Your Summary of Benefits

SCCSIG Medium HMO Plan

Anthem Blue Cross

Modified Premier HMO 30/10%Admit/10% OP

This Summary of Benefits is a brief overview of your plan's benefits only. 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.

Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA), except services provided under the "ReadyAccess" program, OB/GYN services received within the member's medical group/IPA, and services for all mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Calendar Year Deductible Individual $250; Family $500

The calendar year deductible applies to all services except: Emergency services, Preventive Care Services, and Office Visits.

Annual Out-of-Pocket Maximum: Individual $2,500; Family $5,000

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

Covered Services	Per Member Copay
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 and 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)*
Smoking Cessation Program	No copay *(deductible waived)*
Physician Medical Services	
∘ Office & home visits	$30/visit *(deductible waived)*
∘ Specialists	$30/visit *(deductible waived)*
∘ Skilled nursing facility visits	No copay
∘ Hospital visits	No copay
∘ Injectable medications in physician's office *(excluding allergy serum and immunization)*	10%/up to $150 maximum copay
∘ Surgeon & Surgical assistant	No copay
∘ Anesthesiologist or anesthetist	No copay
Acupuncture	$30/visit *(deductible waived)*

Covered Services	Per Member Copay
Outpatient Medical Services (*Services received in a hospital, other than emergency room services, or in any facility that is affiliated with a hospital*)	
• Outpatient surgery & supplies	10%
• Advanced Imaging	10%
• All other X-ray & laboratory tests (*including genetic testing*)	10%
• Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy	10%
• Other Outpatient Medical Services including:	10%
Rehabilitation Therapy (Physical, Occupational, or Speech Therapy, limited to a 60-day period of care)	
General Medical Services (*when performed in non-hospital-based facility*)	
• Advanced Imaging	$100/test
• All other X-ray & laboratory tests (*including genetic testing*)	No copay
• Allergy testing & treatment (including serums)	$30/visit *(deductible waived)*
• Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy	$30/visit *(deductible waived)*
• Rehabilitation Therapy (Physical, Occupational, or Speech Therapy or Chiropractic Care, limited to 60-days period of care)	$30/visit *(deductible waived)*
• Sleep Studies in a sleep lab	$50/night
Emergency Care	
• Physician & medical services	No copay *(deductible waived)*
• Outpatient hospital emergency room services	$150/visit *(copay waived if admitted, then 10% of charges still applies; deductible waived)*
Inpatient Medical Services	
Semi-private room or private room, medically necessary services & supplies	10%/admit
Urgent Care (out of service area)	$30/visit *(waived if admitted; deductible waived)*
Skilled Nursing Facility (*limited to 100 days/calendar year; limit does not apply to mental health and substance abuse*)	
• All necessary services & supplies (*excluding take-home drugs*)	10%/admit
Ambulance Services	
• Ground or air ambulance transportation when medically necessary	10%/trip
Ambulatory Surgical Center	
• Outpatient surgery & supplies	10%

Covered Services	Per Member Copay
Pregnancy and Maternity Care Prenatal & postnatal Professional (physician) services (For your Inpatient copay, see Inpatient Medical Services. For your Outpatient Services copay, see Outpatient Medical Services)	 $30/visit *(deductible waived)*
Abortions (including prescription drug for abortion, mifepristone)	No copay
Prosthetic devices (including Orthotics)	No copay
Durable medical equipment • Hearing aids benefit limited to one hearing aid per ear every three years	10%
Family Planning Services • Infertility studies & tests • Female Sterilization *(including tubal ligation and counseling/consultation)* • Male Sterilization • Counseling & consultation	 50% of covered expense† No copay *(deductible waived)* $100 $30/visit *(deductible waived)*
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 require pre-service review)*	 10%/admit No copay No copay $30/visit *(deductible waived)*
Home Health Care (*limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less*)	$30/visit *(deductible waived)*
Hospice Care (*Inpatient or outpatient services; family bereavement services*)	No copay
Organ and Tissue Transplant • Inpatient Care • Physician office visits • Specialists office visits	 10% $30/visit *(deductible waived)* $30/visit *(deductible waived)*

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† Not applicable to the annual copay maximum

For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to: https://le.anthem.com/pdf?x=CA_LG_HMO

