PPO 2024

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

Please refer to the "Definitions" section for details on what is considered Covered Services and Medically Necessary.

1) **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 war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

2) **Administrative Charges**

   a) Charges to complete claim forms,

   b) Charges to get medical records or reports,

   c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

3) **Aids for Non-verbal Communication** Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by us.

4) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:

   a) Acupuncture,
   b) Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body,
   c) Holistic medicine,
   d) Homeopathic medicine,
   e) Hypnosis,
   f) Aroma therapy,
   g) Massage and massage therapy,
   h) Reiki therapy,
   i) Herbal, vitamin or dietary products or therapies,
   j) Naturopathy,
   k) Thermography,
   l) Orthomolecular therapy,
   m) Contact reflex analysis,
   n) Bioenergetic synchronization technique (BEST),
   o) Iridology-study of the iris,
   p) Auditory integration therapy (AIT),
   q) Colonic irrigation,

r) Magnetic innervation therapy,

s) Electromagnetic therapy,

t) Neurofeedback / Biofeedback.

5) **Applied Behavioral Treatment** (including, but not limited to, Applied Behavior Analysis) unless Medically Necessary.

6) **Autopsies** Autopsies and post-mortem testing unless requested by us as stated in "Physical Examinations and Autopsy" in the "General Provisions" section.

7) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as found in the "Termination and Continuation of Coverage" and in the definition for Covered Services in the "Definitions" sections of this Booklet.

8) **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

9) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.

10) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services. The exception to this exclusion is outlined in "Balance Billing by Out-of-Network Providers" in the "How Your Plan Works" section.

11) **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan as outlined in the "Clinical Trials" section of this Booklet.

12) **Complications of/or Services Related to Non-Covered Services** Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

13) **Compound Ingredients** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants. Please see the "Prescription Drugs Administered by a Medical Provider" section for additional information.

[Option to be added for groups that qualify for religious exemption opt out:

14) **Contraceptives** Contraceptive devices including diaphragms, intrauterine devices (IUDs), and implants.**]**

15) **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 or are given for social reasons. 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:

a) Surgery or procedures to correct deformity caused by disease, trauma, or previous therapeutic process.

b) Surgery or procedures to correct congenital abnormalities that cause Functional Impairment.

c) Surgery or procedures on newborn children to correct congenital abnormalities.

16) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.

17) **Cryopreservation** Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.

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

19) **Delivery Charges** Charges for delivery of Prescription Drugs purchased from a local retail pharmacy.

20) **Dental Devices for Snoring** Oral appliances for snoring.

21) **Dental Services** Except as described under "Dental Services for Pediatric Members", "Dental Services (All Members / All Ages)" and "Surgery".
    a) Dental care for Members age 19 or older, unless covered by the medical benefits of this plan.
    b) Dental services or health care services not specifically listed as covered in this Booklet (including any hospital charges, prescription drug charges and dental services or supplies that do not have an American Dental Association Procedure Code, unless covered by the medical benefits of this plan).
    c) Services of anesthesiologists except as described under "Dental Services" and "Dental Services (All Members / All Ages)" sections and unless otherwise required by law.
    d) Anesthesia services (such as intravenous and non-intravenous conscious sedation, analgesia, and general anesthesia) are not covered when given separate from complex surgical services, except as required by law.
    e) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion unless deemed medically necessary. Includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, and gnathologic recordings.
    f) Dental services provided solely for the purpose of improving the appearance of your teeth when your tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
    g) Case presentations.
    h) Athletic mouth guards.
    i) Enamel microabrasion and odontoplasty.
    j) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan. The exception to this Exclusion for root canal retreatment as described in "Endodontic Therapy" in the "What's Covered" section.
    k) Bacteriologic tests for determination of periodontal disease or pathologic agents, unless covered by the medical benefits of this Plan.
    l) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
    m) Collection of oral cytology sample via scraping of the oral mucosa, unless covered by the medical benefits of this Plan.
    n) Separate services billed when they are an inherent component of another covered service.
    o) Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
    p) Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
    q) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
    r) Placement or removal of sedative filling, base or liner used under a restoration that is billed separately from a restoration procedure (such as a filling).

s) Pulp vitality tests.

t) Adjunctive diagnostic tests.

u) Incomplete root canals.

v) Cone beam images.

w) Anatomical crown exposure.

x) Temporary anchorage devices.

y) Sinus augmentation.

z) Oral hygiene instructions.

aa) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.

bb) For dental services received prior to the effective date of this Plan or received after the coverage under this Plan has ended.

cc) Dental services given by someone other than a licensed provider (dentist or physician) or their employees.

dd) Implant services, including maintenance or repair to an implant or implant abutment.

ee) Dental services for which you would have no legal obligation to pay in the absence of this or like coverage.

ff) For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a member receives the benefits in whole or in part. This exclusion also applies whether or not the member claims the benefits or compensation. It also applies whether or not the member recovers from any third party.

