one (1) time if six (6) months following placement of a complete or partial denture with extractions. Not a benefit within twelve (12) months of the opposite type of reline. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

Repairs and replacement of broken clasps are covered two (2) times per twelve (12) months per arch, up to three (3) clasps per visit per provider. All adjustments made for six months after the date of repair, in the same arch by the same provider are included in the fee for this procedure. **Replace missing or broken teeth** are covered two (2) times per twelve (12) months per arch, up to four (4) teeth per visit per provider. All adjustments made for six months after the date of repair in the same arch and by the same provider are included in the fee for this procedure. .

Adding tooth and clasp to existing partial denture is covered up to a maximum of three (3) teeth per date of service per provider. All adjustments made for six months after the date of repair in the same arch by the same provider are included in the fee for this procedure.

Denture and partial denture adjustments are covered two (2) times per twelve (12) months per provider. Covered once (1) if six (6) months have passed from initial placement, reline or repair.

Denture (complete), resin denture base, cast framework repairs are covered two (2) times per twelve (12) months per arch per provider. All adjustment made for six (6) months after the date of repair in the same arch and by the same provider are included in the fee for this procedure.

Tissue conditioning (upper and lower) is covered two (2) times each appliance per thirty-six (36) months. Not a benefit same date of services as chairside or laboratory reline. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.

Precision attachment

Unspecified removable prosthodontic procedure

Prosthodontic Services – Fixed

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

A bridge made of the following material(s) is covered under this Plan:

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

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

- $\frac{3}{4}$ cast predominantly base metal
- $\frac{3}{4}$ porcelain ceramic
- Full cast predominantly base metal

Bridge adjustments and repairs are covered twelve (12) months after initial placement or repair of crown by the same Provider.

Re-cementation of bridge is covered twelve (12) months after initial placement of bridge. Covered only when given by the same Provider that placed the appliance.

Unspecified fixed prosthodontic procedure

Implants Services

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

Implant supported structures.

- Semi-precision attachment
- Prefabricated
- Custom prefabricated

Implant/Abutment Supported Prosthetics including:

- Connecting bar – implant supported or abutment supported
- Prefabricated abutment – includes modification and placement
- Custom fabricated abutment – includes placement
- Abutment supported porcelain/ceramic crown
- Abutment supported porcelain fused to metal crown (high noble metal)
- Abutment supported porcelain fused to metal crown (predominantly base metal)
- Abutment supported porcelain fused to metal crown (noble metal)

- Abutment supported cast metal crown (high noble metal)
- Abutment supported cast metal crown (predominantly base metal)
- Abutment supported cast metal crown (noble metal)
- Implant supported porcelain/ceramic crown
- Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
- Implant supported metal crown (titanium, titanium alloy, high noble metal)
- Abutment supported retainer for porcelain/ceramic FPD
- Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
- Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
- Abutment supported retainer for porcelain fused to metal FPD (noble metal)
- Abutment supported retainer for cast metal FPD (high noble metal)
- Abutment supported retainer for cast metal FPD (predominantly base metal)
- Abutment supported retainer for cast metal FPD (noble metal)
- Implant supported retainer for ceramic FPD
- Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments
- Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure
- Provisional implant crown
- Repair implant supported prosthesis, by report
- Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment
- Recement implant/abutment supported crown is covered; twelve (12) months after initial placement of crown by same Provider
- Recement implant/abutment supported fixed partial denture (bridge) is covered; twelve (12) months after initial placement of crown by same Provider
- Abutment supported crown – (titanium)
- Repair implant abutment, by report
- Implant removal, by report
- Implant /abutment supported removable denture for edentulous arch – maxillary
- Implant /abutment supported removable denture for edentulous arch – mandibular
- Implant /abutment supported removable denture for partially edentulous arch – maxillary
- Implant /abutment supported removable denture for partially edentulous arch – mandibular

- Implant /abutment supported fixed denture for edentulous arch – maxillary
- Implant /abutment supported fixed denture for edentulous arch – mandibular
- Implant /abutment supported fixed denture for partially edentulous arch – maxillary
- Implant /abutment supported fixed denture for partially edentulous arch – mandibular
- Radiographic/surgical implant index, by report
- Abutment supported retainer crown for FPD (titanium)
- Unspecified implant procedure, by report

Alveoloplasty is covered in conjunction with extractions. Alveoplasty not in conjunction with extractions is covered after six (6) months of any extraction in the same quadrant for the same provider.

Vestibuloplasty is covered one (1) time per arch per sixty (60) months. Vestibuloplasty that includes grafts and/or muscle reattachment is covered one (1) time per arch per lifetime.

Facial prosthetics. Facial prosthetics are covered under this Plan, including, but not limited to:

- Facial moulage (sectional and complete)
- Nasal
- Auricular
- Orbital
- Ocular (permanent and interim)
- Facial
- Nasal septal
- Cranial
- Facial augmentation implant
- Mandibular resection, with and without guide flange
- Obturator (surgical, definitive and interim)
- Speech aids are covered to age eighteen (18)
- Palatal augmentation
- Palatal lift (definitive and interim)
- Obturator prosthesis (modification) is covered two (2) times per twelve (12) months

Facial prosthetics replacements – nasal, auricular, orbital, facial, obturator (surgical and definitive)

Additional maxillofacial procedures, includes:

- Speech aids (modification) are covered two (2) times per twelve (12) months
- Palatal lift (modification) is covered two (2) times per twelve (12) months
- Trismus appliance (not for temporomandibular joint disorder treatment)
- Feeding aids are covered to age eighteen (18)

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

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

Medically Necessary Orthodontic Care

Orthodontic Care

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

Medically Necessary orthodontic care. This Plan will only cover orthodontic care when it is Medically Necessary to restore the form and function of the oral cavity, such as through the result of an injury or from dysfunction resulting from congenital deformities. To be considered Medically Necessary orthodontic care, at least one (1) of the following criteria must be present:

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

Orthodontic treatment may include the following:

- Pre-orthodontic treatment visits are covered one (1) time every three (3) months.
- Periodic treatment visits are covered four (4) times per Year.
- Comprehensive or complete treatment. A full treatment case that includes all radiographs (such as 2D cephalometric (two (2) films per twelve (12) months) per provider, 2D oral/facial images (four (4) per day), 3D photographic images, models, orthodontic appliances and office visits.

- Orthodontic retention is covered one (1) time per arch per course of treatment. Repair or replacement of lost or broken retainer is covered one (1) time per appliance. Replacement covered only within twenty-four (24) months of placement of the orthodontic retainer.
- Complex surgical procedures. Surgical procedures given for orthodontic reasons, such as exposing impacted or unerupted teeth, or repositioning of the permanent teeth one (1) time per arch per lifetime, with active orthodontia treatment), transseptal fiberotomy one (1) time per arch per lifetime, with active orthodontia treatment).

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

The first (1st) payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your dental Provider should submit the necessary forms telling Us when Your appliance is installed. Payments are then made at six (6) month intervals until the treatment is finished or coverage under this Plan ends. Your Cost Share for Medical Necessary orthodontic care applies to Your course of treatment, not individual benefit Years with a multi-Year course of treatment.

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

What Orthodontic Care Does NOT Include. Coverage is NOT provided for:

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

Important: If You opt to receive dental services that are not Covered Services under this Plan, an In Network dental Provider may charge You their usual and customary rate for those services. Prior to providing a patient with dental services that are not covered, the dentist should provide You with a treatment plan that includes each anticipated service to be given, as well as the estimated cost for each service. If You would like more information about Your dental coverage options, call customer service at the telephone

number listed on Your ID Card. To fully understand Your coverage, You should carefully read this entire booklet.

Timely Access to Dental Care

Anthem has contracted with dental Providers to provide covered services in a manner appropriate for Your condition, consistent with good professional practice. Anthem ensures that its network of contracted dentists has the capacity and availability to offer appointments within the following timeframes:

- Urgent care appointments: within 72 hours of the request for an appointment;
- Non-urgent appointments for primary care: within 36 business days of the request for an appointment; and
- Preventive dental care appointments: within 40 business days of the request for an appointment.

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

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

If You need the services of an interpreter, the services will be coordinated with scheduled appointments and will not result in a delay of Your appointment.

Diabetes Equipment, Education and Supplies

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

1. The following Diabetes Equipment and Supplies
 - Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips
 - Insulin Pumps and all related necessary supplies
 - Pen delivery systems for Insulin administration
 - Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent or treat diabetes-related complications
 - Visual aids (but not eyeglasses) to help the visually impaired to properly dose Insulin

Note: This equipment and supplies are covered under the Plan's benefits for the section Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics, and Medical and Surgical Supplies.

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

Note: Diabetes education services are covered under the Plan's benefits for professional services by Physicians.

3. The following medications and supplies are covered under WHAT IS COVERED – PRESCRIPTION DRUGS:
- Insulin, glucagon and other Prescription Drugs for the treatment of diabetes
 - Insulin syringes
 - Urine testing strips and lancet puncture devices.
-

Note: These items must be obtained from a retail Pharmacy.

4. Screening for gestational diabetes and Type 2 Diabetes Mellitus are covered under "Preventive Care" later in this part.

Diagnostic

Certain diagnostic procedures, including advanced imaging procedures, wherever performed, require Precertification (see the part GETTING APPROVAL FOR BENEFITS for details).

Diagnostic Services

This Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Physician and include diagnostic services ordered before a surgery or Hospital admission.

Benefits include the following services:

- **Diagnostic Laboratory and Pathology Services**
- **Diagnostic Imaging Services and Electronic Diagnostic Tests**
 - X-rays / regular imaging services
 - Ultrasound
 - Electrocardiograms (EKG)

- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.
- **Advanced Diagnostic Imaging Services**
Benefits include but are not limited to:
 - Computed Tomography (CT) scan
 - Computed Tomography Angiography (CTA) scan
 - Magnetic Resonance Imaging (MRI) scan
 - Magnetic Resonance Angiogram (MRA) scan
 - Magnetic Resonance Spectroscopy (MRS) scan
 - Nuclear Cardiology (NC) scan
 - Positron Emission Tomography (PET) scans
 - PET/CT Fusion scans
 - Quantitative Computed Tomography (QCT) Bone Densitometry
 - Diagnostic CT Colonography

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

Dialysis

Please see "Therapy Services" later in this part.

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

Covered Services are subject to change. For a list of current Covered Services, please call customer services at the telephone number listed on Your ID Card.

Durable Medical Equipment and Medical Devices

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

- Is meant for repeated use
- Is primarily and customarily used to serve a medical purpose

- Is meant for use outside a medical Facility and appropriate for use in the home
- Is only for the use of the patient and generally not useful to a person who is not ill or injured
- Is ordered by a Physician

Benefits include purchase only equipment and devices (e.g., crutches and customized equipment), purchase or rent to purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices).

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

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it. We cover the following durable medical equipment for use in your home (or another location used as your home):

- Standard curved handle or quad cane and replacement supplies
- Standard or forearm crutches and replacement supplies
- Dry pressure pad for a mattress
- IV pole
- Enteral pump and supplies
- Bone stimulator
- Osteogenesis stimulation devices
- Tracheostomy tube and supplies
- Hospital-grade breast pump and double breast pump kit (one per pregnancy or as required by law)
- Cervical traction (over door) equipment
- Phototherapy blankets or phototherapy (bilirubin) light with photometer for treatment of jaundice in newborns
- Non-segmental home model pneumatic compressor for the lower extremities

Orthotics and Special Footwear

When Medically Necessary, benefits are available for:

- Orthotics (braces, boots, splints) for foot disfigurements resulting from bone deformity, motor impairment, paralysis, or amputation. This includes but is not limited to, disfigurement caused by cerebral palsy, arthritis, polio, spina bifida, diabetes, accident, injury, or developmental disability, and
- Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent or treat diabetes-related complications

Covered Services include determining if You need the device, initial purchase, fitting, adjustment, and repair of a custom made rigid or semi-rigid supportive device.

Prosthetics and Devices

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

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- Artificial limbs and accessories
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes
- Breast prosthesis (whether internal or external) after a Medically Necessary mastectomy, as required by the Women's Health and Cancer Rights Act. Custom-made prostheses when Medically Necessary, up to three (3) brassieres required to hold a prosthesis every twelve (12) months and adhesive skin support attachment for use with external breast prosthesis
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Insureds who require tube feeding in accordance with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury or congenital defect
- Colostomy supplies
- Restoration prosthesis (composite facial prosthesis)
- Prosthetic devices (except electronic voice producing machines) to restore a method of speaking after laryngectomy

This Plan also covers internally implanted prostheses that are implanted during a covered surgery, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints.

Medical and Surgical Supplies

This Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like bandages, thermometers, and petroleum jelly.

Blood and Blood Products

This Plan includes coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank. Benefits include Hospital services for blood, blood plasma, blood derivatives and blood factors, and blood transfusions, including blood processing and storage costs.

Ostomy and Urological Supplies

This Plan includes coverage for ostomy and urological supplies soft goods formulary (listed in the generic):

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

Diabetic Equipment and Supplies

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

Asthma Treatment Equipment and Supplies

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

Emergency Care

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

You are also covered for Emergency Care You get when You are outside of our Service Area. Please see "Inter-Plan Arrangements" in the part CHOICE OF IN NETWORK PROVIDER OR OUT OF NETWORK PROVIDER for an explanation of how these services are covered.

Emergency Services

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

Emergency (Emergency Medical Condition)

"Emergency" or "Emergency Medical Condition" means a medical condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that not getting immediate medical care could result in:

1. placing the patient's health in serious danger or, for a pregnant woman, placing the woman's health or the health of her unborn child in serious danger;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures.

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

Emergency Medical Condition includes a Psychiatric Emergency Medical Condition, which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

1. an immediate danger to himself or herself or to others, or
2. immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Emergency Care

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

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

If You are admitted to the Hospital from the Emergency room, be sure that You or Your Physician calls us as soon as possible. See the part GETTING APPROVAL FOR BENEFITS for more details. If You or Your Physician do not call us, You may have to pay for services that are not Medically Necessary.

Treatment You get after Your condition has stabilized is not Emergency Care. If You continue to get care from an Out of Network Provider, Covered Services will be covered at the Out of Network level unless we agree to cover it as an Authorized Service.

Family Planning Services

Covered Services include:

- Family planning counseling and education (see “Health Education” and “Preventive Care” later in this part)
- Over the counter FDA approved contraceptive methods for women as prescribed by a health care Provider (see “Preventive Care” later in this part)
- Women’s contraceptives and sterilization procedures (see “Preventive Care” later in this part)
- Voluntary and therapeutic abortions (see “Maternity Care” later in this part)
- Men’s sterilization procedures (see “Preventive Care” later in this part for more information)

Fertility Preservation Services

Services for fertility preservation, including preservation and storage costs, are covered when medically necessary for an Insured who will undergo transgender surgery in the treatment of gender dysphoria. Fertility preservation

services are also covered for Insureds who are at risk of infertility due to surgery or gonadotoxic therapies such as chemotherapy, radiation therapy, or hormone therapy in the treatment of cancer or tumors. In addition to the applicable Coinsurance of this Plan, coverage is subject to a Copayment of \$250 for both In Network and Out of Network Providers and a lifetime benefit limit of \$20,000. Note that this benefit covers fertility preservation services only. This Plan does not provide any coverage for the testing or treatment of Infertility.

Habilitation Services

Please see "Rehabilitation and Habilitation Services" later in this part.

Health Education

Health education counseling, programs and material to help You take an active role in protecting and improving your health, including programs for tobacco cessation, chronic conditions (such as diabetes and asthma) and stress management.

Hearing Services

Covered Services include:

- Routine hearing screenings (see "Preventive Care" later in this part)
- Hearing exams to determine the need for hearing correction (see "Preventive Care" later in this part)
- Services related to the ear or hearing, such as outpatient care to treat an ear infection and outpatient Prescription Drugs, supplies and supplements (see "Office Visits" later in this part and the part WHAT IS COVERED – PRESCRIPTION DRUGS)
- Cochlear implants (see "Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies" earlier in this part)

Home Care Services

Precertification is required for Home Care Services (see the part GETTING APPROVAL FOR BENEFITS for details).

Benefits are available for Covered Services performed by a Home Health Care Agency or other professional Provider in Your home. To be eligible for benefits, You must be substantially confined to your home (or a friend's or relative's home). A Physician must determine that it is feasible to effectively supervise and control your care in your home and the services can be safely and effectively provided in your home. Services must be prescribed by a Physician and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff. Covered Services include but are not limited to:

- A registered nurse
- A medical social service worker
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- A health aide who is employed by, or under arrangement with, a Home Health Agency or Visiting Nurse Association. A health aide is covered only if You are also receiving the services of a registered nurse or licensed therapist
- A licensed therapist for Physical Therapy, Occupational Therapy, speech or respiratory therapy
- Necessary medical supplies provided by the Home Health Agency or Visiting Nurse Association
- Private Duty Nursing when Medically Necessary and approved by Anthem

Limitations:

- Limited to 100 visits per Benefit Period. This limit applies separately to rehabilitative services and habilitative services.
- Limited to up to two (2) hours per visit for visits by a nurse, medical social worker or physical, occupational, or speech therapist and up to four (4) hours per visit for visits by a home health aide.
- Up to three (3) visits per day.
- The ordering Physician must be treating the illness or injury necessitating the Home Health Care.
- Providers in California must be a California licensed Home Health Agency or Visiting Nurse Association.
- We will not cover personal comfort items.

Hospice Care

Precertification is required for Hospice Care (see the part GETTING APPROVAL FOR BENEFITS for details).

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

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient Hospital care when needed in periods of crisis.
- Short-term inpatient Hospital care as respite care. Inpatient respite care is limited to a maximum of five (5) consecutive days per admission.
- Skilled nursing services, home health aide services and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes or hyperalimentation
- Physical Therapy, Occupational Therapy, speech therapy and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment and supplies needed for the palliative care of Your condition, including oxygen, related respiratory therapy supplies and incontinence supplies.
- Bereavement (grief) services.

Your Physician and Hospice medical director must certify that You are terminally ill and likely have less than twelve (12) months to live. Your Physician must agree to care by the Hospice and must be consulted in the development of Your care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care are available to the Insured in Hospice. These additional Covered Services will be covered under other sections of this part.

Limitations:

The following services, supplies or care are not covered:

- Services or supplies for personal comfort or convenience, including homemaker services that are not under the supervision of a registered nurse
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition
- Services not directly related to the medical care of the Insured, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services

- Services provided by volunteers

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

Please see "Center of Medical Excellence (CME) for Transplants and Bariatric Surgery" earlier in this part.

Infusion Therapy

Please see "Therapy Services" later in this part.

Inpatient Facility Services

Precertification is required for all inpatient Facility and residential treatment admissions except for Emergency admissions, inpatient Hospital stays for childbirth, and mastectomy surgery, including the length of Hospital stays associated with mastectomy and breast reconstruction surgery for breast cancer. For Emergency admissions, You, Your authorized representative or Physician must tell us within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time. See the part GETTING APPROVAL FOR BENEFITS for details.

For the treatment of mental disorders or Substance Abuse, in addition to Hospitals, the covered services described in this section apply to Residential Treatment Centers, acute psychiatric Facilities, and psychiatric health Facilities to the extent the services are provided by these Facilities, for example room, board, nursing services, and medical social services.

Inpatient Facility Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most Anthem will cover for private rooms is the Hospital's average semi-private room rate unless a private room is Medically Necessary.
- A room in a Special Care Unit if Medically Necessary. The unit must have Facilities, equipment, and supportive services for intensive care or critically ill patients.
- Meals, special diets.
- General nursing services and special nursing care.

- Medical social services and discharge planning.

Benefits for ancillary services include:

- Operating, childbirth, recovery, and treatment rooms and equipment.
- Prescribed Drugs.
- Blood, blood products, and their administration.
- Anesthesia and oxygen supplies and services given by the Hospital.
- Medical and surgical dressings and supplies, casts, and splints.
- Durable medical equipment.
- Radioactive materials used for therapeutic purposes.
- Diagnostic services including imaging, laboratory, and special procedures such as MRI, CT, and PET scans.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when Your condition requires it.
- Benefits include treatment by two or more Physicians during one Hospital stay when the nature or severity of Your health problem calls for the skill of separate Physicians.
- A personal bedside exam by another Physician when asked for by Your Physician. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Physician other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity Care

Maternity Services

If You would like to participate in our Future Moms program, please call us at the telephone number listed on Your ID Card within the first twelve (12) weeks of Your pregnancy to notify us of Your estimated date of delivery, Your Physicians name, and the name of the Hospital You have chosen for delivery of Your child. The Future Moms program helps expectant women establish a healthy lifestyle for a healthy pregnancy. Participation in the Future Moms program is not required nor does it impact eventual coverage of Your maternity services.