Modified 10/30/50 for HMO Plans (Low & Medium) Prescription Drug Benefits

PLEASE NOTE*: This is only a summary of your benefits. Please refer to your Combined Evidence of Coverage and Disclosure Form ("EOC")/Certificate of Insurance ("Certificate") which explains your plan's Exclusions and Limitations as well as the full range of your covered services in detail.*

At Anthem Blue Cross, we know that prescription drugs are the fastest–rising item of your total health care benefits cost. The reasons for the spiraling costs of prescription drugs are varied and include: a general increase of prescription medication use, an aging population, research and development of new medications and the expense of direct to consumer advertising. With prescription drug costs increasing at twice the rate of medical care, we developed ways to contain costs so your copays remain affordable, while maintaining your access to safe, effective prescription drugs. Our Prescription Drug Program provides you with choice, flexibility, affordability and access to an extensive network of retail pharmacies.

Getting a Prescription Filled at a Participating Pharmacy

To get a prescription filled, you need only take your prescription to a participating pharmacy and present your member ID card. The amount you pay for a covered prescription – your copay – will be determined by the drug's type (whether the drug is a brand-name or generic medication and whether it is a formulary or non-formulary medication).

A generic drug contains the same effective ingredients, meets the same standards of purity as its brand-name counterpart and typically costs less. In many situations, you have a choice of filling your prescription with a generic medication or a brand-name medication.

The formulary is a list of approximately 600 recommended brand and generic medications. These medications have undergone extensive review for therapeutic value for a particular medical condition, safety and cost. Copies of our formulary are furnished to your providers and are available online at anthem.com/ca under the Pharmacy section. You or your provider may also contact Pharmacy Customer Service at 800-700-2541.

The following chart summarizes the relation between drug type and your copay amount at a participating pharmacy:

Drug Type	Copay Amount
Generic	$10.00
Brand name formulary	$30.00[1]
Brand name non-formulary	$50.00[1]

Finding a Participating Pharmacy

Because our huge pharmacy network includes major drugstore chains plus a wide variety of independent pharmacies, it is easy for you to find a participating pharmacy. You can also find a participating pharmacy by calling Pharmacy Customer Service at 800-700-2541 or by going to our Web site at anthem.com/ca.

An Extensive Network

Besides saving you money, our extensive network of pharmacies offers you easy accessibility.

- In California there are over 5,100 retail pharmacies. This accounts for nearly 95% of retail pharmacies in the state, including all major chains.
- Nationwide there are more than 61,000 chain and independent pharmacies.

Using a Participating Pharmacy

You can substantially control the cost of your prescription drugs by using our extensive network of participating pharmacies. Participating pharmacies have agreed to charge you not more than the prescription drug maximum allowed amount.

Using a Non-Participating Pharmacy

If you choose to fill your prescription at a non-participating pharmacy, your costs will increase. You will likely need to pay for the entire amount of the prescription and then submit a prescription drug claim form for reimbursement. If you do not have the original pharmacy receipt(s) showing the date filled, name and address of the pharmacy, doctor's name, NDC number, name of drug and strength, quantity and days supply, prescription number, and the amount paid, the pharmacist must sign and complete the appropriate section of the claim form to ensure proper processing of the claim for reimbursement.

Members that submit claims from non-participating pharmacies are reimbursed based on a prescription drug maximum allowed amount. The prescription drug maximum allowed amount may be considerably less than you paid for your medication. You are responsible for any difference in cost between the prescription drug maximum allowed amount and what you paid for your medication.

You may obtain a prescription drug claim form by calling Pharmacy Customer Service at the toll-free number printed on your member ID card or by going to our Web site at anthem.com/ca.

The following chart illustrates potential increased out-of-pocket expenses for going to a non-participating pharmacy:

	Out-of-pocket costs using a participating pharmacy	Out-of-pocket costs using a non-participating pharmacy
Pharmacy's normal charge for brand-name formulary drug	$50.00[2]	$50.00
You are responsible for:	$30.00 copay	$30 copay plus 50% of the prescription drug maximum allowed amount plus any amounts exceeding the prescription drug maximum allowed amount.
Total out-of-pocket expenses	$30.00	Expense varies based on the cost of the medication

You may obtain a prescription drug claim form by calling Pharmacy Customer Service at the toll-free number printed on your member ID card or by going to our Web site at anthem.com/ca.

