Your Summary of Benefits
Loyola Marymount University/RSHM- Actives

Anthem Blue Cross

Custom Lumenos® Health Savings Account (HSA) 2500 20/40 (LHSA633)

This Summary of Benefits is a brief overview of your plan's benefits only. The benefits listed are for both in state and out of state members, there may be differences in benefits depending on where you reside. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

This Lumenos plan is an innovative type of coverage that allows an member to use a Health Savings Account to pay for routine medical care. The program also includes traditional health coverage, similar to a typical health plan, that protects the member against large medical expenses. The member can spend the money in the HSA account the way the member wants on routine medical care, prescription drugs and other qualified medical expenses. There are no copays or deductibles to satisfy first. Unused dollars can be saved from year to year to reduce the amount the member may have to pay in the future. If covered expenses exceed the member's available HSA dollars, the traditional health coverage is available after a limited out-of-pocket amount is paid by the member.

Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. The member is responsible for all costs over the plan maximums. Plan maximums and other important information appear in italics. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

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

Explanation of Maximum Allowed Amount
Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.
Participating Providers- The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.
Non-Participating Providers & Other Health Care Providers-(*includes those not represented in the PPO provider network*)-Reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
Participating Pharmacies & Mail Service Program-members are not responsible for any amount in excess of the prescription drug maximum allowed amount. Non-Participating Pharmacies-members are responsible for any expense not covered under this plan & any amount in excess of the prescription drug maximum allowed amount.

When using non-participating providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay. When using the outpatient prescription drug benefits, members are always responsible for drug expense which is not covered under this plan, as well as any deductible, percentage or dollar copay.

Calendar Year Deductible (*applicable to medical care & prescription drug benefits; family deductible includes employee & one or more enrolled family members, no coverage may be paid for any family member unless the family deductible is met)*

• All Providers	$2,500/individual member; $5,000/family

Annual Out-of-Pocket Maximums *(In-network/out-of-network out-of-pocket maximums are exclusive of each other; includes calendar year deductible & prescription drug maximum allowed amounts; the family out-of-pocket maximum is non-embedded meaning the cost shares of all family members apply to one shared family out-of-pocket. The individual out-of-pocket only applies to individuals enrolled under single coverage.)*

• Participating Providers, Participating Pharmacy & Other Health Care Providers	$3,400/individual member; $6,800/family
• Non-Participating Providers & Non-Participating Pharmacy	$7,000/individual member; $14,000/family

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

for non-covered expenses.

Lifetime Maximum	Unlimited

Covered Services	In-Network	Out-of-Network[§§]
Preventive Care Services		
Preventive Care Services including*, physical exams, preventive screenings *(including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing)*, and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay (*deductible waived*)	40%
Physician Medical Services		
∘ Office & home visits *(includes retail health clinic & online visit)*	20%	40%
∘ Hospital & skilled nursing facility visits	20%	40%
∘ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	40%
∘ Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	20%	40%
Diabetes Education Programs *(requires physician supervision)* ∘ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	20%	40%
∘ **Physical Therapy, Physical Medicine & Occupational Therapy**	20%	40%
∘ **Chiropractic Services** (*limited to 30 visits/calendar year*) [#]	20%	40%
Speech Therapy	20%	40%
Acupuncture ∘ Services for the treatment of disease, illness or injury *(limited to 12 visits/calendar year)*	20%[†]	40%[†]
Diagnostic X-ray & Lab		