Covered Services include services needed during a normal or Complicated Pregnancy and services needed for a miscarriage including:

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

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

Abortion Services

Benefits include services for:

- Voluntary abortion
- Therapeutic abortion, which is a Medically Necessary abortion recommended by a Provider, performed to save the life or health of the mother; prevent harm to the women's physical or mental health; terminate a pregnancy where indications are that the child will have a significantly increased chance of premature morbidity or mortality or be otherwise disabled; or to selectively reduce the number of fetuses to lessen health risks associated with multiple pregnancy.

Mental Health and Substance Abuse (Chemical Dependency) Services

Precertification is required for all Mental Health and Substance Abuse inpatient Facility and residential treatment admissions except in a Medical Emergency (for a list of services that require Precertification, see the part GETTING APPROVAL FOR BENEFITS).

(See the "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" section above for coverage and Precertification requirements for those services.)

Covered Services include but are not limited to the following:

- **Inpatient Services.** Services provided in a Hospital or in other inpatient facilities, including but not limited to Residential Treatment Centers, acute psychiatric Facilities, and psychiatric health Facilities. Also covered are services provided by a Physician while you are an inpatient in one of these facilities. These services are covered subject to the Cost Shares shown in the SUMMARY OF BENEFITS for Mental Health and Substance Abuse inpatient services, under "Mental Health and Substance Abuse (Chemical Dependency) Services".
- **Outpatient Services – Office Visits.** Visits to a Physician (both Specialists and non-Specialists) in the Physician's office for services including but not limited to psychotherapy, prescription drug management, physical therapy, and medical services. These services are covered subject to the Cost Shares shown in the SUMMARY OF BENEFITS for Mental Health and Substance Abuse outpatient services – office visit under "Mental Health and Substance Abuse (Chemical Dependency) Services".
- **Outpatient Services – All Other Outpatient Items and Services.** Services and treatment in the outpatient department of a Hospital or other outpatient Facility, such as partial hospitalization, intensive outpatient programs, and visits to a day treatment center. Also covered are other services provided on an outpatient basis, including in an office setting, such as diagnostic laboratory and radiology and psychological testing. These services are covered subject to the Cost Shares shown in the SUMMARY OF BENEFITS for Mental Health and

Substance Abuse outpatient services – all other outpatient items and services under “Mental Health and Substance Abuse (Chemical Dependency) Services”.

You can get Covered Services from Providers including but not limited to a:

- Psychiatrist,
- Licensed clinical psychologist,
- Licensed educational psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Psychiatric mental health nurse,
- Licensed marriage and family therapist (M.F.T.),
- Licensed professional clinical counselor (L.P.C.C.).

Please see the DEFINITIONS section for a list of the Physicians covered by this Plan.

Occupational Therapy

Please see “Therapy Services” later in this part.

Office Visits

An Office Visit is when You go to a Physician's office and have one or more of **ONLY** the following three services provided:

- History-Gathering of information on an illness or injury.
- Examination
- Physician's medical decision regarding the diagnosis and treatment plan.

Office Visit will not include any other services while at the office of a Physician (e.g., any surgery, Infusion Therapy, diagnostic X-ray, laboratory, pathology and radiology) or any services performed other than the three services specifically listed above.

Covered Services include:

- **Office Visits** with Primary care Physicians and Providers (PCP) and Specialty Care Physicians and Providers
- **Home Visits** for medical care to examine, diagnose, and treat an illness or injury.

Note: Physician visits in the home are different than the “Home Care Services” benefit described earlier in this Plan.

- **Retail Health Clinic Visit** for limited basic health care services to Insureds on a “walk-in” basis. These clinics are normally found in major Pharmacies or retail stores. Health care services are typically given by Physician’s Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children
- **Walk-In Physician’s Office** for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Physician’s office
- **Urgent Care** as described in “Urgent Care Services” later in this part
- **Online Care Visits** when available in Your area. Covered Services include a medical visit with the Physician using the internet by a webcam, chat or voice. Online care visits do not include reporting normal lab or other test results, requesting Office Visits, getting answers to billing, insurance coverage or payment questions, asking for Referrals to Physicians outside the online care panel, benefit Precertification, or Physician to Physician discussions
- **Telehealth** as described in “Telehealth” later in this part.
- **After Hours Care.** If You need care after normal business hours, Your Physician may have several options for You. You should call Your Physician’s office for instructions if You need care in the evenings, on weekends, or during holidays and cannot wait until the office reopens. If You have an Emergency, call 911 or go to the nearest Emergency room (see the WHAT IS NOT COVERED (Exclusions) – MEDICAL). This exclusion does not apply to Emergency Services.
- **Second Opinions.** If You have a question about Your condition or about a plan of treatment, which Your Physician has recommended, You may receive a second medical opinion from another Physician. This second opinion visit will be provided according to the benefits, limitations and exclusions of this Plan. If You wish to receive a second medical opinion, remember that greater benefits are provided when You choose an In Network Provider. You may also ask Your Physician to refer You to an In Network Provider to receive a second opinion.

Office Visits – Additional Services in an Office Setting

Certain diagnostic procedures, including advanced imaging procedures, wherever performed, require Precertification (see the part GETTING APPROVAL FOR BENEFITS for details).

Additional services received during an Office Visit include, but are not limited to:

- Injection administration, including allergy serum
- Diagnostic laboratory and pathology services
- Diagnostic imaging services and electronic diagnostic tests
- Advanced diagnostic imaging services

- Office surgery
- Prescription Drugs for the Drug itself dispensed in the office through infusion or injection

Orthotics

Please see “Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies” earlier in this part.

Osteoporosis

Coverage for services related to diagnosis, treatment, and appropriate management of osteoporosis including, but not limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed Medically Necessary.

Outpatient Facility Services

Precertification is required for all outpatient Facility admissions and specific outpatient services, including diagnostic treatment and other services (see the part GETTING APPROVAL FOR BENEFITS for details).

This Plan includes Covered Services in an:

- Outpatient Hospital, including ambulatory care and Physician services,
- Ambulatory Surgical Center, or
- Mental Health / Substance Abuse Facility.

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

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

Pediatric Dental Services

Please see "Dental Services" in this part.

Pediatric Vision Services

Please see "Vision Services" later in this part.

Phenylketonuria (PKU)

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

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

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

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

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

Physical Therapy

Please see "Therapy Services" later in this part.

Preventive Care

Preventive care is given during an Office Visit or as an outpatient. Screenings and other services are covered for Insureds with no current symptoms or history of a health problem.

Insureds who have current symptoms or a diagnosed health problem will get benefits under the "Diagnostic Services" benefit, not this benefit.

Preventive care services will meet the requirements of federal and State law. Preventive care services stated below are covered by this Plan with no Deductible, Copayments or Coinsurance when You use an In Network Provider. That means Anthem pays 100% of the Maximum Allowed Amount. If obtained from an Out of Network Provider, You will be responsible for the Cost Shares shown in the SUMMARY OF BENEFITS. Covered Services include, but are not limited to, those shown below. Services that apply specifically to children are covered only if children are eligible and covered under this Plan.

- Routine physical maintenance exams, including well woman exams and well baby and well child preventive care.
 - Screening and counseling services, such as obesity counseling, routine vision and hearing screenings and hearing exams to determine the need for hearing correction, health education, and depression screening.
 - Alcohol and Substance Abuse screenings.
 - Developmental screenings to diagnose and assess potential developmental delays.
- Scheduled routine prenatal and postpartum exams.
 - Regularly scheduled preventive prenatal care exams after confirmation of pregnancy.
 - Postpartum consultations and exams that primarily deliver or coordinate preventive care services, such as breastfeeding support and counseling, in accordance with recommendations of the United States Preventive Services Task Force (USPSTF).
- Health education counseling programs in connection with the following:
 - Tobacco use, tobacco use-related diseases, and smoking cessation.
 - Chronic conditions including diabetes and asthma.
 - Stress management.
- Immunizations for children, adolescents, and adults, including the vaccine.
- Routine preventive imaging and laboratory services.
 - Mammograms.

- Abdominal aortic aneurysm ultrasound screenings.
- Bone density scans for osteoporosis.
- Routine laboratory tests including cervical cancer screenings (including HPV testing), prostate specific antigen tests, cholesterol tests, screening for blood lead levels, blood glucose tests, glucose tolerance tests, genetic testing for breast cancer susceptibility, certain sexually transmitted infection tests, HIV tests.
- Flexible sigmoidoscopies and screening colonoscopies.
- Preventive care and screening services for women, in addition to the services listed above, provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), including:
 - Well woman visits that are age and developmentally appropriate, including preconception and prenatal care.
 - Gestational diabetes screening.
 - Screening and counseling for interpersonal and domestic violence.
 - Breastfeeding support, supplies, and counseling, including breast pumps. Coverage of breast pumps is limited to one breast pump per pregnancy or as required by law.
- Women's contraceptives, sterilization procedures, education, and counseling.
 - Includes all FDA-approved contraceptive methods for women, including over-the-counter items, if prescribed by a Physician (male contraceptive methods are not covered).
 - Includes follow-up services related to the Drugs, devices, and procedures including but not limited to management of side effects, counseling for continued adherence, and device placement and removal.
 - No cost shares (deductible, copayments, or coinsurance) will apply to these services if they are prescribed by a Physician and obtained from an In Network Provider (or, for items covered as Prescription Drugs, an In Network Pharmacy).
 - This Plan covers as preventive care (subject to no cost shares) at least one form of contraception in each of the methods identified by the FDA in its current Birth Control Guide including but not limited to oral, injectable, and implantable contraceptives, diaphragms, IUDs, contraceptive patches and rings, surgical sterilization, and emergency contraceptives.
 - If Your Physician determines that the forms of contraception covered as preventive care are not appropriate for You based on Your medical or personal history, coverage will be provided for another contraceptive method that is approved by the FDA and prescribed by Your Physician.
 - For FDA-approved, Self-Administered Hormonal Contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies.
 - Certain contraceptives are covered under the Plan's Prescription Drug benefits. Please see that section in the part WHAT IS COVERED – PRESCRIPTION DRUGS for more information.

This Plan also covers sterilization procedures for men, which are not considered preventive care services. Men's sterilization procedures are subject to any Deductible, Copayments, or Coinsurance that applies to other covered non-preventive care services generally.

You may call customer service at the telephone number listed on Your ID Card for more details about these services or view the federal government's websites: <http://www.healthcare.gov/center/regulations/prevention.html>, <http://www.ahrq.gov/clinic/uspstfix.htm>, and <http://www.cdc.gov/vaccines/recs/acip/>.

Prosthetics

Please see "Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies" earlier in this part.

Psycho-Educational Testing

Psycho-educational testing conducted by a licensed clinical, educational, or counseling psychologist in order to assess and diagnose functional limitations due to learning disabilities, including but not limited to attention deficit hyperactivity disorder (ADHD). This benefit covers psycho-educational test batteries including aptitude, achievement, and cognitive tests to assess for cognitive and learning disabilities; a written report listing test scores, testing procedures followed, interpretation of test results, and date(s) of testing. Consultation with the student to review test results and recommendations for appropriate academic accommodation are also covered under this benefit.

Pulmonary Therapy

Please see "Therapy Services" later in this part.

Radiation Therapy

Please see "Therapy Services" later in this part.

Rehabilitation and Habilitation Services

Precertification is required for Skilled Nursing Facility services (see the part GETTING APPROVAL FOR BENEFITS for details).

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

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

Habilitation services means health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both. Examples of health care services that are not habilitation services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care or education services of any kind, including, but not limited to, vocational training. Habilitation services shall be covered under the same terms and conditions applied to rehabilitation services under the Plan.

Respiratory Therapy

Please see "Therapy Services" later in this part.

Residential Treatment Center

Please see "Inpatient Facility" and "Mental Health and Substance Abuse (Chemical Dependency) Services" in this part.

Skilled Nursing Facility

Precertification is required for Skilled Nursing Facility admissions and services (see the part GETTING APPROVAL FOR BENEFITS for details).

When You require inpatient skilled nursing and related services for convalescent and Rehabilitative Care, Covered Services are available if the Facility is licensed or certified under State law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

We cover the following services:

- Physician and nursing services
- Room and board
- Drugs prescribed by a Physician as part of Your plan of care in the Skilled Nursing Facility
- Durable Medical Equipment if Skilled Nursing Facilities ordinarily furnish the equipment
- Imaging and laboratory services that Skilled Nursing Facilities ordinarily provide
- Medical Social Services
- Blood, blood products and their administration
- Medical Supplies
- Physical, Occupational and speech therapy
- Behavioral Health Treatment for Pervasive Developmental Disorder or Autism
- Respiratory therapy

Limitations:

- Limited to 100 days per Skilled Nursing Day Allowance. A Skilled Nursing Day Allowance begins on the date the enrollee is admitted to a hospital or skilled nursing facility at a skilled level of care. A Skilled Nursing Day Allowance ends on the date the enrollee has not been an inpatient in a hospital or skilled nursing facility, receiving a skilled level of care, for 60 consecutive days. A new Skilled Nursing Day Allowance can begin only after any existing Skilled Nursing Day Allowance ends.
- You must be under active supervision of a Physician treating Your illness or injury.

Speech Therapy

Please see "Therapy Services" later in this part.

Surgery

Surgical procedures, wherever performed, require Precertification (see the part GETTING APPROVAL FOR BENEFITS for details).

This Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

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

Bariatric Surgery

Please see "Center of Medical Excellence (CME) for Transplants and Bariatric Surgery" earlier in this part.

Oral Surgery

Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, ectodermal dysplasia, or other craniofacial anomalies associated with cleft palate;
- Orthognathic (jawbone) surgery for a medical condition or injury directly affecting the upper or lower jawbone or associated joints, including the muscles, nerves, and other tissues related to those joints.
- Oral / surgical correction of Accidental Injuries.
- Treatment of lesions, removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Please see "Dental Services" earlier in the part for more information.

Reconstructive Surgery

Benefits include Reconstructive Surgery to correct deformities caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve bodily function or to create a normal appearance, to the extent possible. Benefits also include surgery performed to restore symmetry after a mastectomy.

Mastectomy and Lymph Node Dissections

Insureds who are getting benefits for a mastectomy or for Follow-Up Care for a mastectomy and who choose breast reconstruction, will also get coverage for:

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

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

Telehealth

Benefits are provided for Covered Services that are appropriately provided through Telehealth, subject to the terms and conditions of this Plan. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. Telehealth does not include consultations between the patient and the health care Provider, or between health care Providers, by telephone, facsimile machine, or electronic mail.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Precertification is required for certain diagnostic procedures and tests (see the part GETTING APPROVAL FOR BENEFITS for details).

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

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Precertification is required for Infusion Therapy (in all settings) (see the part GETTING APPROVAL FOR BENEFITS for details).

Physical Medicine Therapy Services

This Plan includes coverage for therapy services. Some Physical Therapy services may also be habilitative services. Habilitation services are covered under the same terms and conditions applied to rehabilitation services under the Plan (see the "Rehabilitation and Habilitation Services" section above for details). To be a Covered Service, the therapy must be Medically Necessary. Treatment is covered when provided by a physical, occupational or speech therapist who acts within the scope of his or her license. Coverage for Physical, Occupational or Speech Therapy services requires referral by a Physician. Covered Services include:

- **Physical Therapy** – The treatment by a physical method to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes the use of heat, cold, exercise, electricity, ultraviolet, massage and aquatic therapy (as part of a Physician Therapy treatment plan) to improve circulation, strengthen muscles and encourage return of motion.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct speech impairment.
- **Occupational Therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and

bathing. It also includes therapy for tasks needed for the person's job. Occupational Therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.

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

Infusion Therapy

Physician prescribed Infusion Therapy (each course of therapy must be Medically Necessary).

- If services are performed in the home, those services must be billed by and performed by a Provider licensed by State and local laws.
- Drugs and other substances used in Infusion Therapy.
- Professional services to order, prepare, dispense, deliver, administer, train or monitor, including clinical Pharmacy support and any Drugs or other substances used in a Course of Therapy.
- Durable, reusable supplies, and durable medical equipment including, but not limited to, pump, pole and electric monitor. Other supplies such as infusion sets and supplies for external infusion pumps and replacement batteries for infusion pumps.
- Blood transfusions, including blood processing and the cost of un-replaced blood and blood products.

Limitations:

Infusion Therapy benefits will not be provided for:

- Compounding fees such as charges for mixing or diluting Drugs, medicines or solutions or incidental supplies including disposable items such as cotton swabs, tubing, syringes and needles for Drugs, adhesive bandages and intravenous starter kits.
- Drugs and medicines not requiring a Prescription.
- Drugs labeled "Caution, limited by federal law to Investigational use" or Drugs prescribed for Experimental use.
 - If Anthem determines that the requested Drug, device, procedure, or therapy is not covered because it is Investigational or prescribed for Experimental indications, the Insured may request an Independent Medical Review. Refer to the part INDEPENDENT MEDICAL REVIEW.
- Drugs or other substances obtained outside the United States.
- Non-FDA approved homeopathic medications or other herbal medications.
- Charges, including the preparation of the finished product, by an Out of Network Provider that exceeds the Prescription Drug Maximum Allowed Amount.
- Medical Supplies and Equipment used in Infusion Therapy will not be reimbursed under any other benefit of this Plan.

Other Therapy Services

Benefits are available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for You after a cardiac event (heart problem). Benefits do not include on-going conditioning or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home Hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include the following:
 - Dialysis treatments in an outpatient dialysis Facility and inpatient dialysis care if Medically Necessary.
 - All other outpatient consultations, evaluations, and treatment, including visits with a multidisciplinary nephrology team.
 - Home dialysis and training for You and the person who will help You with home self-dialysis.
 - Equipment and medical supplies required for home Hemodialysis and home peritoneal dialysis. Coverage is limited to the standard item of equipment of supplies that adequately meets Your medical needs.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore Your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by X-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, non-pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transgender Services

Precertification is required for all inpatient admissions for transgender surgeries and related travel expense; precertification is not required for all other transgender services (see the part GETTING APPROVAL FOR BENEFITS for details).

Medically Necessary services and supplies provided in connection with gender transition are a Covered Service when You have been diagnosed with gender identity disorder or gender dysphoria by a Physician. This coverage is

provided according to the terms and conditions of this Plan that apply to all other covered medical conditions, including Medical Necessity requirements, utilization management, and exclusions for cosmetic services. Coverage includes, but is not limited to, Medically Necessary services related to gender transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training. Also covered is male to female top surgery, electrolysis, and tracheal shaving.

Coverage is provided for specific services according to Plan benefits that apply to that type of service generally, if this Plan includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, Medically Necessary surgery; hormone therapy would be covered under the Plan's Prescription Drug benefits (if such benefits are included).

Transgender Travel Expense. Certain travel expenses incurred in connection with an approved transgender surgery will be covered, when the Hospital at which the surgery is performed is 75 miles or more from Your place of residence, provided the expenses are authorized in advance by us. Our maximum payment will not exceed \$10,000 per transgender surgery, or series of surgeries (if multiple surgical procedures are performed), for the following travel expenses incurred by You and one companion:

- Ground transportation to and from the Hospital when it is 75 miles or more from Your place of residence.
- Coach airfare to and from the Hospital when it is 300 miles or more from Your place of residence.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Meals, tobacco, alcohol, Drug expenses and other non-food items are excluded.

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

When You request reimbursement of covered travel expenses, You must submit a completed travel reimbursement form and itemized, legible copies of all applicable receipts. Credit card slips are not acceptable. Please call customer service at the telephone number listed on Your ID Card for further information and/or to obtain the travel reimbursement form.

Travel expenses that are not covered include, but are not limited to: meals, alcohol, tobacco, or any other non-food items; child care; mileage within the city where the Hospital is located, rental cars, buses, taxis or shuttle services; frequent flyer miles, coupons, vouchers or travel tickets; prepayments or deposits; services for a condition that is not directly related to, or a direct result of, the surgery; telephone calls; laundry; postage; or entertainment.

Transplant Services

Please see "Center for Medical Excellence (CME) for Transplants and Bariatric Surgery" earlier in this part.

Urgent Care Services

Urgent care benefits are for those services necessary to prevent serious deterioration of Your health resulting from an unforeseen illness, injury or complication of an existing condition, including pregnancy. In the case of pregnancy, this would include services necessary to prevent serious deterioration of the health of a woman or her unborn child.

You are also covered for Urgent Care Services when You are outside of our Service Area. Please see "Inter-Plan Arrangements" in the part CHOICE OF IN NETWORK PROVIDER OR OUT OF NETWORK PROVIDER for an explanation of how these services are covered.

Vision Services

Except for pediatric vision services (see below) and vision screenings covered as preventive care services, coverage is limited to medical and surgical treatment of injuries and illnesses of the eye. Coverage is subject to the same cost-sharing provisions, including any Deductible, Copayments, or Coinsurance, that apply to other covered medical services, except as specified for contact lenses prescribed for aniridia.