Home Delivery Prescription Drug Program

If you take a prescription drug on a regular basis, you may want to take advantage of our Home Delivery program. Ordering your medications by mail is convenient, saves time and depending on your plan design, may even save you money. Besides enjoying the convenience of home delivery, you will also receive a greater supply of medications. To fill a prescription through the mail, simply complete the Home Delivery form. You may obtain the form by calling Customer Service, at the toll-free number listed on your ID card or by going to our Web site at anthem.com/ca.

Once you complete the form, simply mail it with your copay and prescription in the envelope attached to the Home Delivery brochure.

Please note that not all medications are available through the Home Delivery Program. Specialty pharmacy drugs are not available through the home delivery program, see Specialty Pharmacy Program below.

Out-Of-State Prescription Benefits

Our national network of participating pharmacies is available to members when outside California. To find a participating pharmacy, a member can check our Web site or call the toll-free number printed on the ID card. When using a non-participating pharmacy outside of California, the member will follow the same procedures for using a non-participating pharmacy in California as outlined above.

Additional Features That are Part of your Plan

Prior authorization as the term implies, means some drugs require prior authorization before you can get them (this is similar to prior authorization for medical services). Prior authorization applies to a certain medications that are often a second line of therapy. To receive prior authorization, you must meet specific criteria. The criteria will be based on medical policy and the pharmacy and therapeutics established guidelines. You may need to try a drug other than the one originally prescribed if we determine that it should be clinically effective for you. Drugs which require prior authorization are not covered unless you receive a prior approval from Anthem Blue Cross.

In order for you to get a drug which requires prior authorization, your physician needs to make a written request to us for you. We distribute instructions on how to obtain prior authorization to physicians and pharmacies so that you may obtain prior authorization for required medications. You may call Pharmacy Customer Service, at the toll-free number printed on your member ID card, to receive a prior authorization form and/or list of medications requiring prior authorization.

Supply limits are the proper FDA recommendations for prescription medication dosage coupled with our determination of specific quantity supply limits to prescription medications. Although our standard pharmacy plans offer a 30-day supply for medications at a retail pharmacy, the supply limit can vary based on the medication, dosage and usage prescribed by your physician. For example, the supply limit for antibiotics used to treat an infection (e.g., 14 pills to be taken twice a day for one week) is different than blood pressure medication taken on a routine basis (e.g., 120 pills to be taken twice a day for 60 days). By adhering to specified supply limits, members are assured of receiving the appropriate amount of medication.

Specialty Pharmacy Program

Specialty medications are usually dispensed as an injectable drug, but may be available in other forms, such as a pill or inhalant. They are used to treat complex conditions. Prescriptions for specified specialty pharmacy drugs are covered only when ordered through the specialty pharmacy program unless you are given an exception from the specialty drug program *(see EOC/Certificate for details).* The specialty pharmacy program will deliver your medication to you by mail or common carrier *(you cannot pick up your medication).*

You may have to pay the full cost of a specialty pharmacy drug if it is not obtained from the specialty pharmacy program.

Programs for Member's Special Health Needs

We recognize that some of our members have unique health care needs requiring special attention. That's why we developed programs exclusively for them. Our additional medical management programs work in synergy with our pharmacy drug program to help members better manage their health care on an ongoing basis.

Diabetic members can receive free glucometers so that they can effectively and conveniently monitor their glucose levels.

Seniors can better monitor their chronic diseases and multiple medications through our seniors-at-risk program. This program reduces the possibility of toxic drug interactions, and curtails distribution of medications that may adversely affect the senior's chronic condition.

Asthmatic members and their families can take advantage of our program to better control the frequency and severity of the disease.

Members who take multiple prescription medications can take advantage of our pharmacy utilization management programs that encourage the safe, effective distribution of prescription medications. We have a program that protects the welfare of members with multiple prescription medications by carefully monitoring their prescription therapy to help reduce the danger of toxic drug interaction.

For additional information regarding your prescription drug benefits, please call Pharmacy Customer Service at the toll-free number printed on your member ID card.