Covered Services	In-Network	Out-of-Network[§§]
∘ Other diagnostic x-ray & lab	20%	40%
Advanced Imaging *(subject to utilization review)*	20%	40% *(benefit limited to $800/procedure)*
Urgent Care *(physician services)*	20%	40%
Emergency Care		
∘ Emergency room services & supplies	20%	20%
∘ Physician services	20%	20%
Hospital Medical Services *(subject to utilization review for inpatient and certain outpatient services; waived for emergency admissions)*		
∘ Semi-private or private room, medically necessary services & supplies	20%	40%
∘ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	40%
Skilled Nursing Facility *(subject to utilization review)*		
∘ Semi-private room, services & supplies *(limited to 100 days/calendar year; limit does not apply to mental health and substance abuse)*	20%	40%
Related Outpatient Medical Services & Supplies		
∘ Ground or air ambulance transportation, services & disposable supplies *(air ambulance in a non-medical emergency is subject to pre-service review and benefit limited to $50,000 for non-PPO)*	20%	In an emergency or with an authorized referral: 20%; Non-emergency: 40%
∘ Blood transfusions, blood processing & the cost of unreplaced blood & blood products[††]	20%	20%
∘ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)* [††]	20%	20%
Ambulatory Surgical Centers *(certain surgeries are subject to utilization review)*		

Covered Services	In-Network	Out-of-Network[§§]
∘ Outpatient surgery, services & supplies	20%	40% *(benefit limited to $350/admit)*
Pregnancy & Maternity Care ∘ Physician office visits ∘ Prescription drug for abortion *(mifepristone)* Normal delivery, cesarean section, complications of pregnancy & abortion. Refer to the Physician & Hospital Medical Services benefits for both inpatient and outpatient hospital coverage.	 20% 20%	 40% 40%
Mental or Nervous Disorders and Substance Abuse ∘ Inpatient facility care *(subject to utilization review; waived for emergency admissions)* ∘ Inpatient physician visits ∘ Outpatient facility care ∘ Physician office visits *(Behavioral Health treatment for Autism or Pervasive Development disorders requires pre-service review*)	 20% 20% 20% 20%	 40% 40% 40% 40%
Durable Medical Equipment *(may be subject to utilization review)* ∘ Rental or purchase of DME *(breast pump and supplies are covered under preventive care at no charge for in-network)*	20%	40%
Home Health Care *(subject to utilization review)* ∘ Services & supplies from a home health agency *(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less)*	20%	40%
Home Infusion Therapy *(subject to utilization review)* ∘ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	40% (*benefit limited to $600/day*)
Hemodialysis ∘ Outpatient hemodialysis services & supplies	20%	40% *(benefit limited to $350/visit for free standing hemodialysis center)*

Covered Services	In-Network	Out-of-Network[§§]
Hospice Care • Inpatient or outpatient services; family bereavement services	20%	40%
Bariatric Surgery *(subject to utilization review; covered only when performed at a Centers of Medical Excellence [CME] for California; Blue Distinction Centers for Speciality Care [BDCSC] for out of California)* • Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity • Travel expenses for an authorized, specified surgery *(recipient & companion transportation limited to $3,000 per surgery)*	20% No copay	Not covered[‡‡] Not covered[‡‡]
Organ & Tissue Transplants *(subject to utilization review; specified transplants covered only when performed at Centers of Medical Excellence [CME] for California; Blue Distinction Centers for Specialty Care [BDCSC] and for out of California)* • Inpatient services provided in connection with non-investigative organ or tissue transplants • Transplant travel expense for an authorized, specified transplant *(recipient & companion transportation limited to $10,000 per transplant)* • Unrelated donor search, limited to $30,000 per transplant	20% No copay	Not covered[‡‡] Not covered[‡‡]
Prosthetic Devices • Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; wigs for alopecia resulting from chemotherapy or radiation therapy; & therapeutic shoes & inserts for members with diabetes **Outpatient Prescription Drug Benefits** (*Until the calendar year deductible is satisfied, the member pays the prescription drug covered expense, and not the copays listed below.*) Your copay is determined by whether it is tier 1, tier 2, tier 3 or tier 4 drug. To determine tier status, the tiered drug formulary list is furnished to your provider and is also available online at www.anthem.com/ca, click on Customer Care, Download Forms and then choose Anthem Blue Cross Drug List (tiered). You may also contact our pharmacy customer service at 800-700-2541.	20%	40%
Retail Participating Pharmacy		