We cover special contact lenses for aniridia only when prescribed by an In Network Physician or In Network Optometrist. We will cover up to two (2) Medically Necessary contact lenses per eye (including fitting and dispensing) in any Benefit Period to treat aniridia (missing iris) at no cost share. We will not cover an aniridia contact lens if we provided an allowance toward (or otherwise covered) more than one aniridia contact lens for that eye within the previous twelve (12) months (including when we provided an allowance toward, or otherwise covered, one (1) or more aniridia contact lenses under any other Plan).

Vision screenings required to be covered by state law are covered under the part WHAT IS COVERED – MEDICAL, under the section "Preventive Care." These screenings are covered at no cost share when obtained from an In Network Provider

Vision Services - Pediatric

Vision Care that is Covered:

The following vision care benefits are available to Insureds until the last day of the month in which the individual turns nineteen (19) years of age. We will cover vision care that is listed in this section. See Your SUMMARY OF BENEFITS for the benefit frequencies and Your Cost Share amounts for covered vision care. We will not pay for vision care listed in the part WHAT IS NOT COVERED (Exclusions) – MEDICAL under "Vision Care."

Routine Eye Exam with refraction

This Plan covers a complete eye exam with dilation as needed. The exam is used to check all aspects of Your vision, including the structure of the eyes and how well they work together.

Eyeglass Lenses

You have a choice in Your eyeglass lenses. The following lens options are included at no extra cost when received In Network: fashion and gradient tinting; oversized and glass-grey #3 prescription sunglass lenses; blended segment lenses; intermediate vision lenses; standard, premium, select and ultra progressive lenses; photochromic glass lenses, plastic photosensitive lenses; polarized lenses, standard, premium and ultra anti-reflective coating; high index lenses; polycarbonate lenses; scratch-resistant coating.

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

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

Frames

- We offer a selection of frames that are covered under this Plan
- Frames are limited to Once every Benefit Period

Elective Contact Lenses

- A one (1) Year supply of contact lenses is covered every Benefit Period
- Coverage includes fitting, evaluation, and follow-up care for both elective and non-elective contact lenses (see below)
- Elective contact lenses are contacts that You choose instead of eyeglasses for comfort or appearance. You may choose elective contact lenses in lieu of Your eyeglass lenses benefit. We offer a selection of contact lenses that are covered under this Plan

Non-Elective Contact Lenses

- Non-elective contacts may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Non-elective contact lenses are provided when Medically Necessary, including but not limited to the following conditions:
 - Keratoconus, pathological myopia, aphakia, Anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism
 - High Ametropia exceeding -12D or +9D in spherical equivalent
 - Anisometropia of 3D or more
 - Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses

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

Note: If You receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until You satisfy the benefit frequency listed in the SUMMARY OF BENEFITS.

Low Vision

Low vision is a significant loss of vision, but not total blindness. Providers specializing in low vision care can evaluate and prescribe optical devices and provide training instruction to maximize the remaining usable vision for our Insureds with low vision.

Low vision benefits include:

- Comprehensive Low Vision Exam
- Optical/Non-optical aids, including items such as high-power spectacles, magnifiers and telescopes
- Supplemental testing and follow-up care

Timely Access to Vision Care

Anthem ensures that its contracted vision care provider networks have the capacity and availability to offer appointments within the following timeframes:

- Urgent Care appointments within seventy-two (72) hours of the request for an appointment;
- Non-urgent appointments for vision care: within thirty-six (36) business days of the request for an appointment;
- Preventive vision care appointments: within forty (40) business days of the request for an appointment
- After hours care (when a vision provider's office is closed): In Network vision Providers are required to have an answering service or a telephone answering machine during non-business hours, which will provide instructions

on how you can obtain urgent or Emergency Care including, when applicable, how to contact another vision provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or Emergency Care;

- Question for Anthem's customer service by telephone on how to get care or solve a problem: 10 minutes to reach a live person by phone during normal business hours.

WHAT IS NOT COVERED (Exclusions) – MEDICAL

This list of services and supplies are excluded from Your medical coverage under this Plan and will not be covered in any case. Your Prescription Drug benefits are explained in the part WHAT IS COVERED – PRESCRIPTION DRUGS. Exclusions for Prescription Drugs are explained in the part WHAT IS NOT COVERED (Exclusions) – PRESCRIPTION DRUGS.

Acts of War, Disasters, or Nuclear Accidents: In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give You Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of service in the armed forces. This exclusion does not apply to acts of terrorism.

Administrative Charges

- Charges to complete claim forms,
- Charges to get medical records or reports,
- Membership, administrative, or access fees charged by Physicians or other Providers. Examples include, but are not limited to, fees for educational brochures or calling You to give You test results.

After Hours or Holiday Charges: Coverage is not provided for additional charges beyond the Maximum Allowed Amount for basic and primary services for services requested after normal Provider service hours or on holidays. This exclusion does not apply to Emergency Services or to Urgent Care Services.

Alternative/Complementary Medicine: Coverage is not provided for (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy (unless part of a Physical Therapy treatment plan), reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

Breast Reduction/Augmentation: Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes unless the removal or replacement is due to complications resulting from cosmetic breast augmentation. Augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer. No coverage is provided

for surgical treatment of gynecomastia, unless Medically Necessary. Breast reduction is covered only if Medically Necessary.

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.

Charges Over the Maximum Allowed Amount: Charges over the Maximum Allowed Amount for Covered Services.

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. No benefits are available for surgery or treatments to change the texture or look of Your skin or to change the size, shape or look of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts).

This exclusion does not apply to Reconstructive Surgery for breast symmetry after a mastectomy, surgery to correct birth defects and birth abnormalities, 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.

Counseling Services: religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

Court Ordered Care: to include testing or care, unless Medically Necessary and Precertified (see the part GETTING APPROVAL FOR BENEFITS for details).

Custodial Care: Coverage is not provided for assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medicine). This exclusion does not apply to assistance with activities of daily living that is provided as part of covered Hospice Care, Skilled Nursing Facility, inpatient Hospital care, or occupational therapy (see these benefits in the provisions "Hospice Care", "Inpatient Facility Services", "Skilled Nursing Facility", and "Therapy Services" in the part WHAT IS COVERED--MEDICAL.

Dental implants for Insured age nineteen (19) and over: (material implanted into or on bone or soft tissue) or any associated procedure as part of the implantation or removal of implants unless specifically stated as a Covered Service.

Dental Services: Coverage is not provided for:

- Dental care for Insureds age 19 and older except as provided for in the part WHAT IS COVERED – MEDICAL, in the section “Dental Services.”
- Hospital services beyond those specified under “Dental Services” in the part WHAT IS COVERED--MEDICAL, Prescription Drug charges and Dental Services or supplies that do not have an American Dental Association Dental Procedure Code).
- Dental Services completed prior to the date the Insured became eligible for coverage.
- Analgesia, analgesia agents, medicines and Drugs for surgical or non-surgical care.
- Local anesthetic when billed separately from a Covered Service, as this is included as part of the final service, such as for restorative services (fillings, crowns).
- Dental Services performed other than by a licensed dentist, licensed Physician, his or her employees.
- Dental Services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings. This exclusion does not include Medically Necessary orthodontic care for Insureds up to age 19.
- 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 (cavities) exist.
- Incomplete services where the final permanent appliance (denture, partial, bridge) or restorative (crown, filling) has not been placed.
- Athletic mouth guards, enamel micro abrasion and odontoplasty.
- Bacteriologic tests. Please refer to Your medical coverage to determine if this is a covered medical benefit.
- Cytology sample collection. Please refer to Your medical coverage to determine if this is a covered medical benefit.
- Separate services billed when they are an inherent component of another Covered Service.
- Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), and precision attachments.
- Provisional splinting, temporary procedures or interim stabilization.
- Images.
- Anatomical crown exposure.
- Temporary anchorage devices.

- Sinus augmentation.
- Amalgam or composite restorations, inlays, onlays and/or crowns placed for preventive purposes.
- Temporomandibular Joint Disorder (TMJ) except as covered under Your medical coverage.
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.

Dental X Rays, Supplies & Appliances: and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service. The only exceptions to this are for any of the following:

- Transplant preparation.
- Initiation of immunosuppressives.
- Direct treatment of acute traumatic injury, cancer, or cleft palate.
- General anesthesia as listed in the part WHAT IS COVERED – MEDICAL in the sections “Dental Services,” “Dental Services – Pediatric,” “Inpatient Facility Services,” “Outpatient Facility Services” or “Surgery.”

Devices that are not approved by the federal Food and Drug Administration.

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

Disposable Supplies for home use: Bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies. This exclusion shall not apply to disposable supplies covered in WHAT IS COVERED – MEDICAL in the sections “Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies,” “Home Care Services” and “Hospice Care,” and WHAT IS COVERED – PRESCRIPTION DRUGS.

Drugs, medications or other substances that are:

- Not approved by the federal Food and Drug Administration.
- Dispensed or administered in any setting except as specifically stated in the part WHAT IS COVERED – PRESCRIPTION DRUGS.
- Obtained with a non-prescription chemical and dose equivalent (over the counter Drugs).

Note: Your Prescription Drug benefits are also subject to exclusions. For additional information, refer to the part WHAT IS NOT COVERED (Exclusions) – PRESCRIPTION DRUGS.

Durable Medical Equipment, except as specifically stated in the part WHAT IS COVERED – MEDICAL in the section “Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies”:

- Orthopedic shoes or shoe inserts, except as specifically stated in the part WHAT IS COVERED – MEDICAL in the sections “Diabetes Equipment, Education and Supplies” and “Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies”
- Air purifiers, air conditioners, humidifiers
- Exercise equipment, treadmills
- Pools and spas
- Elevators
- Supplies for comfort, hygiene or beautification
- Correction appliances or support appliances and supplies such as stockings

Educational Services: Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Plan under the part WHAT IS COVERED – MEDICAL, in the sections “Diabetes Equipment, Education and Supplies” and “Psycho-Educational Testing”.

Exams: Related to research screenings that are part of a voluntary research program or testing where the screening or exam would be paid for by the research program.

Experimental or Investigational Services: Services or supplies that are Experimental or Investigational. 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 a Covered Service if it is Experimental / Investigational.

If the Insured has a life-threatening or seriously debilitating condition and the requested treatment is not a Covered Service because it is Experimental or Investigational, the Insured may request an Independent Medical Review. See the part INDEPENDENT MEDICAL REVIEW for further details.

This exclusion does not apply to services covered under "Clinical Trials" in the part WHAT IS COVERED – MEDICAL nor to the complications that may arise from non-Covered Services such as cosmetic surgery or Experimental Services.

Eyeglasses/Contact Lenses: for Prescription, fitting, or purchase of eyeglasses or contact lenses unless specifically stated as a Covered Service in this Plan or as required by law. Items and services such as eye surgery or contact lenses to reshape the eye for purposes of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism. This exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition. This exclusion does not apply to Insureds under age 19.

Eye Surgery: Corrective eye surgery to correct errors of refraction. Surgery includes without limitation nearsightedness (myopia), astigmatism and/or farsightedness (presbyopia), LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

Foot Care: Coverage is not provided for:

- routine foot care (including the cutting or removal of corns and calluses).
- nail trimming, cutting or debriding.
- hygienic and preventive maintenance foot care.
- cleaning and soaking the feet.
- applying skin creams in order to maintain skin tone.
- other services that are performed when there is not a localized illness, injury or symptom involving the foot.

Hair loss or growth treatment: Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Health Club Memberships and Fitness Services: Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

Hearing Aids: Hearing aids and hearing tests to determine their efficacy and hearing tests to determine an appropriate hearing aid, except for as stated in WHAT IS COVERED – MEDICAL in the section "Preventive Care." This exclusion does not apply to cochlear implants.

Home Care

- Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider, except for Hospice Care (see the part WHAT IS COVERED – MEDICAL in the section “Hospice Care”).
- Food, housing, homemaker services and home delivered meals with the exception of Medically Necessary enteral and parenteral formulas.

Human Growth Hormone for long-term treatment of pediatric patients with growth failure from lack of adequate endogenous growth hormone secretion, unless Medically Necessary.

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.

Incarceration: Coverage is not provided 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.

Infertility testing and treatment: For testing or treatment related to fertilization or Infertility such as diagnostic tests performed to determine the reason for Infertility and any service billed with an Infertility related diagnosis.

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

Missed or Canceled Appointments.

Non-Authorized Travel Related Expenses: for mileage, lodging and meals costs, and other Insured travel related expenses, except as authorized by us or specifically stated as a Covered Service, see the part WHAT IS COVERED – MEDICAL in the sections “Center of Medical Excellence (CME) for Transplants and Bariatric Surgery” and “Transgender Services”.

Non-Emergency Care Received in an Emergency Room: Coverage is not provided for care received in an Emergency room that is not Emergency Care, except as specified in this Plan. This includes, but is not limited to, suture removal in an Emergency room.

Non-Licensed Providers: Treatment or services provided:

- by a non-licensed Provider under the supervision of a licensed Physician, except as stated in the part WHAT IS COVERED – MEDICAL in the section “Behavioral Health Treatment for Pervasive Developmental Disorders or Autism.”
- for which a health care Provider license is not required.

Not Medically Necessary: Any services or supplies which are not Medically Necessary.

Nutritional or Dietary Supplements: Nutritional and/or 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.

Orthodontic Services: This includes dental braces, other orthodontic appliances and any related service unless specifically stated as a Covered Service. This exclusion does not apply to Insureds up to age 19 or with cleft palate conditions.

Outdoor Treatment Programs and/or Wilderness Programs.

Over the Counter: Coverage is not provided for Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Plan or as required by law. See the part WHAT IS COVERED – MEDICAL in the sections “Family Planning Services” and “Preventive Care.” Also see the part WHAT IS COVERED – PRESCRIPTION DRUGS.

Personal Hygiene, Environmental Control or Convenience Items: Coverage is not provided for personal hygiene, environmental control, or convenience items including but not limited to:

- Air conditioners, humidifiers, air purifiers;
- Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; 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 or similar facility.
- Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
- Charges from a health spa or similar facility;
- Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor’s meals;

- Charges for non-medical self-care except as otherwise stated;
- Purchase or rental of supplies for common household use, such as water purifiers;
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
- Infant helmets to treat positional plagiocephaly;
- Safety helmets for Insureds with neuromuscular diseases; or
- Sports helmets.

Physical Exams: Physical exams to sign up for insurance, as a term of employment, for licensing, or for school activities.

Physician/Other Providers' Charges including:

- Physician or Other Providers' charges for consulting with Insureds by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Insured.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for Your care.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
- Physician stand-by charges.

Private Duty Nursing: Inpatient or outpatient services of a private duty nurse unless provided by a Home Health Care Provider or a Hospice Provider.

Prosthetics: Prosthetics for sports or cosmetic purposes, unless specifically stated as a Covered Service in this Plan or as required by law. This includes wigs and scalp hair prosthetics.

Providers Services: You get from a non-covered Provider, as defined in this Plan. Examples of non-covered Providers include, but are not limited to, masseurs or masseuses, physical therapist technicians, and athletic trainers.

Reversal of Voluntary Sterilization: Reversal of voluntary sterilization or costs associated with the storage of sperm, eggs, embryos and ovarian tissue.

Self-Help Training/Care: For self-help training and other forms of non-medical self care, except as specifically stated in the part WHAT IS COVERED – MEDICAL, in the section “Diabetes Equipment, Education and Supplies” or as required by law.

Services not approved by the federal Food and Drug Administration: Drugs, supplements, tests, vaccines, devices, radioactive materials and any other services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion applies to services provided anywhere, even outside the U.S.

This exclusion does not apply to any of the following:

- Services covered under the “Emergency Care” and “Urgent Care Services” sections of WHAT IS COVERED - MEDICAL that you receive outside the U.S.
- Experimental or investigational services when an investigational application has been filed with the FDA and the manufacturer or the other source makes the services available to You or Anthem through an FDA-authorized procedure, except that we do not cover services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol
- Services covered under “Clinical Trials” in the part WHAT IS COVERED – MEDICAL

Services or Supplies from Family Members: Services prescribed, ordered, referred by or given by a member of Your immediate family, including Your spouse, Domestic Partner, child, brother, sister, parent, in-law, or self.

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.

Shock Wave Treatment: Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

Spinal Decompression Devices: including, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000. Cervical traction (over door) equipment is not excluded.

Surrogacy: Services or supplies provided to a person not covered under this Plan in connection with a surrogate pregnancy including, but not limited to, the bearing of a child by another woman for an infertile couple.

Teeth (Congenital Anomaly): Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Plan under the part WHAT IS COVERED – MEDICAL in the sections “Dental Services” or “Dental Services – Pediatric” or as required by law. This exclusion does not apply to Insureds under the age 19.

Teeth, Jawbone, Gums: For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service under the part WHAT IS COVERED – MEDICAL in the sections “Dental Services” and “Dental Services – Pediatric.”

Telephone/Internet consultations: For telephone consultations or consultations via electronic mail or internet/website, except as required by law, or specifically stated as a Covered Service. See the part WHAT IS COVERED – MEDICAL in the section “Telehealth.”

Temporomandibular or Craniomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

Therapy: Coverage is not provided for services, supplies, and equipment for the following:

- Gastric electrical stimulation.
- Hippotherapy.
- Intestinal rehabilitation therapy.
- Prolotherapy.
- Recreational therapy.
- Sensory integration therapy (SIT).

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

Vision care: We will not pay for services incurred for, or in connection with, any of the items below.

- Vision care for Insured age 19 and older, unless covered by the medical benefits of this Plan.
- For which the Insured has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Insured’s immediate family, including the Insured’s spouse, Domestic Partner, child, brother, sister or parent.

- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a network Provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient Hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Insured has reached the Insured's normal interval for service when seeking replacements.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- No benefit is available for frames purchased outside of our formulary.

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

Weight Loss Programs: Programs, whether or not under medical supervision, unless listed as covered in this 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 including bariatric surgery.

WHAT IS COVERED – PRESCRIPTION DRUGS

What You Pay for Prescription Drugs

You may avoid higher out-of-pocket expenses by choosing an In Network Pharmacy or by utilizing the Student Health Center whenever possible. In addition, you may also reduce your costs by asking your Physician, and your pharmacist, for the more cost-effective generic form of Prescription Drugs.

Prescription Drug Tiers

Your Copayment/Coinsurance amount may vary based upon how the Prescription Drug, including covered Specialty Drugs, has been classified by us into a particular “tier”. Refer to Your SUMMARY OF BENEFITS to determine Your Copayment or Coinsurance amount for each tier, and whether any Deductible applies. The determination of tiers is made by us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. The tier placement of a Prescription Drug may vary based on the dosage and administration (i.e., by mouth, shots, topical or inhaled) of the Prescription Drug. This may result in the coverage of one form of a Prescription Drug but not another or the other forms of administration of a Prescription Drug in a different tier. The placement of a particular drug on a given tier is subject to change. But you will not be required to change to a different Drug if that Drug has previously been approved for you and that Drug is changed to a different tier or removed from the Formulary (see “Prescription Drug List” below for information about the Formulary). Please see the DEFINITIONS section for a description of each tier.

Note: Your Copayments and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem’s designated Pharmacy benefits manager from Drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem’s designated Pharmacy benefits manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by our Insureds, and where proper, certain clinical economic reasons. Not all forms of a Prescription Drug may be included on the Drug List. The inclusion of a Prescription Drug on the Drug List may vary by the dosage and administration (i.e., mouth, shots, topical or inhaled) of the Prescription Drug. This may result in the coverage of one dosage or form of a Prescription Drug but not another. The Drug List is subject to change.

If You have a question regarding whether a Drug is on the Prescription Drug List, please call the telephone number listed on Your ID Card.

Your Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List. To receive Drugs that are not on our Prescription Drug List, see 'Prior Authorization' later in this part. This Prescription Drug List contains a limited number of Prescription Drugs, and may be different than the Prescription Drug List for other Anthem products. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Prescription Drug List is available upon request and online (see SUMMARY OF BENEFITS: PRESCRIPTION DRUG BENEFITS for the link to the Formulary). **In cases where Your Physician prescribes a medication that is not on the Prescription Drug List, it may be necessary to obtain Prior Authorization in order for the Prescription to be a covered benefit. Physicians and Insureds are informed of the Prior Authorization process through the Insured's Plan, Anthem's web site - www.anthem.com/ca and the Provider's manual. Please see the "Prior Authorization" section below on how to file a claim for Medically Necessary Prescription Drugs if payment is denied at the Pharmacy due to failure to obtain prior authorization.**

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA). Prescription Drugs must be prescribed by a licensed Provider and You must get them from a licensed Pharmacy.

Subject to the terms and conditions explained in this section, and the exclusions shown in WHAT IS NOT COVERED (Exclusions) – PRESCRIPTION DRUGS, this Plan covers all Medically Necessary Prescription Drugs, including disposable devices that are Medically Necessary for the administration of a covered outpatient Prescription Drug,

such as spacers and inhalers for the administration of aerosol outpatient Prescription Drugs and syringes for self-injectable medications that are not dispensed in pre-filled syringes.