Covered Services (outpatient prescriptions only)	Per Member Cost Share for Each Prescription or Refill
Retail Pharmacy	
➢ Preventive immunizations administered by a retail pharmacy	No copay
➢ Female oral contraceptives generic and single source brand	No copay
➢ Generic drugs	$10
➢ Brand name formulary drugs[1]	$30
➢ Brand name non-formulary drugs[1]	$50
➢ Compound Drugs[1]	$50
➢ Self-administered injectable drugs, except insulin	copays above apply
Home Delivery Program	
➢ Female oral contraceptives generic and single source brand	No copay
➢ Generic drugs	$10
➢ Brand name formulary drugs[1]	$60
➢ Brand name non-formulary drugs[1]	$100
➢ Self-administered injectable drugs, except insulin	copays above apply
Specialty Pharmacy Drugs *(applicable only to specified drugs that must be obtained through the specialty pharmacy program)*	
➢ Generic drugs	$10
➢ Brand name formulary drugs[1]	$30
➢ Brand name non-formulary drugs[1]	$50
➢ Self-administered injectable drugs, except insulin	copays above apply
Non-participating Pharmacies *(compound drugs & certain specialty pharmacy drugs not covered at a retail pharmacy)*	*Member pays the above retail pharmacy copay plus:* 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount up to $250 per prescription
Supply Limits[3]	
➢ 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);90-day supply for eligible prescriptions obtained through a retail pharmacy, but will require a triple copay
➢ Home Delivery	90-day supply
➢ Specialty Pharmacy	30-day supply

[1] Preferred Generic Program. If a member requests a formulary or non-formulary 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 charge 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 (formulary or non-formulary) is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.

[2] Prescription drug maximum allowed amount.

[3] Supply limits for certain drugs may be different. Please refer to the EOC/Certificate for complete information.

The 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. These formulas are subject to the copay for brand name drugs.
- Folic acid supplementation prescribed by a physician for women planning to become pregnant (folic acid supplement or a multivitamin) prescribed by a physician.
- Aspirin prescribed by a physician for the reduction of heart attack or stroke prescribed by a physician.
- Smoking cessation products and over-the-counter nicotine replacement products (limited to nicotine patches and gum) as prescribed by physician.
- Prescription drugs prescribed by a physician to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products.
- Insulin
- Syringes when dispensed for use with insulin and other self-injectable drugs or medications
- All FDA-approved contraceptives for women, including oral contraceptives; contraceptive diaphragms and over-the-counter contraceptives prescribed by a doctor.
- Injectable drugs which are self-administered by the subcutaneous route (under the skin).
- 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. These items are subject to the copay for brand name drugs.
- Certain over-the-counter drugs approved by the Pharmacy and Therapeutics Process to be included in the prescription drug formulary.

Prescription drug cost shares are included in the medical out-of-pocket maximum. See medical plan summary of benefits for details.

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Prescription Drug Exclusions & Limitations

- Hypodermic syringes &/or needles, except when dispensed for use with insulin & other self-injectable drugs or medications.
- Drugs & medications used to induce spontaneous & non-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, even if written as a *prescription,* that may be obtained without a physician's written prescription, except insulin or niacin for cholesterol lowering and certain over-the-counter drugs approved by the Pharmacy and Therapeutics Process to be included in the prescription drug formulary.
- Drugs & medications dispensed by or while confined in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility.
- Durable medical equipment, devices, appliances & supplies, even if prescribed by a physician, except contraceptive diaphragms, as specified as covered in the EOC/Certificate.
- Services or supplies for which the member is not charged.
- Oxygen.
- Cosmetics & health or beauty aids. However, health aids that are medically necessary and meet the requirements as specified as covered in the EOC/Certificate.
- Drugs labeled "Caution, Limited by Federal Law to Investigational Use," or experimental drugs.
- Drugs or medications prescribed for experimental indications.
- Any expense for a drug or medication incurred in excess of the prescription drug maximum allowed amount.
- Drugs which have not been approved for general use by the Food and Drug Administration. This does not apply to drugs that are medically necessary for a covered condition.
- Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products. This does not apply to medically necessary drugs that the member can only get with a prescription under 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.
- Anorexiants and drugs used for weight loss, except when used to treat morbid obesity (e.g., diet pills & appetite suppressants).
- Drugs obtained outside the U.S, unless they are furnished in connection with urgent care or an emergency.
- Allergy desensitization products or allergy serum.
- Infusion drugs, except drugs that are self-administered subcutaneously.
- Herbal supplements, nutritional and dietary supplements, except as described in this *plan* or that we must cover by law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written *prescription* or from a licensed pharmacist.
- Formulas and special foods for the treatment of phenylketonuria (PKU).
- Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was ineffective.
- Onychomycosis (toenail fungus) drugs except to treat members who are immuno-compromised or diabetic.
- Prescription drugs that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material, thus treating a disease or abnormal medical condition.
- All compound *prescription drugs* when a commercially available dosage form of a *medically necessary* medication is not available, all the ingredients of the *compound drug* are FDA approved in the form in which they are used in the *compound medication* and as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense and are not essentially the same as an FDA approved product from a *drug* manufacturer. Non-FDA approved non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
- Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but which are obtained from a retail pharmacy are not covered by this plan. Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that member should have obtained from the specialty pharmacy program.
- Prescription drugs that are considered multi-source brand drugs. This exclusion only applies to the Essential Drug Formulary plans.
- Off label prescription drugs
- Charges for services not described in your medical records.
- Certain prescription drugs may not be covered if you could use a clinically equivalent drug, unless required by law. "Clinically equivalent" means drugs that for most members, will give you similar results for a disease or condition. If you have questions about whether a certain drug is covered and which drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com. If you or your physician believes you need to use a different prescription drug, please have your physician or pharmacist get in touch with us. We will cover the other prescription drug only if we agree that it is medically necessary and appropriate over the clinically equivalent drug. We will review benefits for the prescription drug from time to time to make sure the drug is still medically necessary. This exclusion only applies to the Traditional Drug Formulary plans.
- Drugs which are over any quantity or age limits set by the plan or us.
- Prescription drugs prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications.
- Drugs prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law or self.
- Services we conclude are not medically necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- Third Party Liability Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