22) **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.

23) **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.

24) **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by Anthem.

25) **Drugs That Are Prescribed Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

26) **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section.

27) **Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

28) **[Standard Emergency Room Services for non-Emergency Care** Services provided in an emergency room that do not meet the definition of Emergency. This includes, but is not limited to, suture removal in an emergency room. For non-emergency care please use the closest network Urgent Care Center or your Primary Care Physician.**]**

29) **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services,

whether you get them before, during, or after you get the Experimental / Investigational service or supply.

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

Please see the "Clinical Trials" section of "What's Covered" for details about coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. Please also read the "Experimental or Investigational" definition in the "Definitions" section at the end of this Booklet for the criteria used in deciding whether a service is Experimental or Investigational.

30) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in the "Vision Services for Pediatric Members", "Vision Services for Adult Members" or "Vision Services (All Members / All Ages)" sections of this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery or accidental injury.

31) **Eye Exercises** Orthoptics and vision therapy.

32) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

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

34) **Foot Care** Routine foot care unless Medically Necessary.

35) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.

36) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.

37) **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.

38) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

    If your Group is not required to have Workers Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

39) **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth unless Medically Necessary.

40) **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 Doctor. This Exclusion also applies to health spas.

41) **Hearing Aids** For Members age 19 or older, hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

42) **Home Health Care**

    a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.

b) Food, housing, homemaker services and home delivered meals. The exception to this Exclusion is homemaker services as described under "Hospice Care" in the "What's Covered" section.

43) **Hospital Services Billed Separately** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.

44) **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis) unless Medically Necessary.

45) **Infertility Treatment** Treatment related to infertility, except as outlined in the "Maternity and Reproductive Health" sub-section in the "What's Covered" section of this booklet.

46) **Lost or Stolen Drugs** Refills of lost or stolen Drugs.

47) **Maintenance Therapy** Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to "Habilitative Services" as described in the "What's Covered" section.

[Standard:

48) **Medical Chats Not Provided through Our Mobile App** Texting or chat services provided through a service other than our mobile app.**]**

49) **Medical Equipment, Devices, and Supplies**

a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.

b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

c) Non-Medically Necessary enhancements to standard equipment and devices.

d) Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is your responsibility.

e) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "Inpatient Hospital Care", "Outpatient Facility Services", "Surgery" and "Medical and Surgical Supplies" sections.

50) **Medicare** For which benefits are payable under Medicare Parts A and/or B except as required by law, as described in the section titled "Medicare" in "General Provisions."

51) **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.

[Standard:

52) **Non-approved Drugs** Drugs not approved by the FDA.**]**

53) **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.

54) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

55) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in the "Durable Medical Equipment (DME), Medical Devices and Supplies", "Preventive Care", "Prescription Drug Benefits" and "Hospice Care" sections of this Booklet 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.

56) **Off label use** Off label use, unless we must cover it by law or if we, or the PBM, approve it. The exception to this exclusion is described in “Covered Prescription Drugs” in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section.

57) **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet under “Dental Services for Pediatric Members and Oral Surgery”.

58) **Personal Care, Convenience and Mobile/Wearable Devices**

   a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,

   b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),

   c) Home workout or therapy equipment, including treadmills and home gyms,

   d) Pools, whirlpools, spas, or hydrotherapy equipment,

   e) Hypoallergenic pillows, mattresses, or waterbeds,

   f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

   g) Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

59) **Prescription Drugs in lieu of Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if You could use a clinically equivalent drug, unless required by law. “Clinically equivalent” means drugs that, for most Members, will give You similar results for a disease or condition. If You have questions about whether a certain drug is covered and which drugs fall into this group, please call the number on the back of Your Identification Card, or visit Our website at [www.anthem.com]." This exclusion does not apply to over-the-counter products that we must cover under federal law with a Prescription.

   If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor 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. Please see “Request for Step Therapy Protocol Exception” in the “What You Pay for Prescription Drugs” section for more information.

60) **Private Duty Nursing** Private duty nursing services given in an inpatient setting (Hospital or Skilled Nursing Facility). Private duty nursing services are a Covered Service only when given as part of the “Home Health Care Services” benefit.

61) **Prosthetics** Prosthetics for sports or cosmetic purposes.

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

   a) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

   b) Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

   c) Services or care provided or billed by a school, Custodial Care center for the developmentally

disabled, or outward-bound programs, even if psychotherapy is included. Licensed professional counseling, as described in the "What's Covered" section of this Booklet, and provided as part of these programs, is considered a Covered Service.