Benefits are available for the following:

- Prescription Drugs from a Retail Pharmacy;
- Specialty Drugs;
- Self Administered Injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin including syringes;
- Disposable needles and syringes needed for injecting Covered Prescription Drugs and supplements;
- All FDA-approved contraceptive methods for women, including over-the-counter items, if prescribed by a Physician (male contraceptive methods are not covered). This Plan covers at least one form of contraception in each of the methods identified by the FDA in its current Birth Control Guide including but not limited to oral, injectable, and implantable contraceptives, diaphragms, contraceptive patches and rings, and emergency contraceptives. In order to be covered as preventive care, contraceptive Prescription Drugs must be either a Generic or single-source Brand Drug (a single-source Brand Drug is a Drug for which there is no Generic equivalent), be prescribed by a Physician, and obtained from an In Network Pharmacy. Multi-source Brand Drugs (those that have a Generic equivalent) will be covered as preventive care if Medically Necessary as determined by Your Physician (see 'Prior Authorization' later in this part). For FDA-approved, Self-Administered Hormonal Contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies. Certain contraceptives are covered under the Plan's medical benefits. Please see that section in the part WHAT IS COVERED – MEDICAL under the section "Preventive Care" for more details;
- Flu Shots (including administration);
- AIDS vaccine (when approved).
- Appropriate pain management medications for terminally ill patients.
- Weight loss Drugs when Medically Necessary for the treatment of morbid obesity. (See WHAT IS NOT COVERED (Exclusions) – PRESCRIPTION DRUGS for exclusions.)
- One-hundred (100) day supply of Drugs prescribed for the treatment of sexual dysfunction disorders.

Retail Pharmacy

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

You can visit one of the local Retail Pharmacies in our network. Give the Pharmacy the Prescription from Your Physician and Your Identification Card and they will file Your claim for You. Refer to Your SUMMARY OF BENEFITS for any Copayment, Coinsurance, and/or Deductible that applies when You obtain Prescription Drugs. If You do not have Your Identification Card, the Pharmacy will charge You the full retail price of the Prescription and will not be able to file the claim for You. You will need to ask the Pharmacy for a detailed receipt and send it to us with a written request for payment.

Helpful tip: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to You in a medical setting (e.g., Physician's office, home care visit, or outpatient Facility) are covered in the part WHAT IS COVERED – MEDICAL in the sections "Centers for Medical Excellence (CME) for Transplants and Bariatric Surgery," "Home Care Services," "Inpatient Facility Services," "Office Visits," "Office Visits – Additional Services in an Office Setting," "Outpatient Facility Services," "Skilled Nursing Facility," "Therapy Services" or "Urgent Care Services." Please read those parts for important details.

Specialty Pharmacy

Specialty Drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty Drugs may require nursing services or special programs to encourage patient compliance. **Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.**

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have Your Prescription for a Specialty Drug filled through Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a thirty (30) day supply per fill. The Specialty Preferred Provider will deliver Your Specialty Drugs to You by mail or common carrier for self administration in Your home. You cannot pick up Your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or Your Physician may order Your Specialty Drug from the Specialty Preferred Program by calling **1-800-870-6419**. The Specialty Preferred Provider has dedicated care coordinators to help You take charge of Your health problem and offers toll-free twenty-four (24) hour access to nurses and pharmacists to answer Your questions about Specialty Drugs. A dedicated care coordinator will work with You and Your Physician to get prior authorization. When You call the Specialty Preferred Provider, a dedicated care coordinator will guide You through the process up to and including actual delivery of Your Specialty Drug to You. When You order Your Specialty Drug by telephone, You will need to use a credit or debit card to pay for it. You may also submit Your Specialty Drug Prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once You have met Your Deductible, if any, You will only have to pay the cost of Your Copayment or Coinsurance as found in the SUMMARY OF BENEFITS. When You order Your Specialty Drug by mail, You will need to use a check, money order, credit or debit card to pay for it.

You or Your Physician may obtain a list of Specialty Drugs available through the Specialty Preferred Provider by contacting Member Services by calling toll free **1-800-870-6419** or online at www.anthem.com/ca. You or Your Physician may also obtain order forms by contacting Member Services or by accessing our website at www.anthem.com/ca.

Attn: **Anthem Specialty Pharmacy Program**

2825 Perimeter Road

Mail Stop – INRX01 A700

Indianapolis, IN 46241

Phone: **1-800-870-6419**

Fax: **1-800-824-2642**

How to obtain an exception to the Specialty Pharmacy Program

If You believe that You should not be required to get Your Specialty Drug through the Specialty Pharmacy Program, You or Your Physician must complete an exception to the Specialty Pharmacy Program form to request an exception and send it to us. The form can be mailed or faxed to us. If You need a copy of the form, You may call us at the telephone number listed on Your ID Card to request one. You can also get the form online at www.anthem.com/ca. If we have given You an exception, it will be in writing for the approved amount of time as medically appropriate. If You believe that You still should not be required to get Your medication through the Specialty Pharmacy Program, when Your prior exception approval expires, You must again request an exception. If we deny Your request for an exception, it will be in writing and will tell You why we did not approve the exception.

Urgent or Emergency Need of a Specialty Drug Subject to the Specialty Pharmacy Program

If You are out of a Specialty Drug which must be obtained through the Specialty Pharmacy Program, we will authorize an override of the Specialty Pharmacy Program requirement for seventy-two (72) hours, or until the next business day following a holiday or weekend to allow You to get a seventy-two (72) hour Emergency supply of medication, or the smallest packaged quantity, whichever is greater, if Your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If You order Your Specialty Drug through the Specialty Preferred Provider and it does not arrive, if Your Physician decides that it is Medically Necessary for You to have the Drug immediately, we will authorize an override of the Specialty Pharmacy Program requirement for a thirty (30) day supply or less to allow You to get an Emergency supply of medication from an In Network Pharmacy near You. A customer service representative from the Specialty Preferred Provider will coordinate the exception and You will not be required to pay additional Coinsurance or Copayment.

Oral Anti-Cancer Prescription Drugs

With few exceptions, most orally administered anti-cancer medications are considered Specialty Drugs. For orally administered anti-cancer medications, the Deductible, if any, will not apply and the Copayment will not exceed the

lesser of the applicable Copayment shown in the SUMMARY OF BENEFITS or \$200 for a 30-day supply for medications obtained at a Retail Pharmacy.

Important Details about Prescription Drug Coverage

Your Prescription Drug coverage includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, Your prescribing Physician may be asked to give more details before we can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your In Network Pharmacist will be told of any rules when You fill a Prescription, and will also be told about any details we need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for Your health and safety. Certain Drugs may require prior authorization. Also, an In Network Pharmacist can help arrange prior authorization or dispense an Emergency amount. If there are patterns of over utilization or misuse of Drugs, we will notify Your personal Physician and Your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact Your Provider to get the details we need to decide if prior authorization should be given. We will give the results of our decision to both You and Your Provider. Insureds must use the prior authorization process outlined here to request coverage for medications not on the Prescription Drug List. In addition, the prior authorization process is used to approve requests from Your Provider for contraceptive methods that are Medically Necessary for You based on Your medical or personal history.

Your Physician may submit a prior authorization form to Anthem. This form is available by calling the telephone number listed on Your ID Card, online at www.anthem.com/ca or by contacting the Specialty Preferred Provider at **1-800-870-6419** (see "How to obtain an exception to the Specialty Pharmacy Program" above). You may call customer service at the telephone number listed on Your ID Card to ask that a prior authorization form be faxed to Your Physician. If Your request is urgent, Anthem offers a seventy-two (72) hour override for California Insureds to receive three (3) days of their medication. Your Physician may also request the seventy-two (72) hour override. This temporary supply is provided as a courtesy pending completion of the review request. If approved, the Drug or Drugs will be provided for the duration of therapy.

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

The prior authorization review process is outlined below:

- The PBM handles the first review.
 - If the Anthem defined criteria is met, the PBM will communicate to the Physician and Insured about length of time and approval provided.
 - If the Anthem defined criteria is NOT met, the PBM will communicate to the Physician and Insured about the denial.
 - The letters contain steps for additional review including information about filing a Grievance.
 - In some cases, a secondary review is handled by the Medical Reviewers at Anthem if additional medical justification needs to be established.
- For Pain Management requests for terminally ill patients, if a request is denied or more information is required, the Provider will be contacted within one working day of that determination. The requested treatment will be authorized if this timeframe expires.

- Anthem medical reviewers handle the second review.
 - This review may require or include Physician peer-to-peer discussion and additional documentation prior to final decision.
 - Any decision is communicated to both Physician and Insured along with our standard Grievance process for the Insured to use if needed.
- How to file a claim for reimbursement for Medically Necessary Prescription Drugs if payment is denied at the Pharmacy due to failure to obtain prior authorization (further details can be found in the part IMPORTANT INFORMATION ABOUT THIS PLAN, in the sections "How to file medical claims" and "How to send a member claim form"):
 - Provide Anthem with a Notice of Claim and member claim form.
 - The member claim form can be found online at www.anthem.com/ca or requested by calling customer service at the telephone number listed on Your ID Card.
 - Prior to submitting Your member claim form and itemized bill, You should make copies of the documents for Your own records and attach the original bills to the completed member claim form. The bills and the member claim form should be mailed to:

Prescription Drug Program

Attn: Commercial Claims

P.O. Box 2872

Clinton, IA 52733-2872

Except for expedited reviews of urgent requests, either the PBM or Anthem, as appropriate, will make a determination and notify You and the Provider within 72 hours of receiving the completed request. For urgent requests, determination and notification will be made within 24 hours. For requests of Medically Necessary contraceptives, Anthem will approve the request based on the Provider's determination within two days.

If prior authorization is denied You have the right to file a Grievance as outlined in the part COMPLAINTS AND GRIEVANCES.

For a list of Drugs that need prior authorization, please call the telephone number listed on Your ID Card or visit www.anthem.com/ca. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under Your Prescription Drug coverage. Your Provider may check with us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or Generic Drugs are covered under the Prescription Drug coverage.

Step Therapy

Step therapy is a process in which You may need to use one type of drug before we will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost effective Prescription Drugs. If a Physician decides that a certain Prescription Drug is needed, the prior authorization will apply.

Administered by a Medical Provider

This Plan also covers Prescription Drugs when they are administered to You as part of a Physician's visit, home care visit, or at an outpatient Facility. This includes Drugs for Infusion Therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when Your Provider orders the Drug and administers it to You. Benefits for Drugs that You inject or get at a Pharmacy (i.e., Self Administered Injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the "Retail Pharmacy" section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Retail Pharmacy" benefit. Also, if Prescription Drugs are covered under the "Retail Pharmacy" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the SUMMARY OF BENEFITS. In most cases, You must use a certain amount of Your Prescription (e.g., 85%) before it can be refilled.

Federally Classified Schedule II attention deficit hyperactivity disorder (ADHD) Drugs that require a tamper-resistant prescription form are covered up to a 60-day supply and require a double copay.

Half-Tablet Program

The Half-Tablet Program lets You pay a reduced Copayment on selected "once daily dosage" Drugs on our approved list. The program lets You get a thirty (30) day supply (fifteen (15) tablets) of the higher strength Drug when the Physician tells You to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and You should talk to Your Physician about the choice when it is available. To get a list of the Drugs in the program call the telephone number listed on Your ID Card.

Special Programs

From time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, over the counter Drugs, or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, we may allow access to network rates for Drugs not listed on our Formulary.

Claims and Member Service

For information and assistance, the Insured may call customer service at the telephone number listed on Your ID Card or write us at:

Anthem Blue Cross Life and Health Insurance Company

Anthem Prescription Drug Program

21555 Oxnard Street

Woodland Hills, CA 91367

WHAT IS NOT COVERED (Exclusions) – PRESCRIPTION DRUGS

In addition to the exclusions in WHAT IS COVERED – PRESCRIPTION DRUGS, certain items are not covered under the Prescription Drug benefit:

Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by us or the Pharmacy Benefits Manager (PBM).

Note: Administration charges for Drugs administered by a medical provider are covered as a medical service in the part WHAT IS COVERED – MEDICAL, in the sections “Hospice Care”, “Office Visits – Additional Services in an Office Setting”, and “Therapy Services”.

An allergenic extract or vaccine.

Note: Allergenic extract or vaccine is covered in the part WHAT IS COVERED – MEDICAL, in the sections “Office Visits” and “Office Visits – Additional Services in an Office Setting.”

Compound Drugs: Compounded products unless the Drug is listed on our Drug Formulary or one of the ingredients requires a Prescription by law.

Drugs over quantity limits: Drugs in quantities which are over the limits set by Anthem.

Drugs over the quantity prescribed or refills after one (1) Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one (1) Year after the date of the original Prescription Order.

Drugs that do not need a Prescription: Anthem may exclude over the counter Drugs or Prescription Drugs with over the counter equivalents except for prescribed contraceptives and over the counter Drugs recommended by the U.S. Preventive Service Task Force when prescribed by a health care Provider.

Drugs used for cosmetic purposes.

Items covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.

Note: Durable Medical Equipment (DME) is covered in the part WHAT IS COVERED – MEDICAL, in the section “Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies.”

Lost or stolen Drugs: Stolen Drugs or refills of lost Drugs (excluding those from Specialty Pharmacy).

Mail service programs: Prescription Drugs dispensed by any Mail Service program, unless we must cover them by law.

Non-approved Drugs: Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require FDA approval in order to be sold in the United States but are not approved by the FDA.

Off label use: Off label use is covered, as long as it meets the following criteria:

1. The drug is FDA-approved;
2.
 - a. The drug is prescribed for the treatment of a life-threatening condition; or
 - b. The drug is prescribed for treatment of a chronic and seriously debilitating condition, is medically necessary to treat that condition, and is on the formulary. If the drug is not on the formulary, the request for coverage shall be considered pursuant to California state Health & Safety Code § 1367.24;
3. The drug has been recognized for treatment of that condition by any of the following:
 - a. The American Hospital Formulary Service's Drug Information;
 - b. One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
 - i. The Elsevier Gold Standard's Clinical Pharmacology;
 - ii. The National Comprehensive Cancer Network Drug and Biologics Compendium;
 - iii. The Thomson Micromedex DrugDex;
 - iv. Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

Any medically necessary services associated with the administration of a drug are also covered.

Prescription Drugs prescribed for the purpose of treating infertility, except when medically necessary or prescribed for other purposes.

Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.

Weight loss Drugs: Weight loss Drugs unless Medically Necessary for treatment of morbid obesity.

Note: Medically Necessary weight loss Drugs are covered in the part WHAT IS COVERED – PRESCRIPTION DRUGS in the section “Covered Prescription Drugs.”

GETTING APPROVAL FOR BENEFITS

Covered Services must be Medically Necessary for benefits to be covered. (See the part DEFINITIONS for the terms "Medically Necessary and Medical Necessity.") A service, treatment or admission may not be Medically Necessary even though it is prescribed or recommended by a Physician. For example, a service that was initially prescribed or requested may not be Medically Necessary if You have not previously tried alternative treatments that are more cost-effective. If a service, treatment or admission is not Medically Necessary, it is excluded from coverage as set forth in the part WHAT IS NOT COVERED (Exclusions) – MEDICAL.

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

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

Review criteria are based on many sources including medical policy and clinical guidelines. We may decide that a requested treatment is not Medically Necessary if a clinically equivalent treatment that is more cost-effective is available and appropriate.

If You have any questions regarding the medical policies or clinical guidelines, please call customer service at the telephone number listed on Your ID Card.

As described in this part, this Plan includes the processes of Precertification, Continued Stay Review, and Retrospective review to decide when services are Medically Necessary. Through the Precertification process, You may determine the Medical Necessity of a service, treatment or admission before receiving the service, treatment or admission. Anthem will not deny a service, treatment or admission on grounds it is not Medically Necessary if You obtain Precertification before obtaining the service, treatment or admission provided the Precertification is not modified or revoked prior to receiving the service, treatment or admission and the service, treatment or admission remains the same. Please consider obtaining Precertification to avoid having a service, treatment or admission denied after it is received because it is not Medically Necessary.

Precertification does not guarantee coverage for or payment of the service, treatment or admission subject to the Precertification review. In addition to being Medically Necessary, on the date You get a service, treatment or admission:

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

If You disagree with a Medical Necessity determination made by us, You have the right to file a Grievance as outlined in the part COMPLAINTS AND GRIEVANCES and a request for Independent Medical review as outlined in the part INDEPENDENT MEDICAL REVIEW.

Precertification

Precertification is the required review of a service, treatment or admission for a Medical Necessity determination and must be done before the service, treatment or admission start date.

In Network Providers will initiate the review on Your behalf. An Out of Network Provider may or may not initiate the review for You and it is Your responsibility to initiate the process and ask Your Physician to request Precertification. You may also call us directly at the telephone number listed on Your ID Card.

Precertification criteria are based on multiple sources including medical policy, clinical guidelines, and Pharmacy and therapeutics guidelines. Services for which Precertification is required (i.e., services that need to be reviewed by us to determine whether they are Medically Necessary) are the following:

- All inpatient Facility and residential treatment admissions, including detoxification and rehabilitation except as follows:
 - Emergency admissions. You, Your authorized representative, or Physician must tell us within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time;
 - Admissions for childbirth, for the first 48 hours following a vaginal delivery or 96 hours following a cesarean section. Admissions longer than 48 or 96 hours require precertification;
 - Admissions for mastectomy surgery, including the length of Hospital stays associated with mastectomy and breast reconstruction surgery for breast cancer.
- Skilled Nursing Facility stays;
- Bariatric surgery and organ and tissue transplants Center of Medical Excellence (CME) procedures (see Center of Medical Excellence (CME) requirements in the part WHAT IS COVERED – MEDICAL);
- All Infusion Therapy (in any setting) inclusive of Specialty Drugs and related services (for each course of Therapy) in any setting, including, but not limited to: Physician's office, infusion center, outpatient Hospital or clinic, or Your home or other residential setting;
- Home Care Services, except when provided for outpatient Mental Health and Substance Abuse services;
- Hospice Care;
- Surgical procedures, wherever performed;
- The following diagnostic procedures and tests, including advanced imaging procedures, wherever performed, except when provided for outpatient Mental Health and Substance Abuse services:
 - Computerized Tomography (CT)
 - Computerized Tomography Angiography (CTA)
 - Magnetic Resonance Imaging (MRI)
 - Magnetic Resonance Angiography (MRA)
 - Magnetic Resonance Spectroscopy (MRS)
 - Nuclear Cardiology (NC)
 - Positron Emission Tomography (PET)
 - PET and PET/CT Fusion
 - QTC Bone Densitometry
 - Diagnostic CT Colonography
 - Echocardiogram
 - Magnetoencephalography (MEG)
 - Sleep study

- Anesthesia for gastrointestinal endoscopic procedures
- Capsule endoscopy-gastrointestinal track
- Manipulation of spine under anesthesia;
- Ambulance in a non-Emergency, except when provided for outpatient Mental Health and Substance Abuse services.
- Transgender surgeries, including transgender travel expense. Precertification is not required for all other transgender services.

If You have any questions regarding the Precertification process, please call customer service at the telephone number listed on Your ID Card.

For all services that require Precertification, the failure to obtain Precertification prior to the service, treatment or admission start date will result in the claim for the services being subject to Retrospective review as described in this part. If the service, treatment or admission is determined not to be Medically Necessary, the claim will be denied as a non-Covered Service and You will have no benefits under this Plan for such service, treatment, or admission. **For more information regarding Your potential responsibility for Non-Covered Services, see the part HOW YOUR COVERAGE WORKS, in the section "Insured Cost Share."**

Continued Stay Review

A Continued Stay Review is conducted during the course of treatment to determine the Medical Necessity of a service, treatment or admission when Precertification was not obtained prior to the service, treatment or admission, such as an Emergency admission to a Hospital, or when services continue for a longer period than was originally approved, for example if You are admitted to a Hospital and Your stay continues beyond the number of days originally requested.

Retrospective Review

A Retrospective review is conducted to determine the Medical Necessity or Experimental/Investigational nature of a service, treatment or admission that either required Precertification that was not obtained prior to the service, treatment or admission or did not need Precertification, and for which no Continued Stay review was performed. Medical reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

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

Revoking or modifying a Precertification Review decision

Anthem will determine **in advance** whether certain services (including procedures and admissions) are Medically Necessary and are the appropriate length of stay, if applicable. These review decisions may be revoked or modified prior to the service being rendered for reasons including but not limited to the following:

- Your coverage under this Plan ends;
- You reach a Benefit Maximum that applies to the service in question;
- Your benefits under the Plan change so that the service is no longer covered or is covered in a different way.

Who is responsible for Precertification	
Services given by an In Network Provider	Services given by an Out of Network Provider
Provider	<ul style="list-style-type: none"> • The Insured must get precertification. • If the Insured fails to get Precertification for a service that requires Precertification, the service will be subject to Retrospective Review and will be denied if the service, treatment or admission is not Medically Necessary and the Insured may be financially responsible for the service, treatment or admission in whole or in part. • For Emergency admissions, You, Your authorized representative or Physician must tell us within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time.