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

Chiropractic Care and Acupuncture Rider Plan 15/20

The benefits described in this Rider are provided through an agreement between Anthem Blue Cross and American Specialty Health Plans of California (ASH Plans). The services listed below are covered only if provided by an ASH Plans Chiropractor and/or ASH Plans Acupuncturist. These benefits are provided in addition to the benefits described in the Anthem Blue Cross HMO Evidence of Coverage (EOC) document. However, when expenses are incurred for treatment received from an ASH Plans Chiropractor or ASH Plans Acupuncturist, no other benefits other than the benefits described in this Rider will be paid.

Covered Services	Member's Copayment
Office Visit to a Chiropractor or Acupuncturist	$15/visit
Maximum Benefits	
Office visits to a Chiropractor or Acupuncturist	20 visits per calendar year (chiropractic and acupuncture visits combined)
Chiropractic appliances	$50 per calendar year

Covered Services

Chiropractor Services: Member has up to 20 visits, combined with visits for acupuncture services, in a calendar year for chiropractor care services that are determined by ASH PLANS to be medically/clinically necessary. All visits to an ASH Plans chiropractor or ASH Plans acupuncturist will be applied towards the maximum number of visits in a calendar year. The ASH Plans chiropractor is responsible for submitting a treatment plan to ASH Plans for prior approval.

Covered services include:

- An initial new patient exam by an ASH Plans chiropractor to determine the appropriateness of chiropractic services.
- Follow-up office visits as set forth in a treatment plan approved by ASH Plans and provided by an ASH Plans chiropractor
- An established patient exam performed by an ASH Plans chiropractor to assess the need to continue, extend or change a treatment plan approved by ASH Plans.
- Adjunctive physiotherapy modalities and procedures as set forth in a treatment plan approved by ASH Plans and provided by ASH Plans chiropractor.
- Radiological x-rays and laboratory tests when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered services include radiological consultations when determined by ASH Plans to be medically/clinically necessary and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or hospital which has contracted with ASH Plans to provide those services.
- Chiropractic Appliances: Up to $50 per calendar year when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered chiropractic appliances are limited to:
  - elbow supports, back supports (thoracic), lumbar braces and supports, rib supports, or wrist supports;
  - cervical collars or cervical pillows;
  - ankle braces, knee braces, or wrist braces;
  - heel lifts;
  - hot or cold packs;
  - lumbar cushions;
  - rib belts or orthotics; and
  - home traction units for treatment of the cervical or lumbar regions.

Acupuncture Services. Member has up to 20 visits, combined with visits for chiropractic care, in a calendar year for acupuncture services that are determined by ASH Plans to be medically/clinically necessary. All visits to an ASH Plans chiropractor or ASH Plans acupuncturist will be applied towards the maximum number of visits in a calendar year. The ASH Plans acupuncturist is responsible for submitting a treatment plan to ASH Plans for prior approval.

Covered services include:

- An initial new patient exam by an ASH Plans acupuncturist to determine the appropriateness of acupuncture services.
- Follow-up office visits as set forth in a treatment plan approved by ASH Plans and provided by an ASH Plans acupuncturist
- An established patient exam performed by an ASH Plans acupuncturist to assess the need to continue, extend or change a treatment plan approved by ASH Plans.
- Adjunctive physiotherapy modalities and procedures as set forth in a treatment plan approved by ASH Plans and provided by ASH Plans acupuncturist.