63) **Routine Physicals and Immunizations** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.

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

65) **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits** Services that require in-person contact and/or equipment that cannot be provided remotely.

66) **Sexual Dysfunction** Services or supplies for male or female sexual problems.

67) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.

[Standard for all except those groups that qualify to opt out:

68) **Sterilization** Services to reverse elective sterilization.**]**

[Option to be added for those groups that qualify to opt out:

69) **Sterilization** For female sterilization or reversal of sterilization.**]**

70) **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

71) **Temporomandibular Joint Treatment** Fixed or removable appliances that move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

72) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services, Cellular and Gene Therapy Services", "Transportation and Lodging" or "Travel Benefit" sections of this Booklet.

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

74) **Vision Services**

a) Eyeglass lenses, frames, or contact lenses for Members age 19 and older, unless listed as covered in the "Vision Services for Pediatric Members", "Vision Services for Adult Members" or "Vision Services (All Members / All Ages)" sections of this Booklet.

b) Safety glasses and accompanying frames.

c) For two pairs of glasses in lieu of bifocals.

d) Plano lenses (lenses that have no refractive power).

e) Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.

f) Vision services unless specified in the "Vision Services for Pediatric Members" and "Vision Services for Adult Members" sections of this Booklet.

g) Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed the "Vision Services for Pediatric Members" section of the "Schedule of Benefits".

h) Blended lenses.

i) Oversize lenses.

j) Sunglasses and accompanying frames.

k) For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.

l) For vision services for pediatric members, no benefits are available for frames or contact lenses not on the Anthem formulary.

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

76) **Weight Loss Programs** Programs, whether or not under medical supervision.

This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

77) **Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries to lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.

78) **Wilderness or other outdoor camps and/or programs.** Licensed professional counseling, as described in the "What's Covered" section of this Booklet, and provided as part of these programs, is considered a Covered Service.

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

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

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2. **Charges Not Supported by Medical Records** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
3. **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan as outlined in the "Clinical Trials" section of this Booklet.
4. **Compound Ingredients** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants. Please see the "Prescription Drugs Administered by a Medical Provider" section for additional information.

[Option to be added for groups that qualify for religious exemption opt out:

5. **Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law.**]**
6. **Delivery Charges** Charges for delivery of Prescription Drugs purchased from a local retail pharmacy.
7. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy

in the office as described in the “Prescription Drugs Administered by a Medical Provider” section or Drugs covered under the “Medical and Surgical Supplies” benefit – they are Covered Services.

8. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at www.anthem.com. If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to “Prescription Drug List” in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” for details on requesting an exception.
9. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
10. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
11. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by Anthem.
12. **Drugs That Are Prescribed Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
13. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What’s Covered" section.

    This Exclusion does not apply to over-the-counter drugs that we must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.
14. **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
15. **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim**.**
16. **Gene Therapy** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, benefits may be available under the Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services benefit. Please see that section for details.
17. **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth unless Medically Necessary.
18. **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis) unless Medically Necessary.
19. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
20. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and glucose monitors. Items not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit may be covered under the “Durable Medical Equipment (DME), Devices, and Supplies” benefit. Please see that section for details.
21. **Items Covered Under the “Allergy Services” Benefit** Allergy desensitization products or allergy serum. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail

Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.

22. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
23. **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
24. **Non-approved Drugs** Drugs not approved by the FDA.
25. **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
26. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in the "Durable Medical Equipment (DME), Medical Devices, and Supplies", "Preventive Care", "Prescription Drug Benefits" and "Hospice Care" sections of this Booklet 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.
27. **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.

    The exception to this Exclusion is described in "Covered Prescription Drugs" in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.
28. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
29. **Over-the-Counter Items** Drugs, devices and products permitted to be dispensed without a prescription and available over the counter.

    This Exclusion does not apply to over-the-counter products that we must cover as a "Preventive Care" benefit under federal law with a Prescription. This exclusion also does not apply to injectable insulin with a Prescription.
30. **Prescription Drugs in lieu of Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if You could use a clinically equivalent drug, unless required by law. "Clinically equivalent" means drugs that, for most Members, will give You similar results for a disease or condition. If You have questions about whether a certain drug is covered and which drugs fall into this group, please call the number on the back of Your Identification Card, or visit Our website at [www.anthem.com]." This exclusion does not apply to over-the-counter products that we must cover under federal law with a Prescription.

    If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor 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. Please see "Request for Step Therapy Protocol Exception" in the "What You Pay for Prescription Drugs" section for more information.
31. **[Optional: Sanctioned or Excluded Providers** Any Drug, Drug regimen, treatment, or supply that is furnished, ordered or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies.**]**
32. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
33. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
34. **Weight Loss Drugs** Any Drug mainly used for weight loss.

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