We use our clinical coverage guidelines, such as medical policy clinical guidelines, preventive care clinical coverage guidelines, and other applicable policies and procedures to help make our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. Medical policies and clinical guidelines reflect the

standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time. This Plan takes precedence over these guidelines.

If You have any questions regarding the medical policies or clinical guidelines, please call customer service at the telephone number listed on Your ID Card.

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

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

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

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

You may find out whether a Provider is taking part in certain programs by checking Your on-line Provider Directory, on-line Precertification list or contacting the customer service at the telephone number listed on Your ID Card.

Request Categories

- **Urgent** – A request for Precertification or Continued Stay Review that is conducted prior to or while You are receiving treatment for a medical condition that in the view of the treating Provider or any Physician with knowledge of Your medical condition could, without such care or treatment, seriously threaten Your life or health or Your ability to regain maximum function or subject You to severe pain that cannot be adequately managed without such care or treatment.
- **Precertification** – A request for review that is conducted prior to the service, treatment or admission.
- **Continued Stay Review** – A request for review that is conducted during the course of treatment or admission.

- **Retrospective** – A request for review that is conducted after the service, treatment or admission has concluded. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for Medical Necessity according to the timeframes listed below. The timeframes and requirements listed are based on State and federal laws. Where State laws are stricter than federal laws, we will follow State laws. If You live in and/or get services in a state other than the State where this Plan was issued other state-specific requirements may apply. You may call customer service at the telephone number listed on Your ID Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
Precertification Urgent	Seventy-two (72) hours from the receipt of the request or, if sufficient information is not received to make a determination, Forty-eight (48) hours from the earlier of the receipt of the additional information requested or the end of the time period afforded to provide the additional information
Precertification non-Urgent	Five (5) business days from the receipt of all information reasonably necessary and requested
Continued Stay Review when hospitalized at the time of the request	Seventy-two (72) hours from the receipt of all information reasonably necessary and requested, or Seventy-two (72) hours from the receipt of the request and prior to expiration of current certification
Continued Stay Review Urgent when request is received more than twenty-four (24) hours before the end of the previous Authorization	Twenty-four (24) hours from the receipt of the request
Continued Stay Review Urgent when request is received less than twenty-four (24) hours before the end of the previous Authorization or no previous Authorization exists	Seventy-two (72) hours from the receipt of the request
Continued Stay Review non-Urgent	Five (5) business days from the receipt of all information reasonably necessary and requested
Retrospective	Thirty (30) days from the receipt of all information reasonably necessary and requested, or Thirty (30) calendar days from the receipt of the request

If more information is needed to make our decision, we will follow State and federal law and tell the requesting Provider and send written notice to You or Your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

We will give notice of our decision as required by State and federal law. Notice may be given by the following methods:

- **Verbal:** Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.
- **Written:** Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and You or Your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date You get the service:

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

For a copy of the Medical Necessity Review Process, please contact customer service at the telephone number listed on Your ID Card.

If You disagree with a determination by us, You have the right to file a Grievance as outlined in the part COMPLAINTS AND GRIEVANCES and a request for Independent Medical review as outlined in the part INDEPENDENT MEDICAL REVIEW.

Individual Case Management

Case Management helps coordinate services for Insureds with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Insureds who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary. These programs are given at no extra cost to You.

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

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

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

Medically Necessary Orthodontic Care

Before You receive Medically Necessary Orthodontic Care, Your dental Provider should submit a prior authorization form to Anthem for this service. This form is available by calling the telephone number listed on Your ID Card or online at www.anthem.com/ca. You may call customer service at the telephone number listed on Your ID Card to ask that a prior authorization form be faxed to Your dentist.

The prior authorization process is outlined below:

- The Dental Professional Review area handles the review.
- If the Anthem defined criteria are met, the Dental Professional Review area will communicate to the dentist and Insured about the approval.
- If the Anthem defined criteria are NOT met, the Dental Professional Review area will communicate to the dentist and Insured about the denial.
- The letters of response contain steps for additional review, including information about filing a Grievance.
- If prior authorization is denied, You have the right to file a Grievance as outlined in the part COMPLAINTS AND GRIEVANCES.

REPATRIATION OF REMAINS EXPENSE INSURANCE

This coverage pays benefits toward reimbursement of the expenses incurred to meet the minimum legal requirements for transportation of human remains by the person or persons who incurred them preparing and transporting Your remains to Your country of legal residence, subject to the "Conditions for Benefits" below. The total amount of the benefit for repatriation will not be more than the Maximum Amount of Insurance (see SUMMARY OF BENEFITS).

CONDITIONS FOR BENEFITS

We will pay benefits if Your death occurs under these conditions:

1. Your death occurred while You were insured by this coverage;
2. Your death occurred while You were in the United States; and
3. One or more persons have incurred expense for the preparation and transportation of Your remains to Your country of legal residence for burial.

EXCLUSIONS

No payment will be made under this plan for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

Not Covered. Services received before Your effective date.

Death Outside the United States. Services furnished to prepare and transport Your remains to Your country of legal residence if Your death occurred outside the United States.

NO RIGHT TO CONVERT

If Your Repatriation of Remains Expense Insurance ceases, You cannot "convert" that insurance to an individual policy.

MEDICAL EVACUATION EXPENSE INSURANCE

This coverage pays benefits toward reimbursement of the expenses incurred transporting You back to Your country of legal residence for medical care and treatment, subject to the following:

CONDITIONS FOR BENEFITS

We will pay medical evacuation benefits if these conditions are met:

1. Your illness commenced, or injury occurred, while You were insured by this coverage;
2. Your illness commenced, or injury occurred, while You were in the United States; and
3. Your physician, in the United States, certifies in writing that You are:
 - Medically stable; and
 - You require further medical care and treatment for Your accident or illness; and
4. You have incurred expense for Your transportation back to Your country of legal residence for Your medical care and treatment.

BENEFITS FOR MEDICAL EVACUATION

We will pay benefits toward reimbursement of the expenses incurred transporting You back to Your country of legal residence for medical care and treatment. The total amount of the benefit for medical evacuation will not be more than the Maximum Amount of Insurance (see SUMMARY OF BENEFITS: MEDICAL EVACUATION EXPENSE INSURANCE).

EXCLUSIONS

No payment will be made under this plan for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

Mild conditions. Services for medical evacuation when You have mild lesions, simple injuries such as sprains or simple fractures, or mild illness, which can be treated in the United States (or for domestic Students outside the United States, in the country where You are studying) and does not prevent You from continuing to participate in the Exchange Visitor Program for which You came to the United States.

Not covered. Services received before Your effective date; services not specifically stated, such as care or treatment of an illness or injury.

Not needed. Services for medical evacuation when Your physician does not certify, in writing, that You need further medical care or treatment for an illness or injury that commenced or occurred, respectively, in the United States.

Illness and Injury Outside the United States. Services furnished and billed by a provider, unless such services or supplies are furnished in connection with an illness that commenced, or injury that occurred, while You were in the United States.

Traveling Companions. The cost of airfare for a family member or traveling companion accompanying You.

NO RIGHT TO CONVERT

If Your Medical Evacuation Expense Insurance ceases, You cannot "convert" that insurance to an individual policy.

COORDINATION OF BENEFITS

If You are covered by more than one medical plan, Your benefits under this Plan will be coordinated with the benefits of those other plans, as shown below. These coordination provisions apply separately to each Insured, per Benefit Period, and are largely determined by California law. Any coverage You have for medical or dental benefits will be coordinated as shown below.

The term "other plan" means any of the following types of coverage with which the benefits under this Plan will be coordinated:

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

"Other plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

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

EFFECT ON BENEFITS

This provision will apply in determining an Insured's benefits under this Plan for any Benefit Period if the benefits under this Plan and any other plans exceed the allowable charges for that Benefit Period.

1. If this Plan is the primary plan (the plan that pays first), then its benefits will be determined first without taking into account the benefits or services of any other plan.
2. If this Plan is not the primary plan, then its benefits may be reduced so that the benefits and services of all the plans combined do not exceed allowable charges.

3. The benefits of this Plan will never be greater than the sum of the benefits that would have been paid if you were covered under this Plan only.

ORDER OF BENEFITS DETERMINATION

The first of the following rules which applies will determine the order in which benefits are payable. The rule addressing the coverage of dependent children (provision 3) applies only if children are eligible and covered under this Plan.

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision. This would include Medicare in all cases, except when the law requires that this Plan pays before Medicare.
2. A plan which covers You as the primary insured (such as a student or an employee) pays before a plan which covers You as a dependent. But, if You are retired and eligible for Medicare, Medicare pays (a) after the plan which covers You as a dependent of an active employee, but (b) before the plan which covers You as a retired employee.
3. For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the calendar year pays before the plan of the parent whose birthday falls later in the calendar year. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

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

- a. If the parent with custody of that child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that child as a dependent pays first.
- b. If the parent with custody of that child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
 - i. The plan which covers that child as a dependent of the parent with custody.
 - ii. The plan which covers that child as a dependent of the stepparent (married to the parent with custody).
 - iii. The plan which covers that child as a dependent of the parent without custody.
 - iv. The plan which covers that child as a dependent of the stepparent (married to the parent without custody).
- c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that child's health care coverage, a plan which covers that child as a dependent of that parent pays first.

4. The plan covering You as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering You as other than a laid-off or retired employee or the dependent of such a person. But if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.
5. The plan covering You under a continuation of coverage provision in accordance with state or federal law pays after a plan covering You as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the other plan do not agree under these circumstances with the Order of Benefit Determination provisions of this Plan, this rule will not apply.
6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, the allowable charges are split equally between the two plans.

OUR RIGHTS UNDER THIS PROVISION

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

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

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

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

THIRD PARTY LIABILITY

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

- We will automatically have a lien upon any amount You receive from the third party or the third party's insurer or guarantor by judgment, award, settlement or otherwise. Our lien will be in the amount of the benefits we pay under this Plan for treatment of the illness, disease, injury or condition for which the third party is liable. Our lien will not exceed the amount we actually paid for those services, if we paid the Provider other than on a capitated basis, and, if we paid the Provider on a capitated basis, our lien will not exceed 80% of the usual and customary charges for those services in the geographic area in which they were rendered. In addition, if You engaged an attorney to gain Your recovery from the third party, our lien shall not exceed one-third of the monies due You under any final judgment, compromise or settlement agreement and, if You did not engage an attorney, our lien shall not exceed one-half of the monies due You under any final judgment, compromise or settlement agreement. Where a final judgment includes a special finding by a judge, jury or arbitrator that You were partially at fault, our lien shall be reduced by the same comparative fault percentage by which Your recovery was reduced. Our lien is subject to a pro rata reduction commensurate with Your reasonable attorney's fees and costs in accordance with the common fund doctrine.
- You agree to advise us in writing of Your claim against a third party within sixty (60) days of making such claim, and that You will take such action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our lien rights. You agree not to take any action that may prejudice our rights or interests under this Plan. You agree also that failing to give us such notice, or failing to cooperate with us, or intentionally taking any action that prejudices our rights will be a material breach of this Plan. In the event of such material breach, You will be personally responsible and liable for reimbursing to us the amount of benefits we paid.
- We will be entitled to collect on our lien even if the amount recovered by or for the Insured (or his or her estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss suffered by the Insured.

IMPORTANT INFORMATION ABOUT THIS PLAN (General Provisions)

Below is important information regarding this Plan.

Benefits not transferable: You are the only person entitled to receive benefits under this Plan. FRAUDULENT USE OF SUCH BENEFITS CAN RESULT IN CANCELLATION OF YOUR COVERAGE AND APPROPRIATE LEGAL ACTION MAY BE TAKEN.

Continuation of care after termination of a Provider: Subject to the terms and conditions set forth below, we will pay benefits at the In Network Provider level for Covered Services (subject to applicable Deductibles, Copayment and Coinsurance and other terms) rendered by a Provider whose participation we have terminated from our network.

- The Insured must be under the care of the In Network Provider at the time of our termination of the Provider's participation in our network. The terminated Provider must agree in writing to provide services to the Insured in accordance with the terms and conditions of his/her agreement with us prior to termination from our network. The Provider must also agree in writing to accept the terms and reimbursement rates under his/her agreement with Anthem prior to termination from our network. If the Provider does not agree with these contractual terms and conditions, we are not required to continue the Provider's services beyond the contract termination date.
- Such benefits will not apply to Providers who have been terminated due to medical disciplinary cause or reason, fraud or other criminal activity.

We will furnish such benefits for the continuation of services by a terminated Provider only for any of the following conditions:

- An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.
- A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by us in consultation with the Insured and the terminated Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.
- A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy.

- A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) Year or less. Completion of Covered Services shall be provided for the duration of a terminal illness, which may exceed twelve (12) months from the Provider's contract termination date.
- The care of a Newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.
- Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within one-hundred eighty (180) days of the Provider's contract termination date.

If You would like information on the process or the policy and procedure for requesting completion of Covered Services, contact customer service at the telephone number listed on Your ID Card. Eligibility is based on the Insured's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Plan.

We will notify You as to whether or not Your request for continuation of care is approved. We will also notify the Provider if the request is approved. If approved, the Insured will be financially responsible only for applicable Deductibles, Coinsurance and/or Copayments under this Plan. Financial arrangements with terminated Providers are negotiated on a case-by-case basis. We will request that the terminated Provider agree to negotiated reimbursement and/or contractual requirements that apply to In Network Providers, including payment terms. If the terminated Provider does not agree to the same reimbursement and/or contractual requirements, we are not required to continue that Provider's services. If You disagree with our determination regarding continuation of care, please refer to the part INDEPENDENT MEDICAL REVIEW.

Transition Assistance for New Insureds: Transition assistance is a process that allows for completion of Covered Services for new Insureds receiving services from an Out of Network Provider. The Insured must be under the care of the Out Network Provider at the time of enrollment in this Plan. The newly-covered Insured's must have had prior coverage that terminated for one of the following reasons:

- The Insured's prior carrier ceased to provide or arrange for the provision of health care services for new individual health benefit plans in this state or
- The Insured's prior carrier withdrew an individual health benefit plan from the market, or from any portion of a market.

We will furnish such benefits for the continuation of services by an Out of Network Provider only for any of the following conditions:

- An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.
- A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by us in consultation with the Insured and the terminated Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the Insured's enrollment date.
- A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy.
- A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) Year or less. Completion of Covered Services shall be provided for the duration of a terminal illness, which may exceed twelve (12) months from the Injured's enrollment date.
- The care of a Newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the Insured's enrollment date.
- Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within one-hundred eighty (180) days of the Insured's enrollment date.

If You would like information on the process or the policy and procedure for requesting transition assistance, contact customer service at the telephone number listed on Your ID Card. Eligibility is based on the Insured's clinical condition; it is not determined by diagnostic classifications. Transition assistance does not provide coverage for services not otherwise covered under the Plan.

We will notify You as to whether or not Your request for continuation of care is approved. We will also notify the Provider if the request is approved. If approved, the Insured will be financially responsible only for applicable Deductibles, Coinsurance and/or Copayments under this Plan. Financial arrangements with Out of Network Providers are negotiated on a case-by-case basis. We will request that the Out of Network Provider agree to negotiated reimbursement and/or contractual requirements that apply to In Network Providers, including payment terms. If the Out of Network Provider does not agree to the same reimbursement and/or contractual requirements,

we are not required to continue that Provider's services. If You disagree with our determination regarding transition assistance, you are afforded due process, including having a Physician review the request.

How to file medical claims: In Network Providers will bill Anthem directly for services rendered to You. In order for the Provider to submit a claim on Your behalf, You must give the Provider information necessary for the claim to be filed, such as Your Anthem ID card.

- **Notice of Claim and claim forms:** For Out of Network Providers, the Provider may or may not bill Anthem for services rendered to You. If an Out of Network Provider does not submit a claim to Anthem, in order for the claim to be considered for reimbursement, You must provide us with a Notice of Claim within twenty (20) days of the date of service. You will be deemed to have provided adequate notice if You or someone on Your behalf provides sufficient information to identify You. If this is not possible, Anthem must be notified as soon as it is reasonably possible to do so. When Anthem receives a Notice of Claim, We will send you a claim form for filing proof of a claim. If Anthem fails to furnish the necessary claim forms within fifteen (15) days, You may file a claim without using a claim form by sending Anthem written proof of claim as described below and You will be deemed to have complied with the requirement to submit a proof of claim. The member claim form can be found online at www.anthem.com/ca or requested by calling customer service at the telephone number listed on Your ID Card.
- **Proof of claim:** Anthem must receive written proof of claim within ninety (90) days after the date of service for which claim is being made from a contracted professional Provider and no later than one hundred and eighty (180) days for claims from a non-contracted professional Provider. Send a copy of your itemized bill to Anthem at the address indicated under the provision **How to send a member claim form** below. A claim will not be reduced or denied for failure to provide proof within this time if it is shown that it was not reasonably possible to furnish proof, and that proof was provided as soon as it was reasonably possible. However, no claim will be paid if proof is received more than fifteen (15) months after the date of loss, unless You were legally unable to notify Us.

All information on the member claim form necessary to determine benefits and pay the claim must be complete and legible. If the member claim form is not legible or is missing information necessary to determine benefits and pay the claim, the form will be returned to You for any missing, incomplete or illegible information. The information on the itemized bill will be used to determine benefits so it must support the information on the member claim form. The member claim form contains more detailed instructions on how to complete the form and what information is needed.

If You are filing a member claim form for more than one Out of Network Provider, a separate member claim form is required for each Provider. If You are filing a member claim Form for more than one Insured, a separate member claim form is required for each Insured.

When You receive health care outside of the United States, You will need to submit an itemized bill and medical records for services rendered. The itemized bill and medical records must be translated into English and include the billed charges.

Note: You are responsible, at Your own expense, for obtaining an English language translation of foreign country Provider claims and medical records.

How to send a member claim form: Prior to submitting Your member claim form and itemized bill, You should make copies of the documents for Your own records and attach the original bills to the completed member claim form. The bills and the member claim form should be mailed to:

Anthem Blue Cross Life and Health Insurance Company
21555 Oxnard Street
Woodland Hills, CA 91367

Laws governing the Plan: This Plan is subject to the laws of the State of California. Any provision of this Plan which, on its Effective Date, is in conflict with any law is amended to conform to the minimum requirements of such law.

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

Liability of Insured to Pay Providers: In accordance with Anthem's In Network Provider agreements, Insureds will not be required to pay any In Network Provider for amounts owed to that Provider by Anthem (other than Copayments/Coinsurance), even in the unlikely event that Anthem fails to pay the Provider. Insureds are liable, however, to pay Out of Network Providers for any amounts not paid to those Providers by Anthem.

Notice: We will meet any notice requirements by mailing the notice to You at the address listed in our records. You will meet any notice requirements by mailing the notice to:

Anthem Blue Cross Life and Health Insurance Company
21555 Oxnard Street
Woodland Hills, CA 91367

Payment to Providers and Provider reimbursement: Benefits for In Network Providers are based on the Maximum Allowed Amount. In Network Providers have an agreement in effect with us and have agreed to accept the Maximum

Allowed Amount as payment in full. You will not be required to pay any In Network Provider for amounts owed to that Provider by us (excluding Deductible, Copayments/Coinsurance, and services or supplies that are not a covered benefit of the Plan), even in the unlikely event that we fail to pay the Provider.

In the event You become deceased before any payment due under this Plan is required to be paid to You, any such payment will be made to Your estate. Any payment made by us in good faith pursuant to this provision shall fully discharge our obligations under this Plan to the extent of such payment.

Out of Network Providers do not have an agreement with Anthem. Your personal financial costs when using Out of Network Providers may be considerably higher than when You use In Network Providers. You will be responsible for any balance of a Provider's bill which is above the Maximum Allowed Amount payable under this Plan for Out of Network Providers. In certain situations, however, if you receive non-Emergency covered services at an In Network Hospital or Facility at which, or as a result of which, you receive services from an Out of Network Provider, you will pay no more than the cost sharing that you would pay for the same covered services received from an In Network Provider. Please see INSURED COST SHARE for more information. You should read the SUMMARY OF BENEFITS and the part WHAT IS COVERED – MEDICAL carefully to determine those differences. We pay the benefits of this Plan directly to In Network Hospitals, In Network Physicians, medical transportation Providers, certified nurse midwives, registered nurse practitioners and other In Network Providers, whether You have authorized assignment of benefits or not. If You receive non-Emergency Services from an Out of Network Provider, we may make payment directly to that Provider when you assign benefits in writing. In all cases, we will pay Providers directly when Emergency Services and care are provided to You. We will continue such direct payment until the Emergency Care results in stabilization.

Physical examination and autopsy: At our own expense, we have the right and opportunity to examine the Insured claiming benefits when and as often as it may reasonably be required during the pendency of a claim and also to have an autopsy done in the case of death where it is not otherwise prohibited by law.