Chiropractic Care and Acupuncture Rider Exclusions & Limitations

Care Not Approved: Any services provided by an ASH Plans chiropractor or an ASH Plans acupuncturist that are not approved by ASH Plans except as specified as covered in the Evidence of Coverage (EOC). An ASH Plans chiropractor or ASH Plans acupuncturist is responsible for submitting a treatment plan to ASH Plans for prior approval.

Care Not Covered: In addition to any service or supply specifically excluded in the EOC, no benefits will be provided for chiropractic or acupuncture services or supplies in connection with:

- Diagnostic scanning, such as magnetic resonance imaging (MRI) or computerized axial tomography (CAT) scans. Diagnostic services for acupuncture.
- Thermography.
- Hypnotherapy.
- Behavior training.
- Sleep therapy.
- Weight programs.
- Any non-medical program or service.
- Pre-employment examinations, any chiropractic or acupuncture services required by an employer that are not medically/clinically necessary, or vocational rehabilitation.
- Services and/or treatments which are not documented as medically/clinically necessary.
- Massage therapy.
- Acupuncture performed with reusable needles.
- Acupuncture services benefits are not provided for magnets used for diagnostic or therapeutic use, ion cord devices, manipulation or adjustments of the joints, physical therapy services, iridology, hormone replacement products, acupuncture point or trigger-point injections (including injectable substances), laser/laser biostim, colorpuncture, NAET diagnosis and/or treatment, and direct moxibustion.
- Any service or supply for the exam and/or treatment by an ASH chiropractor for conditions other than those related to neuromusculoskeletal disorders.
- Services from an ASH Plans acupuncturist for exam and/or treatment for conditions not related to neuromusculoskeletal disorders, nausea or pain, incluing, without limitation, asthma or addictions such as nicotine addiction.
- Transportation costs including local ambulance charges.
- Education programs, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing.
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services, or other related services;
- All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephone compatible with hearing aids;
- Adjunctive therapy not associated with spinal, muscle or joint manipulation.
- Laboratory and diagnostic x-ray studies, except as specified as covered in the EOC.

Non-ASH Plans Chiropractors or non-ASH Plans Acupuncturists: Services and supplies provided by a chiropractor or an acupuncturists who does not have an agreement with ASH Plans to provide covered services under this plan.

Work Related: Care for health problems that are work-related if such health problems are covered by workers' compensation, an employer's liability law or similar law. We will provide care for a work-related health problem, but we have the right to be paid back for that care as described in the EOC.

Government Treatment: Any services actually given to the member by a local, state or federal government agency, except when this plan's benefits, must be provided by 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.

Drugs: Prescription drugs or medicines, including a non-legend or proprietary medicine or medication not requiring a prescription.

Supplement. Vitamins, minerals, dietary and nutritional supplements or other similar products and any herbal supplements.

Air Conditioners: Air purifiers, air conditioners, humidifiers, supplies or any other similar devices or appliances. All appliances or durable medical equipment, except as specified as covered in the EOC.

Personal Items: Any supplies for comfort, hygiene or beauty purposes, including therapeutic mattresses.

Out-Of-Area and Emergency Care: Out-of-area care is not covered under this Chiropractic and Acupuncture Care benefit, except for emergency services. The member should follow the procedures specified by their Anthem Blue Cross HMO plan to obtain emergency or out-of-area care.

Third Party Liability

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

Modified Infertility Treatment Rider

To Accompany Blue Cross HMO Plans

Blue Cross of California offers the option to choose infertility treatment with all medical plans.

Infertility Treatment Benefit

Medical care that is covered, when provided for the diagnosis and treatment of infertility, shall be those services and supplies specified in the Evidence of Coverage (EOC) as covered for the treatment of illness generally. The member must be under the direct care and treatment of a physician for infertility. Benefits are NOT payable for laboratory medical procedures involving the actual in vitro fertilization process.

The member's copayment will be **50%** of covered expense incurred (Note: Any copayment made for infertility treatment will not be applied to the Annual Copayment Maximums). In no event will benefit payments exceed **$4,000** for all covered expense incurred in a calendar year.

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Effective 1/2000Printed 9/27/2018