Covered Services	In-Network	Out-of-Network[§§]
∘ Preventive Immunizations administered by a retail pharmacy	No copay *(deductible waived)*	
∘ Female oral contraceptives generic and single source brand	No copay *(deductible waived)*	
∘ Tier 1 drugs *(includes diabetic supplies)*	$10	
∘ Tier 2 drugs	$30[f]	
∘ Tier 3 drugs *(includes compound drugs)*	$50[f]	
∘ Tier 4 drugs [§]	30% of prescription drug maximum allowed amount *(maximum $150 copay per fill)*	All Tiers: 30% of the prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount *(compound drugs & specialty pharmacy drugs not covered)*
Home Delivery Program		
∘ Female oral contraceptives generic and single source brand	No copay (*deductible waived)*	
∘ Tier 1 drugs *(includes diabetic supplies)*	$10	
∘ Tier 2 drugs	$60[f]	
∘ Tier 3 drugs	$100[f]	
∘ Tier 4 drugs [§]	30% of prescription drug maximum allowed amount *(maximum $300 copay per fill)*	
Specialty Pharmacy Program Certain specialty pharmacy drugs may only be obtained through the specialty pharmacy program and are limited to a 30 day supply. Please contact customer service number on the back of your ID card to see if your drug is on the specialty pharmacy program or you can get a list of drugs required to be dispensed by our specialty pharmacy program at anthem.com/ca. From our home page: Click on **Customer Care;** Then select "**I need to: Choose: Download Forms**"; In the pharmacy library section, click on "**Specialty Drug List**."	Applicable copay applies	
Supply Limits[‡]		

Covered Services	In-Network	Out-of-Network[§§]
∘ Retail Pharmacy (*participating and non-participating*)	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)	
∘ Home Delivery	90-day supply	
∘ Specialty Pharmacy	30-day supply	

The Outpatient Prescription Drug Benefit covers the following:

- All eligible immunizations administered by a participating retail pharmacy.
- Outpatient prescription drugs and medications which the law restricts to sale by prescription.

Formulas prescribed by a physician for the treatment of phenylketonuria.

- Insulin.
- Syringes when dispensed for use with insulin and other self-injectable drugs or medications.
- Prescription oral contraceptives; contraceptive diaphragms.
- Injectable drugs which are self-administered by the subcutaneous route (under the skin) by the patient or member.
- Drugs that have Food and Drug Administration (FDA) labeling for self-administration
- All compound prescription drugs that contain at least one covered prescription ingredient
- Diabetic supplies (i.e., test strips and lancets)
- Prescription drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
- Inhaler spacers and peak flow meters for the treatment of pediatric asthma.
- Smoking cessation products requiring a physician's prescription.
- Certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
In addition to the benefits described above, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.

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

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

Additional visits as authorized if medically necessary; pre-service review must be obtained prior to receiving the services.

‡ Supply limits for certain drugs may be different. Please refer to the Certificate of Insurance or EOC for

Covered Services	In-Network	Out-of-Network[§§]

complete information.

§ Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program.

f Preferred Generic Program. If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost of that type of prescription drug. The Preferred Generic Program does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.

†† These providers may not be represented in the PPO network in the state where the member receives services.

‡‡ Exception: If service is performed at a Centers of Medical Excellence [CME] for California or Blue Distinction Centers for Speciality Care [BDCSC] for out of California, the services will be covered same as the PPO (in-network) benefit.

§§ Member pays copay plus all charges in excess of the maximum allowed amount.

Lumenos HSA Plan - Exclusions and Limitations

Benefits are not provided for expenses incurred for or in connection with the following items:

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

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

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the Certificate or EOC.

Excess Amounts. Any amounts in excess of covered expense or any medical benefit maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the Certificate or EOC.

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

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the Certificate or EOC.

Voluntary Payment. Services for which the member is not legally obligated to pay. Services for which the member is not charged. Services for which no charge is made in the absence of insurance coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:
1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

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

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

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the Certificate or EOC.

Orthodontia. Braces and other orthodontic appliances or services.
Dental Services or Supplies. For dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:
1. Extraction, restoration, and replacement of teeth; 2. Services to improve dental clinical outcomes. This exclusion does not apply to the following:
1. Services which we are required by law to cover; 2. Services specified as covered in this booklet; 3. Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.