Receipt of information: We are entitled to receive from any Provider of service information about You that is necessary to administer claims on Your behalf according to federal/State law. This right is subject to all applicable confidentiality requirements. You agree to assist in obtaining this information if needed. Failure to assist us in obtaining the necessary information when requested may result in the delay or rejection of Your claims until the necessary information is received by us.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. Contact us at the

telephone number listed on Your ID Card for a copy of our policies and procedures for preserving Your medical record confidentiality.

Relationship of Parties: Providers are independent contractors. Anthem is not responsible for any claim for damages or injuries suffered by the Insured while receiving care from any Provider.

Right of recovery: When the amount paid by us to You or Your Provider exceeds the amount for which we are liable under this Plan, we have the right to recover the excess amount from You or Your Provider, unless prohibited by law.

Submission of Claims: Either the Student or Provider of service must claim benefits by sending Anthem properly completed claims forms itemizing the services or supplies received and the charges. These claim forms must be received by Anthem within fifteen (15) months from the date services or supplies are received. Anthem will not be liable for benefits if a completed claim form is not furnished to Anthem within this time period, except in the absence of legal capacity. Claims forms must be used, canceled checks or receipts are not acceptable.

Terms of coverage:

- In order for You to be entitled to benefits under this Plan on a specific date, Your coverage under this Plan must be in effect on the date You received services or supplies except as specifically stated in the parts CONTINUED BENEFITS and IMPORTANT INFORMATION ABOUT THIS PLAN (General Provisions), continuation of care after termination of a Provider.
- This Plan, including all terms, benefits, conditions, limitations and exclusions, may be changed by us as provided in the Policy.
- The benefits to which You may be entitled will depend on the terms of coverage as set out in the Plan in effect on the date You receive the service or supply.

Time of payment of claim: Any benefits determined to be due under this Plan shall be paid within thirty (30) working days after we receive a complete written proof of loss and determination that benefits are payable. A claim together with all additional information reasonably necessary to determine our obligation under this Plan and reasonable access to information concerning provider services is required. Information necessary to determine our obligation under this Plan includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for us to determine the Medical Necessity for the health care services provided.

Workers' compensation insurance: This Plan does not take the place of or affect any requirement for or coverage by workers' compensation insurance. Additionally, as stated in the part WHAT IS NOT COVERED (Exclusions) -

MEDICAL, this Plan does not cover any condition for which benefits are covered by any worker's compensation law or similar law.

COMPLAINTS AND GRIEVANCES

If You have a Grievance or complaint against Anthem, including Your ability to access health care in a timely manner, You may contact us to discuss Your concern and/or obtain a Grievance form at:

Anthem Blue Cross Life and Health Insurance Company
21555 Oxnard Street
Woodland Hills, CA 91367

If You need help with a Grievance involving an Emergency, a Grievance or complaint that has not been satisfactorily resolved, regarding your ability to access health care in a timely manner, a Grievance or an issue that has remained unresolved for more than thirty (30) days, You may contact the Department of Insurance for assistance. They can be reached at:

California Department of Insurance, Consumer Services Division
300 South Spring St., South Tower
Los Angeles, CA 90013
Toll-free phone number: 1-800-927-HELP (4357)
TDD Number: 1-800-482-4TDD (4833)

Anthem's Grievance process and the Department of Insurance's complaint review process are in addition to other dispute resolution procedures that may be available to You, and Your failure to use these processes does not preclude Your use of any other remedy provided by law. Additional information of these rights is explained in the parts INDEPENDENT MEDICAL REVIEW, BINDING ARBITRATION, and IMPORTANT INFORMATION ABOUT THIS PLAN.

Language assistance and discrimination. If you believe Anthem has failed to offer language assistance services or has discriminated based on race, color, national origin, age, disability, or sex you may file a Grievance as mentioned above. You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

INDEPENDENT MEDICAL REVIEW

If an Insured has had any Covered Service denied, modified or delayed or has had coverage denied because proposed treatment is determined by us to be Investigational or Experimental or not Medically Necessary, the Insured may ask for review of that denial, modification or delay by an external independent medical review organization. To request a review, please call the telephone number listed on Your ID Card or write to us at **Anthem Blue Cross Life and Health Insurance Company, 21555 Oxnard Street, Woodland Hills, CA 91367**. To request an Independent Medical Review (IMR) from the California Department of Insurance (CDI), all of the following conditions must be satisfied.

For Denials, Modifications or Delays Based on a Determination that a Service is Experimental or Investigative

The Insured must have a life threatening or seriously debilitating condition.

- A life threatening condition is a condition or disease where the likelihood of death is high unless the course of the condition or disease is interrupted and/or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is survival.
- A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.

The proposed treatment must be recommended by either (a) the Insured's In Network Physician who certifies in writing that it is more likely to be beneficial than standard treatment, or (b) the Insured or the Insured's board certified or board eligible Physician who is qualified to treat the Insured, has requested treatment that, based on two documents of acceptable medical and scientific evidence (described below), is likely to be more beneficial than any available standard treatment. The Physician certification must include a statement of the evidence relied upon in certifying the recommendation.

"Acceptable medical and scientific evidence" means the following sources:

- Peer reviewed scientific studies published in medical journals with national recognized standards,
- Medical journals recognized by the Secretary of Health and Human Services under Section 1861 (t) (2) of the Social Security Act,
- The American Hospital Formulary Service's-Drug Information and the American Dental Association Accepted Dental Therapeutics,

- Any of the following reference compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
 - The Elsevier Gold Standard's Clinical Pharmacology.
 - The National Comprehensive Cancer Network Drug and Biologics Compendium.
 - The Thomson Micromedex DrugDex.
- Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, MEDLARS database Health Services Technology Assessment Research,
- Finding, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes and
- Peer reviewed abstracts accepted for presentation at major medical association meetings.

For Denials, Modifications or Delays Based on a Determination that a Service is not Medically Necessary

The CDI will review Your application for IMR to confirm that:

- Your Provider has recommended a health care service as Medically Necessary,
- You have received urgent care or Emergency Services that a Provider determined was Medically Necessary or
- You have been seen by an In Network Provider for the diagnosis or treatment of the medical condition for which You seek independent review.

The disputed health care service has been denied, modified or delayed by us based in whole or in part on a decision that the health care service is not Medically Necessary

AND

You have filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. If Your grievance requires expedited review You may bring it immediately to the CDI's attention. The CDI may waive the requirement that You follow our grievance process in extraordinary and compelling cases.

General

If Your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is Experimental or Investigational or is Medically Necessary. You will receive a copy of the assessment made in Your case. If the IMR determines the service is not Experimental or Investigational or is Medically Necessary, we will provide available benefits for the health care service.

Within three (3) business days of our receipt from the Department of Insurance of a request by a qualified Insured for an IMR (and within 24 hours of approval of the request for review involving an imminent and serious threat to the health of the Insured), we will provide the IMR organization designated by the Department with a copy of all relevant medical records and documents for review and any information submitted by the Insured or the Insured's Physician. Additionally, any newly developed or discovered relevant medical records identified by us or our In Network Providers after the initial documents are provided will be forwarded immediately to the IMR organization.

For non-urgent cases, the IMR organization designated by the CDI must provide its determination within thirty (30) days of receipt of Your application and supporting documents. For urgent cases involving an imminent and serious threat to Your health, including but not limited to, serious pain, the potential loss of life, limb or major bodily function or the immediate and serious deterioration of Your health, the IMR organization must provide its determination within three (3) business days.

The IMR process is in addition to any other procedures or remedies that may be available to You. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We must provide You with an IMR application form with any grievance disposition letter that denies, modifies or delays health care services. A decision not to participate in the IMR process may cause You to forfeit any statutory right to pursue legal action against us regarding the disputed health care service.

For more information regarding the IMR process or to request an application form please call the telephone number listed on Your ID Card.

BINDING ARBITRATION

ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. It is understood that any dispute including disputes relating to the delivery of services under the Plan or any other issues related to the Plan, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. YOU AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL OR TO PARTICIPATE IN A CLASS ACTION IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The arbitration findings will be final and binding except to the extent that State or federal law provides for the judicial review of arbitration proceedings.

The arbitration is initiated by the Insured making a written demand on Anthem Blue Cross Life and Health Insurance Company. The arbitration will be conducted by a single neutral arbitrator from Judicial Arbitration and Mediation Services ("JAMS"), according to JAMS' applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by a single neutral arbitrator from another neutral arbitration entity, by agreement of the Insured and Anthem Blue Cross Life and Health Insurance Company, or by order of the

court, if the Insured and Anthem Blue Cross Life and Health Insurance Company cannot agree. If the parties cannot agree on the individual neutral arbitrator, the arbitrator will be selected in accordance with JAMS Rule 15 (or any successor rule).

For claims of medical malpractice for which the total amount of damages claimed is \$50,000 or less, the Insured and Anthem Blue Cross Life and Health Insurance Company shall select a single neutral arbitrator who shall have no jurisdiction to award more than \$50,000. If the Insured and Anthem Blue Cross Life and Health Insurance Company cannot agree on the selection of an arbitrator for such a claim, the process described above for selecting an arbitrator shall apply.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. Unless You and Anthem Blue Cross Life and Health Insurance Company agree otherwise, the arbitrator may not consolidate more than one person's claims, and may not otherwise preside over any form of a representative or class proceeding.

Please send all Binding Arbitration demands in writing to:

Anthem Blue Cross Life and Health Insurance Company

21555 Oxnard Street

Woodland Hills, CA 91367

DEFINITIONS

Listed below are the definitions that contain the meaning of key terms used in this Plan. Throughout the Plan, the terms printed in bold face below will appear with the first letter of each word in capital letters.

Accidental Injury is physical harm or disability which is the result of a specific, unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental Injury does not include illness or infection, except infection of an accidental cut or wound.

Adopted Child and Adoptive Child: A child whose birth parent or appropriate legal authority has signed a written document granting the Student, enrolled Spouse or enrolled Domestic Partner the right to control health care of the child or, absent this document, other evidence exists of this right.

Ambulatory Surgical Center is a freestanding outpatient surgical Facility. It must be licensed as an outpatient clinic according to State and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations or the Accreditation Association of Ambulatory Health Care.

Ancillary Provider means an independent clinical laboratory, durable/home medical equipment, and/or Specialty Pharmacy.

Anthem Blue Cross Life and Health Insurance Company ("Anthem") is a life and disability insurance company regulated by the California Department of Insurance (CDI). In this Plan, the words "we," "us," "our," "Anthem," and "Anthem Blue Cross Life and Health" refer to Anthem Blue Cross Life and Health Insurance Company.

Authorized Referral occurs when an Insured, because of his or her medical needs, requires the services of a specialist who is an Out of Network Physician, or requires special services or Facilities not available at a Contracting Hospital, but only when the Referral has been authorized by Anthem *before* services are rendered and when the following conditions are met:

1. there is no In Network Physician who practices in the appropriate specialty or there is no Contracting Hospital which provides the required services or has the necessary Facilities,
2. the adequacy and accessibility requirements of State or federal law are met; and
3. the Insured is referred to Hospital or Physician that does not have an agreement with Anthem for a Covered Service by an Anthem In Network Physician.

If there is a shortage of one or more types of Providers to ensure timely access to Covered Services, Anthem will also assist covered individuals to locate available and accessible contracting Providers in neighboring Service Areas for obtaining health care services in a timely manner appropriate to the Insured's health needs.

For additional information on how to obtain an Authorized Referral, see the part HOW YOUR COVERAGE WORKS.

Authorized Service(s): A Covered Service You get from an Out of Network Provider that we have agreed to cover at the In Network level. Such service may be authorized because an In Network Provider is not located:

1. within a thirty (30) mile radius of the principal residential address that we have on file, or
2. within the county in which the principal residence is located, whichever is less.

You will have to pay any In Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out of Network Provider's charge. Please see Your SUMMARY OF BENEFITS and the part CLAIMS AND PAYMENTS for more details.

Benefit Maximum. The most we will cover for a Covered Service during a Benefit Period.

Benefit Period means a school year (beginning on the date shown on the first page of this certificate and ending one year later) for which a health benefit plan provides coverage for health benefits.

Brand Name Drug (Brand Drug): Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance is Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service as stated in the SUMMARY OF BENEFITS. You pay Coinsurance after any Deductible You owe. For example, if the Plan's allowed amount for an Office Visit is \$100 and You have met Your Deductible, Your Coinsurance payment of 20% would be \$20. Your Coinsurance does not apply to charges for services which are not covered or charges in excess of the amount we will allow for payment and will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contracting Hospital is a Hospital which has a contract with us to provide care to our Insureds. A Contracting Hospital is not necessarily an In Network Hospital. To determine whether a Hospital contracts with Anthem, You may contact us at the telephone number listed on Your ID Card or check www.anthem.com/ca.

Copayment is the fixed amount (for example \$15) due and payable by the Insured to the Provider for a covered health care service as stated in the SUMMARY OF BENEFITS, usually when You receive the service. The amount can vary by the type of covered health care service.

Cosmetic Surgery is surgery that is performed to alter or reshape normal structures of the body in order to improve appearance

Cost-Share: The term Cost-Share means the amount which the Insured is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance and/or Deductibles.

Covered Services are health care services that are Medically Necessary services, Drugs, or supplies for which You are entitled to receive benefits and that are listed in the parts WHAT IS COVERED – MEDICAL and WHAT IS COVERED – PRESCRIPTION DRUGS.

Custodial Care is care provided primarily to meet Your personal needs that does not require the regular services of trained medical or Health Professionals, including, but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets and supervision of medications which are ordinarily self administered.

Deductible: The term Deductible means the amount of charges You may have to pay for any Covered Services and Prescription Drugs before any benefits are available to You under this Plan. Your Deductible is stated in Your SUMMARY OF BENEFITS. The Prescription Drug Deductible, if any, may be separate from the Medical Deductible and may or may not accumulate towards satisfying the Medical In Network or Out of Network Provider Deductibles. Additional information is available in the parts CLAIMS AND PAYMENTS and WHAT IS COVERED – PRESCRIPTION DRUGS.

Dental Services are diagnostic, preventive or corrective procedures on or to the teeth or gums, no matter why the services are provided and whether in treatment of a medical, dental or any other type of condition.

Dependents are members of the Student's family who are eligible and accepted under this Plan as stated in the part YOUR ELIGIBILITY.

Diabetes Equipment and Supplies means the following items for the treatment of diabetes (insulin or non-insulin and gestational) as Medically Necessary or medically appropriate:

- blood glucose monitors
- blood glucose monitors designed to assist the visually impaired

- blood glucose testing strips
- ketone urine testing strips
- insulin pumps and related necessary supplies
- lancets and lancet puncture devices
- pen delivery systems for the administration of insulin
- insulin syringes
- visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin

Diabetes Outpatient Self-Management Training Program includes training provided to a qualified Insured after the initial diagnosis of diabetes in the care and management of that condition. This includes nutritional counseling and proper use of Diabetes Equipment and Supplies, additional training authorized on the diagnosis of a Physician or other health care practitioner of a significant change in the qualified Insured's symptoms or condition that requires changes in the qualified Insured's self-management regime and periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes. Diabetes Outpatient Self-Management Training must be provided by a health care practitioner or Provider, who is licensed, registered or certified in California to provide appropriate health care services.

Domestic Partner or Domestic Partnership are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. Further, they must have either filed a Declaration of Domestic Partnership with the Secretary of State of the State of California in accordance with Section 298.5 of the Family Code, or have been issued an equivalent document by a local agency of California, another state, or a local agency of another state under which the partnership was created. A Domestic Partner must meet the eligibility requirements for Domestic Partners outlined under the part YOUR ELIGIBILITY.

Drugs means Prescription Drugs approved by the State of California or the federal Food and Drug Administration (FDA) for general use by the public. Insulin is considered a Prescription Drug.

Effective Date is the date on which Your coverage under this Plan begins.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition:

1. A medical screening examination that is within the capability of the Emergency department of a Hospital, including ancillary services routinely available to the Emergency department to evaluate such Emergency Medical Condition, and
2. Within the capabilities of the staff and Facilities available at the Hospital, such further medical examination and treatment to Stabilize the patient.
3. Being in active labor when there is inadequate time for a safe transfer to another Hospital prior to delivery, or when such a transfer would pose a threat to the health and safety of the Insured or unborn child.

Experimental and Experimental Procedures are those that are mainly limited to laboratory and/or animal research but which are not widely accepted as proven and effective procedures within the organized medical community.

Facility includes, but not limited to, a Hospital, Ambulatory Surgical Center, Mental Health / Substance Abuse Facility, or Skilled Nursing Facility, as defined in this Plan. The Facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals.

Family Plan means a Plan in which the Student is enrolled with one or more Dependents. For additional information on Newborns during the first thirty-one (31) days from birth and Adopted Children during first thirty-one (31) days from the date the Student, enrolled spouse, or enrolled Domestic Partner is granted the right to control health care for an Adopted Child, refer to the part YOUR ELIGIBILITY.

Formulary is a list which we have developed of outpatient Prescription Drugs which may be cost-effective, therapeutic choices. Any In Network Pharmacy can assist You in purchasing Drugs listed on the Formulary. You may also get information about covered Formulary Drugs by calling the telephone number listed on Your ID Card. The Formulary may be accessed online (see SUMMARY OF BENEFITS: PRESCRIPTION DRUG BENEFITS for the link to the Formulary) and shows which drug tier each drug is in.

Generic Drugs (Generic): Prescription Drugs that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

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

Home Health Agencies and Visiting Nurse Associations are home health care Providers which are licensed according to State and local laws to provide skilled nursing and other services on a visiting basis in Your home or which are approved as home health care Providers under Medicare and the Joint Commission on Accreditation of Healthcare Organizations.

Hospice Care is a coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available twenty-four (24) hours a day, seven (7) days a week. The Hospice must meet the licensing requirements of the State or locality in which it operates.

Hospital is a health Facility which provides diagnosis, treatment and care of persons who need acute inpatient Hospital care under the supervision of Physicians, and it must be licensed to provide general acute inpatient and outpatient services according to State and local laws. It must also be registered as a general Hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations.

For the purpose of Severe Mental Illness and Serious Emotional Disturbance of a Child only, the term "Hospital" includes an acute psychiatric Facility which is a Hospital specializing in psychiatric treatment or a designated psychiatric unit of a Hospital licensed by the state to provide twenty-four (24) hour acute inpatient care for persons with psychiatric disorders. For the purpose of this Plan, the term acute psychiatric Facility also includes a psychiatric health Facility which is an acute twenty-four (24) hour Facility as defined in California Health and Safety code 1250.2. It must be:

- licensed by the California Department of Health Services,
- qualified to provide short-term inpatient treatment according to State law,
- accredited by the Joint Commission on Accreditation of Healthcare Organizations,
- staffed by an organized medical and professional staff which includes a Physician as medical director, and
- actually providing an acute level of care.

Infertility means the presence of a demonstrated condition recognized by a licensed medical Physician as the inability to conceive or carry a pregnancy to a live birth after a Year or more of regular sexual relations without contraception.

Infusion Therapy is the administration of Drugs or Prescription substances by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin) and intrathecal (into the spinal canal) routes. For the purpose of this Plan, it shall also include Drugs administered by aerosol (into the lungs) and by a feeding tube.

In Network Pharmacy is a Pharmacy that has an In Network Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered.

In Network Provider is a Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Insureds through negotiated payment arrangements under this Plan.

Insured shall mean both the Student and all other Dependents who are enrolled or automatically enrolled for coverage under this Plan.

Investigational and Investigational Procedures are those that have progressed to limited use on humans but which are not widely accepted as proven and effective procedures within the organized medical community.

Maintenance Medication is a Drug You take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If You are not sure if the Prescription Drug You are taking is a Maintenance Medication, please call customer service at the telephone number listed on Your ID Card or check our website at www.anthem.com for more details.

Maximum Allowed Amount for this Plan is the maximum amount of reimbursement we will allow for Covered Services and supplies. See the section 'Maximum Allowed Amount' in the part HOW YOUR COVERAGE WORKS.

Medical Emergency means a Psychiatric Emergency Medical Conditions or a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity including, without limitation, sudden and unexpected severe pain that the absence of immediate medical or psychiatric attention could reasonably result in:

- permanently placing the Insured's health in jeopardy or
- causing other serious medical or psychiatric consequences or
- causing serious impairment to bodily functions or
- causing serious and permanent dysfunction of any bodily organ or part.

Medically Necessary and Medical Necessity services are procedures, treatments, supplies, devices, equipment, Facilities or Drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to an Insured for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the Insured's illness, injury or disease; and
- not primarily for the convenience of the Insured, Physician or other health care Provider; and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Insured's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national Physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors. In evaluating new technology and whether to consider it as eligible for coverage under this Plan, we consider peer-reviewed medical literature, consultations with Physicians, Specialists and other health care professionals, policies and procedures of government agencies and study results showing the impact of the new technology on long-term health.

Mental Health Conditions including Substance Abuse, for the purposes of this Plan, are conditions that are listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders. Mental health conditions include Serious Emotional Disturbances of a Child and Severe Mental Illness as defined in this Plan.

Minimum Essential Coverage: Government sponsored programs (Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health, or benefits risk pool.

Negotiated Price applies only to out of state and, in cases of Medical Emergency some foreign country Providers. This often consists of a simple discount which reflects the actual price paid by the on-site Blue Cross/Blue Shield Licensee/Plan. However, sometimes it is an estimated price that factors into the actual price expected, settlements, withholds, any other contingent payment arrangements and non-claims transactions with Your health care Provider or specified group of Providers. The Negotiated Price may also be billed charges reduced to reflect an average expected savings with Your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The Negotiated Price will also be adjusted in the future to correct for over -or underestimation of past prices. However, the amount You pay is considered a final price.

Newborn is a recently born infant within thirty-one (31) days of birth.

Office Visit is when You go to a Physician's office and have one or more of **ONLY** the following three services provided:

- History-Gathering of information on an illness or injury.
- Examination
- Physician's medical decision regarding the diagnosis and treatment plan.

For purposes of this definition, Office Visit will not include any other services while at the office of a Physician (e.g., any surgery, Infusion Therapy, diagnostic X-ray, laboratory, pathology and radiology) or any services performed other than the three services specifically listed above.

Other Eligible Providers do not enter into agreements with us. These Providers are:

- blood banks
- certified registered nurse anesthetists

Out of Network Pharmacy is a Pharmacy that does not have an In Network Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, You will be responsible for a larger portion of Your pharmaceutical bill when You go to an Out of Network Pharmacy.

Out of Network Provider is a Provider that does *not* have an agreement or contract with us, or our subcontractor(s) to give services to our Insured through negotiated payment arrangements under this Plan. You will often get a lower level of benefits when You use Out of Network Providers.

Pharmacy means a licensed retail Pharmacy.

Pharmacy Benefits Manager (PBM) is a Pharmacy benefits management company with which Anthem contracts to manage Pharmacy benefits. Anthem's Pharmacy Benefits Manager has a nationwide network of retail Pharmacies and clinical services that include Formulary management.

The management and other services the Pharmacy Benefits Manager provides include, but are not limited to: managing a network of retail Pharmacies. Anthem's Pharmacy Benefits Manager, in consultation with Anthem, also provides services to promote and assist Insureds in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, Drug interactions or Drug/pregnancy concerns.

Physical and/or Occupational Therapy/Medicine is the therapeutic use of physical agents other than Drugs. It comprises the use of physical, chemical and other properties of heat, light, water, electricity, massage, exercise and radiation.

Physician means:

- A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided or
- A Provider that is
 - licensed to practice where the care is provided,
 - rendering a service within the scope of that license and such license is required to render the service, and
 - providing a service for which benefits are specified in this Plan. A Provider includes, but is not limited to:
 - Dentist (D.D.S.)
 - Optometrist (O.D.)
 - Dispensing optician
 - Podiatrist or chiropodist (D.P.M. or D.S.C.)
 - Licensed clinical psychologist
 - Licensed educational psychologist or other Provider permitted by California law to provide behavioral health treatment services for the treatment of pervasive developmental disorder or autism only
 - Licensed clinical social worker (C.S.W. or L.C.S.W.)
 - Marriage and family therapist (M.F.T.)

- Licensed professional clinical counselor (L.P.C.C.)
- A qualified autism service provider, qualified autism service professional, and a qualified autism service paraprofessional, as described in the part WHAT IS COVERED – MEDICAL, in the section “Behavioral Health Treatment for Pervasive Developmental Disorder or Autism”
- Acupuncturist
- Chiropractor
- Physical therapist (P.T. or R.P.T.)
- Speech pathologist
- Speech therapist
- Audiologist
- Occupational therapist (O.T.R.)
- Respiratory therapist
- Registered nurse practitioner (R.N.P.)
- Certified nurse midwife
- Psychiatric Mental Health Nurse
- Certified registered nurse anesthetist (C.R.N.A.)

Plan is the set of benefits, conditions, exclusions and limitations described in this document.

Policy is the blanket Policy we have issued to the Policyholder.

Policyholder refers to the education entity to which we have issued the Policy. The name of the Policyholder is University of California, Berkeley.

Prescription means a written order issued by a Physician.

Prescription Drug means Drug.

Prescription Drug Maximum Allowed Amount is the maximum amount we allow for Prescription Drugs. The amount is determined by Anthem using cost information provided to by the Pharmacy Benefits Manager. The Prescription Drug Maximum Allowed Amount is subject to change.

Primary Care Physician (PCP) is a Physician who gives or directs health care services for You. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan.

Provider is a professional or Facility licensed according to applicable law that gives health care services within the scope of that license and is covered according to the terms of this Plan. This includes any Provider that state law says we must cover when they give You services that State law says we must cover. Covered Providers are described throughout this Plan. If You have a question about a Provider not described in this Plan please call customer service at the telephone number listed on Your ID Card.

Psychiatric Emergency Medical Conditions means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others, or
- Immediately unable to provide for, or utilize, food, shelter or clothing, due to the mental disorder.

Reconstructive Surgery is surgery that is Medically Necessary and appropriate and is performed to correct deformities caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve bodily function or to create a normal appearance, to the extent possible.

Benefits include Reconstructive Surgery to correct deformities caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve bodily function or to create a normal appearance, to extent possible. Benefits include surgery performed to restore symmetry after a mastectomy.

Residential Treatment Center is an inpatient treatment Facility where the Insured resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a mental disorder or Substance Abuse. The Facility must be licensed to provide psychiatric treatment of Mental Health Conditions or rehabilitative treatment of Substance Abuse according to State and local laws and requires a minimum of one Physician visit per week in the Facility. Wilderness programs are not considered Residential Treatment Centers.

Self-Administered Hormonal Contraceptives are products with the following routes of administration:

- Oral;
- Transdermal;
- Vaginal;
- Depot Injection.

Self Administered Injectable Drugs are injectable Drugs which are self administered by the subcutaneous route (under the skin) by the patient or Dependent.

Serious Emotional Disturbances of a Child is the presence of one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than a primary

substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. The child must also meet one or more of the following criteria: 1) as a result of the mental disorder, the child has substantial impairment in at least two of the following areas: a) self care, b) school functioning, c) family relationships, or d) ability to function in the community, and either the child is at risk of being removed from the home or has already been removed from the home, or the mental disorder and impairments have been present for more than six (6) months or are likely to continue for more than one (1) Year without treatment; 2) the child displays one of the following: a) psychotic features, b) risk of suicide, or c) risk of violence; 3) the child meets special education eligibility requirements under California Education Code Section 56320.

Service Area is the State of California.

Severe Mental Illness includes the following psychiatric illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual (DSM):

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Anorexia nervosa
- Bulimia nervosa
- Pervasive Developmental Disorders or autism

Skilled Nursing Facility is a Facility that provides continuous nursing services. It must be licensed according to State and local laws and be recognized as a Skilled Nursing Facility under Medicare.

For purposes of Severe Mental Illness and Serious Emotional Disturbances of a Child only, a Skilled Nursing Facility will also include a Residential Treatment Center.

Specialist (Specialty Care Physician / Provider or SCP) A Specialist is a Physician who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs: Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These Drugs often need

special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail Pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility. With respect to a pregnant woman who is having contractions, the term "Stabilize" also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Student is the primary Insured who meets the Plan's rules for coverage in the part YOUR ELIGIBILITY.

Substance abuse conditions are defined under the definition for Mental Health Conditions.

Telehealth means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at an originating site and the health care Provider is at a distant-site. Telehealth facilitates patient self-management and caregiver support for patients and includes real-time interactions and the transmission of a patient's medical information from an originating site to the distant site without the presence of the patient. The originating site and the distant-site are licensed to provide Telehealth according to applicable law.

Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.

Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier contains preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.

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

Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3. This tier contains high cost Drugs including Specialty Drugs that may be Generic, single source Brand Drugs or multi-source Brand Drugs.

Please note that while the amount of the Coinsurance or Copay is usually higher for Drugs in higher tiers, the Cost Share that actually applies is determined by the Plan, and may be the same for two or more tiers. Please see the SUMMARY OF BENEFITS to determine the Copayment or Coinsurance amount for each tier.

Urgent Care Services are those services necessary to prevent serious deterioration of Your health resulting from an unforeseen illness, injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. In the case of pregnancy, this would include services necessary to prevent serious deterioration of the health of a woman or her unborn child.

Year and Yearly is a twelve (12) month period starting each January 1 at 12:01 a.m. Pacific Time.

You and Your means the Student and any Dependents covered under this Plan.

APPENDIX I – YOUR RIGHTS AND RESPONSIBILITIES

You have certain rights and responsibilities to help make sure that You get the most from this Plan. It helps You know what You can expect from Your overall health care benefit experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with Your doctors and other Health Professionals about all health care options and treatment needed for Your condition, no matter what the cost or whether it is covered under this Plan.
- Work with Your doctors in making choices about Your health care.
- Be treated with respect and dignity.
- Privacy of Your personal health information, as long as it follows State and federal laws and our privacy policies.
- Get information about our company and services, and our network of doctors and other health care Providers.
- Get more information about Your Rights and Responsibilities and give us Your thoughts and ideas about them.
- Give us Your thoughts and ideas about any of the rules of this Plan and in the way it works.
- Make complaints or appeal about: our organization, any benefit or coverage decisions we make, Your coverage, or care received.
- Say no to any care, for any condition, sickness or disease, without it affecting any care You may get in the future; and the right to have Your doctor tell You how that may affect Your health now and in the future.
- Get all of the most up-to-date information about the cause of Your illness, Your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that You will not be able to understand certain information, that information will be given to someone else that You choose.

You have the responsibility to:

- Choose a network Primary Care Physician (doctor), also called a PCP, if the Plan requires it.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with Your health care Providers and call their office if You have a delay or need to cancel.
- Read and understand, to the best of Your ability, all information about Your health benefits or ask for help if You need it.
- To the extent possible, understand Your health problems and work with Your doctors or other health care professionals to make a treatment plan that You all agree on.

- Give us, Your doctors and other health care professionals the information needed to help You get the best possible care and all the benefits You are entitled to. This may include information about other health coverage and insurance benefits You have in addition to Your coverage with us.
- Tell Your doctors or other health care professionals if You don't understand any care You are getting or what they want You to do as part of Your care plan.
- Follow the care plan that You have agreed on with Your Doctors and other health care professionals.
- Follow all Plan rules and policies.
- Let our customer service department know if You have any changes to Your name or address, or Dependents covered under this Plan.

If You have any questions or need additional information, call customer service at the telephone number listed on Your ID Card.

APPENDIX II – CDT CODES FOR DENTAL SERVICES

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D0120	Periodic oral evaluation - established patient – once per 6 months
D0140	Limited oral evaluation - problem focused
D0145	Oral evaluation for a patient under three (3) years of age and counseling with primary caregiver
D0150	Comprehensive oral evaluation - new or established patient
D0160	Detailed and extensive oral evaluation - problem focused, by report
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit) – covered twelve (12) times per twelve (12) months. Covered six (6) times per three (3) months for temporomandibular joint conditions.
D0171	Re-evaluation – post-operative office visit
D0180	Comprehensive periodontal evaluation - new or established patient
D0210	Intraoral - complete series of radiographic images – one complete series per provider every thirty-six (36) months
D0220	Intraoral - periapical first radiographic image – twenty (20) times per twelve (12) months, per provider includes D0230 below
D0230	Intraoral - periapical each additional radiographic image – twenty (20) films per twelve (12) months, includes D0220 above
D0240	Intraoral - occlusal radiographic image – two (2) times per six (6) months per provider except when documented as essential for a follow-up/post-operative exam (such as after oral surgery)
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector – one (1) film per day
D0251	Extra-oral posterior dental radiographic image – four (4) films per day
D0270	Bitewing - single radiographic image – once per date of service
D0272	Bitewings - two radiographic images - once per six (6) months, per provider
D0273	Bitewings - three radiographic images – once per six (6) months per provider
D0274	Bitewings - four radiographic images - once per (6) months, per provider
D0277	Vertical bitewings - 7 to 8 radiographic images
D0290	Posterior- anterior or lateral skull & facial bone survey radiographic image
D0310	Sialography
D0320	Temporomandibular joint arthrogram, including injection – three (3) times per day
D0322	Tomographic survey – twice per twelve (12) months, per provider
D0330	Panoramic radiographic image - once per thirty-six (36) months per provider (except when documented as essential for a follow-up/post-operative exam.)
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis – two (2) times every twelve (12) months per provider
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally – four (4) times per day
D0351	3D photographic image - covered as part of orthodontic care
D0460	Pulp vitality tests
D0470	Diagnostic casts - covered as part of orthodontic care
D0502	Other oral pathology procedures, by report
D0601	Caries risk assessment and documentation, with a finding of low risk
D0602	Caries risk assessment and documentation, with a finding of moderate risk

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D0603	Caries risk assessment and documentation, with a finding of high risk
D0999	Unspecified diagnostic procedure, by report
D1110	Prophylaxis - adult – one (1) time per six (6) months, includes D1120 below
D1120	Prophylaxis - child – one (1) time per six (6) months, includes D01110 above
D1206	Topical application of fluoride varnish – one (1) time per six (6) months, includes D1208
D1208	Topical application of fluoride – excluding varnish - one (1) time per six (6) months, includes D1206 above
D1310	Nutritional counseling for control of dental disease
D1320	Tobacco counseling for the control and prevention of oral disease
D1330	Oral hygiene instructions
D1351	Sealant - per tooth – for 1st, 2nd and 3rd molars. Covered one (1) time per tooth per thirty-six (36) months per provider. The original provider is responsible for any repair or replacement during the thirty-six (36) month period.
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth – for 1st, 2nd and 3rd molars only for an active cavity in a pit or fissure of a tooth. Covered one (1) time per tooth per thirty-six (36) months per provider. The original provider is responsible for any repair or replacement during the thirty-six (36) month period.
D1353	Sealant repair – per tooth – for 1st, 2nd and 3rd molars. Covered one (1) time per tooth per thirty-six (36) months per provider on the occlusal surfaces that are free of decay and/or restorations. The original provider is responsible for any repair or replacement during the thirty-six (36) month period.
D1510	Space maintainer - fixed - unilateral – one (1) time per quadrant
D1515	Space maintainer - fixed - bilateral – one (1) time per arc
D1520	Space maintainer - removable - unilateral – one (1) time per quadrant
D1525	Space maintainer - removable - bilateral – one (1) time per arch
D1550	Re-cement or re-bond space maintainer – covered once per provider per applicable quadrant or arch.
D1555	Removal of fixed space maintainer - covered only by provider <i>other than</i> who placed space maintainer
D1575	Distal shoe space maintainer – fixed – unilateral
D2140	Amalgam - one surface, primary or permanent – once per tooth per twelve (12) months for primary teeth; once per thirty-six (36) months for permanent teeth
D2150	Amalgam - two surfaces, primary or permanent – once per tooth per twelve (12) months primary teeth; once per thirty-six (36) months for permanent teeth
D2160	Amalgam - three surfaces, primary or permanent – once per tooth per twelve (12) months for primary teeth; once per thirty-six (36) months for permanent teeth
D2161	Amalgam - four or more surfaces, primary or permanent – once per tooth per twelve (12) months for primary teeth; once per thirty-six (36) months for permanent teeth
D2330	Resin-based composite - one surface, anterior – once per tooth per twelve (12) months for primary teeth; once per thirty-six (36) months for permanent teeth
D2331	Resin-based composite - two surfaces, anterior – per tooth per twelve (12) months for primary teeth; once per thirty-six (36) months for permanent teeth
D2332	Resin-based composite - three surfaces, anterior –once per tooth per twelve (12) months for primary teeth; once per thirty-six (36) months for permanent teeth
D2335	Resin-based composite four or more surfaces or involving incisal angle (anterior) – once per tooth per twelve (12) months for primary teeth; once per thirty-six (36) months for permanent teeth

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D2390	Resin-based composite crown, anterior – once per tooth per twelve (12) months for primary teeth; once per thirty-six (36) months for permanent teeth
D2391	Resin-based composite – one surface, posterior – once per tooth per twelve (12) months for primary teeth; once per thirty-six (36) months for permanent teeth
D2392	Resin-based composite - two surfaces, posterior – once per tooth per twelve (12) months for primary teeth; once per thirty-six (36) months for permanent teeth.
D2393	Resin-based composite - three surfaces, posterior – once per tooth per twelve (12) months for primary teeth; once per thirty-six (36) months for permanent teeth
D2394	Resin-based composite - four or more surfaces, posterior – once per tooth per twelve (12) months for primary teeth; once per thirty-six (36) months for permanent teeth.
D2710	Crown - resin-based composite (indirect) – once per tooth per sixty (60) months
D2712	Crown - 3/4 resin-based composite (indirect) – once per tooth per sixty (60) months
D2721	Crown - resin with predominantly base metal – once per tooth per sixty (60) months
D2740	Crown - porcelain/ceramic substrate - once per tooth per sixty (60) months
D2751	Crown - porcelain fused to predominantly base metal – once per tooth per sixty (60) months
D2781	Crown - 3/4 cast predominantly base metal – once per tooth per sixty (60) months
D2783	Crown - 3/4 porcelain/ceramic - once per tooth per sixty (60) months;
D2791	Crown - full cast predominantly base metal - once per tooth per sixty (60) months;
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration – once per tooth per twelve (12) months per provider;
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core
D2920	Re-cement or re-bond crown - covered twelve (12) months after initial placement of crown by same provider
D2921	Reattachment of tooth fragment, incisal edge or cusp
D2929	Prefabricated porcelain/ceramic crown – primary tooth – once per twelve (12) months
D2930	Prefabricated stainless steel crown - primary tooth - once per twelve (12) months
D2931	Prefabricated stainless steel crown - permanent tooth – once per thirty six (36) months. Not a benefit for 3 rd molars, unless the 3 rd molar occupies the 1 st or 2 nd molar position.
D2932	Prefabricated resin crown –once per tooth per twelve (12) months for primary teeth; once per thirty-six (36) months for permanent teeth. Not a benefit for 3 rd molars, unless the 3 rd molar occupies the 1 st or 2 nd molar position.
D2933	Prefabricated stainless steel crown with resin window – once per tooth per twelve (12) months for primary teeth; once per thirty-six (36) months for permanent teeth. Not a benefit for 3 rd molars, unless the 3 rd molar occupies the 1 st or 2 nd molar position.
D2940	Protective restoration – once per six (6) months per provider
D2941	Interim therapeutic restoration – primary dentition
D2949	Restorative foundation for an indirect restoration
D2950	Core buildup, including any pins when required
D2951	Pin retention - per tooth, in addition to restoration – once per tooth
D2952	Post and core in addition to crown, indirectly fabricated – once per tooth
D2953	Each additional indirectly fabricated post - same tooth
D2954	Prefabricated post and core in addition to crown – once per tooth
D2955	Post removal - not covered in conjunction with endodontic treatment
D2957	Each additional prefabricated post - same tooth

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D2971	Additional procedures to construct new crown under existing partial denture framework
D2980	Crown repair necessitated by restorative material failure - covered twelve (12) months after initial placement or repair of crown by same provider
D2999	Unspecified restorative procedure, by report
D3110	Pulp cap - direct (excluding final restoration)
D3120	Pulp cap - indirect (excluding final restoration)
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament - once per tooth
D3221	Pulpal debridement, primary and permanent teeth - once per tooth
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development - once per tooth
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - once per tooth
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) - once per tooth
D3310	Endodontic therapy, anterior tooth (excluding final restoration) - covered once per tooth on permanent teeth only
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration) - covered once per tooth on permanent teeth only
D3330	Endodontic therapy, molar (excluding final restoration) - covered once per tooth on permanent teeth only
D3331	Treatment of root canal obstruction; non-surgical access
D3333	Internal root repair of perforation defects is to be performed in conjunction with endodontic procedures and not separately
D3346	Retreatment of previous root canal therapy - anterior - covered once per permanent tooth; twelve (12) months after initial root canal by same provider
D3347	Retreatment of previous root canal therapy - bicuspid - covered once per permanent tooth; twelve (12) months after initial root canal by same provider
D3348	Retreatment of previous root canal therapy - molar - covered once per permanent tooth; twelve 12 months after initial root canal by same provider
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.) – once per permanent tooth
D3352	Apexification/recalcification – interim medication replacement – once per permanent tooth
D3410	Apicoectomy - anterior - covered ninety (90) days after root canal therapy on a permanent tooth and by same provider or twenty-four (24) months after apicoectomy/periradicular surgery on a permanent tooth by same provider
D3421	Apicoectomy - bicuspid (first root) - covered ninety (90) days after root canal therapy on a permanent tooth and by same provider or twenty four (24) months after apicoectomy/periradicular surgery on a permanent tooth by same provider
D3425	Apicoectomy - molar (first root) - covered ninety (90) days after root canal therapy on a permanent tooth by same provider and twenty four (24) months after apicoectomy/periradicular surgery on a permanent tooth by same provider
D3426	Apicoectomy (each additional root)
D3427	Periradicular surgery without apicoectomy