Hearing Aids or Tests. Hearing aids, except as specified as covered in the Certificate or EOC. Routine hearing tests, except as specified as covered in the Certificate.

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

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

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

Scalp Hair Prostheses. Scalp hair prostheses, including wigs or any form of hair replacement, except as specified as covered in the Certificate.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Certificate or EOC.

Sterilization Reversal. Reversal of sterilization.

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

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic Supplies. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC.
Air Conditioners. Air purifiers, air conditioners or humidifiers.

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

Chronic Pain. Treatment of chronic pain, except as specified as covered in the Certificate or EOC.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

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

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the Certificate or EOC. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone, except as specified as covered in the Certificate, EOC, or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the Certificate or EOC.

Acupuncture. Acupuncture treatment, except as specified as covered in the Certificate or EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

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

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

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

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

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

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

Private Duty Nursing. Private duty nursing services.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition, except as specified as covered in the Certificate or EOC. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Clinical Trials. Services and supplies in connection with clinical trials, except as specified as covered in the Certificate or EOC.

Varicose Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

Outpatient prescription drug services and supplies are not provided for or in connection with the following:
-Immunizing agents, biological sera, blood, blood products or blood plasma
-Hypodermic syringes &/or needles, except when dispensed for use with insulin & other self injectable drugs or medications
-Drugs & medications used to induce spontaneous & non-spontaneous abortions
-Drugs & medications dispensed or administered in an outpatient setting, including outpatient hospital facilities and physicians' offices
-Professional charges in connection with administering, injecting or dispensing drugs
-Drugs & medications that may be obtained without a physician's written prescription, except insulin or niacin for cholesterol lowering and certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.
-Drugs & medications dispensed by or while confined in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility
-Durable medical equipment, devices, appliances & supplies, even if prescribed by a physician, except contraceptive diaphragms, as specified as covered in the Certificate
-Services or supplies for which the member is not charged.
-Oxygen.
-Cosmetics & health or beauty aids.
-Drugs labeled "Caution, Limited by Federal Law to Investigational Use", or Non-FDA approved investigational drugs. Any drugs or medications prescribed for experimental indications.
-Any expense for a drug or medication incurred in excess of (a) the Prescription Drug Maximum Allowed Amount Limited for drugs dispensed by non-participating pharmacies; or (b) the outpatient prescription drug maximum allowed amount for drugs dispensed by participating pharmacies or through the mail service program.
-Drugs which have not been approved for general use by the State of California Department of Health Services or the Food and Drug Administration. This does not apply to drugs that are medically necessary for a covered condition.
-Over-the-counter smoking cessation drugs. This does not apply to medically necessary drugs that the member can only get with a prescription under state and federal law.
-Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of drug for medically necessary treatment of a medical condition other than one that is cosmetic.
-Drugs used primarily to treat infertility (including, but not limited to, Clomid, Pergonal and Metrodin), unless medically necessary for another covered condition.
-Anorexiants and drugs used for weight loss, except when used to treat morbid obesity (e.g., diet pills & appetite suppressants)
-Drugs obtained outside the U.S. unless they are furnished in connection with urgent care or an emergency.
-Allergy desensitization products or allergy serum
-Infusion drugs, except drugs that are self-administered subcutaneously
-Herbal supplements, nutritional and dietary supplements except for formulas for the treatment of phenylketonuria.
-Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was ineffective.
-Compound medications obtained from other than a participating pharmacy. Members will have to pay the full cost of the compound drugs if member obtains drug at a non participating pharmacy.
-Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy are not covered by this plan. Members will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that member should have obtained from the specialty pharmacy program.

Pre-Existing Condition Exclusion - No payment will be made for services or supplies for the treatment of a pre-existing condition during a period of six months following either: (a) the member's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. However, this limitation does not apply to an member who is under age 19 or to conditions of pregnancy. Also if an member was covered under creditable coverage, as outlined in the member's Certificate, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six month period.

Third Party Liability - Anthem Blue Cross Life and Health Insurance Company is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

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

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