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D3430	Retrograde filling - per root
D3910	Surgical procedure for isolation of tooth with rubber dam
D3999	Unspecified endodontic procedure, by report
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant – once per quadrant per thirty-six (36) months
D4211	Gingivectomy or gingivoplasty - one (1) to three (3) contiguous teeth or tooth bounded spaces per quadrant - once per quadrant per thirty-six (36) months
D4249	Clinical crown lengthening – hard tissue
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four (4) or more contiguous teeth or tooth bounded spaces per quadrant - once per quadrant per thirty-six (36) months
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one (1) to three (3) contiguous teeth or tooth bounded spaces per quadrant – once per quadrant per thirty-six (36) months
D4265	Biologic materials to aid in soft and osseous tissue regeneration
D4341	Periodontal scaling and root planing - four or more teeth per quadrant – once per quadrant per twenty (24) months
D4342	Periodontal scaling and root planing - one to three teeth per quadrant – once per quadrant per twenty (24) months
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation – once per quadrant per twenty four (24) months
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
D4910	Periodontal maintenance – four (4) times per twelve (12) months; up to twenty-four (24) months following scaling and root-planing, includes D1110/D1120 above
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff) - once per provider within thirty (30) days of gingivectomy/gingivoplasty or osseous surgery
D4999	Unspecified periodontal procedure, by report
D5110	Complete denture - maxillary – once per 60 months. All adjustments made for six (6) months after the date of service, by the same provider, are included in the fee for this procedure.
D5120	Complete denture - mandibular – once per 60 months. All adjustments made for six (6) months after the date of service, by the same provider, are included in the fee for this procedure.
D5130	Immediate denture - maxillary – once per arch per lifetime. All adjustments made for six (6) months after the date of service, by the same provider, are included in the fee for this procedure.
D5140	Immediate denture - mandibular – once per arch per lifetime. All adjustments made for six (6) months after the date of service, by the same provider, are included in the fee for this procedure.
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) - once per sixty (60) months. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) - once per sixty (60) months. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) – once per sixty (60) months. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) – once per sixty (60) months. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth) - covered once per arch per lifetime. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth) - covered once per arch per lifetime. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) - covered once per arch per lifetime. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) - covered once per arch per lifetime. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5410	Adjust complete denture - maxillary – two (2) times per twelve (12) months per provider; six (6) months after initial placement, reline, or repair
D5411	Adjust complete denture - mandibular - two (2) times per twelve (12) months per provider; six (6) months after initial placement, reline, or repair
D5421	Adjust partial denture - maxillary - two (2) times per twelve (12) months per provider; six (6) months after initial placement, reline, or repair
D5422	Adjust partial denture - mandibular - two (2) times per twelve (12) months per provider; six (6) months after initial placement, reline, or repair
D5510	Repair broken complete denture base - two (2) times per twelve (12) months per provider; six (6) months after initial placement, reline, or repair
D5511	Repair broken complete denture base, mandibular – two (2) times per twelve (12) months per provider; six (6) months after initial placement, reline or repair
D5512	Repair broken complete denture base, maxillary – two (2) times per twelve (12) months, per provider; six (6) months after initial placement
D5520	Replace missing or broken teeth - complete denture (each tooth) – two (2) times per twelve (12) months per arch and up to four (4) teeth per visit per provider. All adjustments made for six months after the date or repair, in the same arch and by the same provider are included in the fee for this procedure
D5610	Repair resin denture base – two (2) times per twelve (12) months per arch per provider; All adjustments made for six months after the date or repair, in the same arch and by the same provider are included in the fee for this procedure.
D5611	Repair resin denture base, mandibular – two (2) times per twelve (12) months per provider; All adjustments made for six months after the date or repair, in the same arch and by the same provider are included in the fee for this procedure.
D5612	Repair resin denture base, maxillary - two (2) times per twelve (12) months per provider; All adjustments made for six months after the date or repair, in the same arch and by the same provider are included in the fee for this procedure.

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D5620	Repair cast framework – two (2) times per twelve (12) months per arch per provider. All adjustments made for six months after the date of repair, in the same arch and by the same provider are included in the fee for this procedure.
D5621	Repair cast framework, mandibular – two (2) times per twelve (12) months per provider; All adjustments made for six months after the date of repair, in the same arch and by the same provider are included in the fee for this procedure.
D5622	Repair cast framework, maxillary – two (2) times per twelve (12) months per provider; All adjustments made for six months after the date of repair, in the same arch and by the same provider are included in the fee for this procedure.
D5630	Repair or replace broken clasp - per tooth – two (2) times per twelve (12) months per arch and up to three (3) clasps per visit per provider; .All adjustments made for six months after the date or repair, in the same arch and by the same provider are included in the fee for this procedure.
D5640	Replace broken teeth - per tooth – two (2) times per twelve (12) months per arch and up to four (4) teeth per visit per provider; All adjustments made for six months after the date or repair, in the same arch and by the same provider are included in the fee for this procedure.
D5650	Add tooth to existing partial denture - covered up to three (3) teeth per visit per provider; All adjustments made for six months after the date or repair, in the same arch and by the same provider are included in the fee for this procedure.
D5660	Add clasp to existing partial denture -covered up to three (3) clasps per visit per provider; All adjustments made for six months after the date or repair, in the same arch and by the same provider are included in the fee for this procedure.
D5730	Reline complete maxillary denture (chairside) – once per six (6) months following D5130/D5863 with extractions; once per twelve (12) months following D5110/D5863 without extractions. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5731	Reline complete mandibular denture (chairside) – once per six (6) months following D5140/D5865 with extractions; once per twelve (12) months following D5120/D5865 without extractions. Not a benefit within 12 months of a laboratory reline complete mandibular denture. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5740	Reline maxillary partial denture (chairside) – once per six (6) months following D5211/D5213 with extractions; once per twelve (12) months following D5211/D5213 without extractions. Not a benefit within 12 months of a laboratory reline maxillary partial denture. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5741	Reline mandibular partial denture (chairside) – once per six (6) months following D5212/D5214 with extractions; once per twelve (12) months following D5212/D5214 without extractions. Not a benefit within 12 months of a laboratory reline mandibular partial denture. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5750	Reline complete maxillary denture (laboratory) – once per six (6) months following D5130/D5863 with extractions; once per twelve (12) months following D5110/D5863 without extractions. Not a benefit within 12 months of a chairside reline maxillary denture. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5751	Reline complete mandibular denture (laboratory) – once per six (6) months following D5140/D5865 with extractions; once per twelve (12) months following D5120/D5865 without extractions. Not a

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
	benefit within 12 months of a chairside reline complete mandibular denture. All adjustments m for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5760	Reline maxillary partial denture (laboratory) – once per six (6) months following D5213 with extractions; once per twelve (12) months following D5213 without extractions. Not a benefit within 12 months of a chairside reline maxillary partial denture with resin base. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5761	Reline mandibular partial denture (laboratory) – once per six (6) months following D5214 with extractions; once per twelve (12) months following D5214 without extractions. Not a benefit within 12 months of a chairside reline mandibular partial denture. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5850	Tissue conditioning, maxillary – two (2) times each appliance per thirty-six (36) months. Not a benefit same date of service as chairside or laboratory reline. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5851	Tissue conditioning, mandibular – two (2) times each appliance per thirty-six (36) months. Not a benefit same date of service as chairside or laboratory reline. All adjustments made for six (6) months after the date of service, by the same provider are included in the fee for this procedure.
D5862	Precision attachment, by report
D5863	Overdenture – complete maxillary
D5864	Overdenture – partial maxillary
D5865	Overdenture – complete mandibular
D5866	Overdenture – partial mandibular
D5899	Unspecified removable prosthodontic procedure, by report
D5911	Facial moulage (sectional)
D5912	Facial moulage (complete)
D5913	Nasal prosthesis
D5914	Auricular prosthesis
D5915	Orbital prosthesis
D5916	Ocular prosthesis
D5919	Facial prosthesis
D5922	Nasal septal prosthesis
D5923	Ocular prosthesis, interim
D5924	Cranial prosthesis
D5925	Facial augmentation implant prosthesis
D5926	Nasal prosthesis, replacement
D5927	Auricular prosthesis, replacement
D5928	Orbital prosthesis, replacement
D5929	Facial prosthesis, replacement
D5931	Obturator prosthesis, surgical
D5932	Obturator prosthesis, definitive
D5933	Obturator prosthesis, modification – two (2) times per twelve (12) months
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	Trismus appliance (not for TMD treatment)

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D5951	Feeding aid
D5952	Speech Aid prosthesis, pediatric
D5953	Speech aid prosthesis, adult
D5954	Palatal augmentation prosthesis
D5955	Palatal lift prosthesis, definitive
D5958	Palatal lift prosthesis, interim
D5959	Palatal lift prosthesis, modification – two (2) times per twelve (12) months
D5960	Speech aid prosthesis, modification – two (2) times per twelve (12) months
D5982	Surgical stent
D5983	Radiation carrier
D5984	Radiation shield
D5985	Radiation cone locator
D5986	Fluoride gel carrier
D5987	Commissure splint
D5988	Surgical splint
D5991	Vesiculobullous disease medicament carrier
D5999	Unspecified maxillofacial prosthesis, by report
D6010	Surgical placement of implant body: endosteal implant
D6011	Second stage implant surgery
D6013	Surgical placement of mini implant
D6040	Surgical placement: eosteal implant
D6050	Surgical placement: transosteal implant
D6052	Semi-precision attachment abutment
D6055	Connecting bar – implant supported or abutment supported
D6056	Prefabricated abutment – includes modification and placement
D6057	Custom fabricated abutment – includes placement
D6058	Abutment supported porcelain/ceramic crown
D6059	Abutment supported porcelain fused to metal crown (high noble metal)
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061	Abutment supported porcelain fused to metal crown (noble metal)
D6062	Abutment supported cast metal crown (high noble metal)
D6063	Abutment supported cast metal crown (predominantly base metal)
D6064	Abutment supported cast metal crown (noble metal)
D6065	Implant supported porcelain/ceramic crown
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)
D6068	Abutment supported retainer for porcelain/ceramic FPD
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072	Abutment supported retainer for cast metal FPD (high noble metal)
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)
D6074	Abutment supported retainer for cast metal FPD (noble metal)
D6075	Implant supported retainer for ceramic FPD

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure
D6085	Provisional implant crown
D6090	Repair implant supported prosthesis, by report
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment
D6092	Re-cement or re-bond implant/abutment supported crown - covered twelve (12) months after initial placement of crown by same provider
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture - covered twelve (12) months after initial placement of crown by same provider
D6094	Abutment supported crown - (titanium)
D6095	Repair implant abutment, by report
D6100	Implant removal, by report
D6110	Implant /abutment supported removable denture for edentulous arch – maxillary
D6111	Implant /abutment supported removable denture for edentulous arch – mandibular
D6112	Implant /abutment supported removable denture for partially edentulous arch – maxillary
D6113	Implant /abutment supported removable denture for partially edentulous arch – mandibular
D6114	Implant /abutment supported fixed denture for edentulous arch – maxillary
D6115	Implant /abutment supported fixed denture for edentulous arch – mandibular
D6116	Implant /abutment supported fixed denture for partially edentulous arch – maxillary
D6117	Implant /abutment supported fixed denture for partially edentulous arch – mandibular
D6190	Radiographic/surgical implant index, by report
D6194	Abutment supported retainer crown for FPD (titanium)
D6199	Unspecified implant procedure, by report
D6211	Pontic - cast predominantly base metal - once per tooth per sixty (60) months; only in conjunction with D5211/D5212/D5213/D5214 and same date of service as D6721/D6740/D6751/D6781/D6783/D6791
D6241	Pontic - porcelain fused to predominantly base metal – once per tooth per sixty (60) months; only in conjunction with D5211/D5212/D5213/D5214 and same date of service as D6721/D6740/D6751/D6781/D6783/D6791
D6245	Pontic - porcelain/ceramic – once per tooth per sixty (60) months; only in conjunction with D5211/D5212/D5213/D5214 and same date of service as D6721/D6740/D6751/D6781/D6783/D6791
D6251	Pontic - resin with predominantly base metal – once per tooth per sixty (60) months; only in conjunction with D5211/D5212/D5213/D5214 and same date of service as D6721/D6740/D6751/D6781/D6783/D6791
D6721	Retainer crown - resin with predominantly base metal - once per tooth per sixty (60) months; in conjunction with D5211/D5212/D5213/D5214
D6740	Retainer crown - porcelain/ceramic - once per tooth per sixty (60) months; in conjunction with D5211/D5212/D5213/D5214

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D6751	Retainer crown - porcelain fused to predominantly base metal – once per tooth per sixty (60) months in conjunction with D5211/D5212/D5213/D5214
D6781	Retainer crown - 3/4 cast predominantly base metal – once per tooth per sixty (60) months in conjunction with D5211/D5212/D5213/D5214
D6783	Retainer crown - 3/4 porcelain/ceramic – once per tooth per sixty (60) months in conjunction with D5211/D5212/D5213/D5214
D6791	Retainer crown - full cast predominantly base metal – once per tooth per sixty (60) months in conjunction with D5211/D5212/D5213/D5214
D6930	Re-cement or re-bond fixed partial denture - covered twelve (12) months after initial placement of crown by same provider
D6980	Fixed partial denture repair necessitated by restorative material failure - covered twelve (12) months after initial placement or repair of crown by same provider
D6999	Unspecified fixed prosthodontic procedure, by report
D7111	Extraction, coronal remnants - deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications
D7250	Removal of residual tooth roots (cutting procedure)
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth is covered once per arch regardless of the number of teeth involved for permanent anterior tooth only.
D7280	Exposure of an unerupted tooth
D7283	Placement of device to facilitate eruption of impacted tooth - covered with orthodontia
D7285	Incisional biopsy of oral tissue-hard (bone, tooth) – once per arch per date of service, regardless of the areas involved
D7286	Incisional biopsy of oral tissue-soft – three (3) times per date of service, regardless of the areas involved.
D7290	Surgical repositioning of teeth – once per arch per lifetime; with orthodontia
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report – once per arch per lifetime; with active orthodontia treatment
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant - covered following six (6) months of any extraction in the same quadrant for the same provider.
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant covered following six (6) months of any extraction in the same quadrant for the same provider
D7340	Vestibuloplasty - ridge extension (secondary epithelialization) – once per arch per 60 months

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) – once per arch per lifetime with orthodontia
D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7465	Destruction of lesion(s) by physical or chemical method, by report
D7471	Removal of lateral exostosis (maxilla or mandible) - once per quadrant for the buccal and or facial exostosis only.
D7472	Removal of torus palatinus – once per quadrant per lifetime
D7473	Removal of torus mandibularis – once per quadrant
D7485	Reduction of osseous tuberosity – once per quadrant
D7490	Radical resection of maxilla or mandible
D7510	Incision and drainage of abscess - intraoral soft tissue – once per quadrant per same date of service
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) – once per quadrant per same date of service
D7520	Incision and drainage of abscess - extraoral soft tissue – once per quadrant per same date of service
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces) – once per quadrant per same date of service
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue covered once per date of service
D7540	Removal of reaction producing foreign bodies, musculoskeletal system
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone – once per quadrant per date of service; following 30 days of an extraction
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	Maxilla - open reduction (teeth immobilized, if present)
D7620	Maxilla - closed reduction (teeth immobilized, if present)
D7630	Mandible - open reduction (teeth immobilized, if present)
D7640	Mandible - closed reduction (teeth immobilized, if present)
D7650	Malar and/or zygomatic arch - open reduction
D7660	Malar and/or zygomatic arch - closed reduction
D7670	Alveolus - closed reduction, may include stabilization of teeth
D7671	Alveolus - open reduction, may include stabilization of teeth

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7710	Maxilla - open reduction
D7720	Maxilla - closed reduction
D7730	Mandible - open reduction
D7740	Mandible - closed reduction
D7750	Malar and/or zygomatic arch - open reduction
D7760	Malar and/or zygomatic arch - closed reduction
D7770	Alveolus - open reduction stabilization of teeth
D7771	Alveolus, closed reduction stabilization of teeth
D7780	Facial bones - complicated reduction with fixation and multiple approaches
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical discectomy, with/without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrotomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7871	Non-arthroscopic lysis and lavage
D7872	Arthroscopy - diagnosis, with or without biopsy
D7873	Arthroscopy: lavage and lysis of adhesions
D7874	Arthroscopy: disc repositioning and stabilization
D7875	Arthroscopy: synovectomy
D7876	Arthroscopy: discectomy
D7877	Arthroscopy: debridement
D7880	Occlusal orthotic device, by report
D7881	Occlusal orthotic device adjustment
D7899	Unspecified TMD therapy, by report
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
D7920	Skin graft (identify defect covered, location and type of graft)
D7940	Osteoplasty - for orthognathic deformities
D7941	Osteotomy - mandibular rami
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy - segmented or subapical
D7945	Osteotomy - body of mandible
D7946	LeFort I (maxilla - total)
D7947	LeFort I (maxilla - segmented)

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft
D7949	LeFort II or LeFort III - with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach
D7952	Sinus augmentation via a vertical approach
D7955	Repair of maxillofacial soft and/or hard tissue defect
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure - once per arch
D7963	Frenuloplasty
D7970	Excision of hyperplastic tissue - per arch – once per arch
D7971	Excision of pericoronal gingiva
D7972	Surgical reduction of fibrous tuberosity – once per quadrant per day
D7980	Sialolithotomy
D7981	Excision of salivary gland, by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy
D7991	Coronoidectomy
D7995	Synthetic graft - mandible or facial bones, by report
D7997	Appliance removal (not by dentist who placed appliance), includes removal of arch bar – once per arch per day
D7999	Unspecified oral surgery procedure, by report
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8210	Removable appliance therapy – once per lifetime
D8220	Fixed appliance therapy – once per lifetime
D8660	Pre-orthodontic treatment examination to monitor growth and development – once every three (3) months
D8670	Periodic orthodontic treatment visit – four (4) visits per year (paid quarterly)
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s) – one (1) appliance per arch per course of treatment
D8681	Removable orthodontic retainer adjustment
D8691	Repair of orthodontic appliance – one (1) repair per appliance
D8692	Replacement of lost or broken retainer – one (1) replacement per arch per course of treatment within twenty four (24) months of D8680
D8693	Re-cement or re-bond fixed retainer
D8694	Repair of fixed retainers, includes reattachment
D8999	Unspecified orthodontic procedure, by report
D9110	Palliative (emergency) treatment of dental pain - minor procedure – once per day
D9120	Fixed partial denture sectioning
D9210	Local anesthesia not in conjunction with operative or surgical procedures – once per day
D9211	Regional block anesthesia is included in the fee for other procedures and is not payable separately.

CDT Code	CDT-17 Nomenclature with Limitations/Exclusions
D9212	Trigeminal division block anesthesia is included in the fee for other procedures and is not payable separately.
D9215	Local anesthesia in conjunction with operative or surgical procedures is covered one (1) time per day per provider.
D9220	Procedure Deep Sedation/General Anesthesia- first thirty (30) minutes
D9222	Deep sedation/analgesia - first fifteen (15) minutes
D9223	Deep sedation/general anesthesia – each fifteen (15) minute increment
D9230	Inhalation of nitrous oxide/analgesia- documentation must specifically identify the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment. Not covered on the same date of service as deep sedation/general anesthesia (D9220 and D9221), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248) and when all associated procedures on the same date of service by the same provider are denied.
D9239	Intravenous moderate (conscious) sedation/anesthesia - first fifteen (15) minutes is covered once per date of service.
D9241	Intravenous conscious sedation/analgesia first 30 minutes is covered once per date of service.
D9243	Intravenous moderate (conscious) sedation/analgesia – each fifteen (15) minute increment is covered once per date of service.
D9248	Non-intravenous conscious sedation is covered once per date of service.
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician
D9311	Consultation with a medical health professional
D9410	House/extended care facility call – once per day
D9420	Hospital or ambulatory surgical center call - units are in hours
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed once per day, per provider.
D9440	Office visit - after regularly scheduled hours – once per day, per provider.
D9610	Therapeutic parenteral drug, single administration – four (4) times per day
D9612	Therapeutic parenteral drugs, two or more administrations, different medications - alternates to D9610, which equals four (4) times per day
D9910	Application of desensitizing medicament – once per twelve (12) months per provider
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report – one (1) treatment per day per provider; within thirty (30) days of extraction
D9950	Occlusion analysis - mounted case – once per twelve (12) months for analysis for temporomandibular joint disorder
D9951	Occlusal adjustment - limited – once per twelve (12) months, per quadrant, per provider and for natural teeth only.
D9952	Occlusal adjustment - complete – once per twelve (12) months following occlusion analysis mounted case for temporomandibular joint dysfunction disorders only.
D9999	Unspecified adjunctive procedure, by report