2021-2022

Colorado College

Student Health Insurance Plan (SHIP)

www.anthem.com/studentadvantage

Anthem Student Advantage

Keeping you at your personal best

A00292COMENABS 06/21

Anthem | STUDENT ADVANTAGE

COLORADO COLLEGE

Important notice

This is a brief description of your student health plan underwritten by Anthem Blue Cross and Blue Shield (Anthem). If you would like more details about your coverage and costs, you can get the complete terms in the policy or plan document online at https://student.anthem.com/welcome.

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Welcome to Anthem Student Advantage

As your new school year begins, it's important to understand your health care benefits and how they work. Your Anthem Student Advantage plan will help guide you through that process with information about who is eligible, what is covered, how much it costs, and the best ways to access care.

What you need to know about Anthem Student Advantage

Who is eligible?

› Degree-seeking students registered for at least one block during the fall (8/1/21 – 12/31/21) and/or one block in the spring (1/1/22 – 7/31/22).

Please refer to the Anthem policy for additional eligibility provisions.

Coverage periods and rates

Coverage will become effective at 12:01 a.m., and will end at 11:59 p.m. on the dates shown below.

Costs and dates of coverage

Term	Enrollment Deadline	Coverage Dates	Rate
Fall	8/31/2021	8/1/2021 – 12/31/2021	$1,190
Spring/Summer	1/31/2022	1/1/2022 – 7/31/2022	$1,627
Summer	6/15/2022	6/1/2022 – 7/31/2022	$680

*The above rates include premiums for the plan and commissions and administrative fees.
*Rates are pending approval with the state and subject to change.

Important dates for the coverage period

Enrollment/waiver deadlines

You must enroll or submit a waiver application by:

Fall - August 31, 2021

Spring/Summer - January 31, 2022

Summer Only - June 15, 2022

If you have questions about enrollment and waiver options, visit www.coloradocollege.edu/offices/studenthealthcenter/insurance/ or contact the waiver administrator at 1-877-974-7462, ext. 315.

Keep in touch with your benefits information

Student Health Center

819 North Tejon Street
Colorado Springs, CO 80903

Please see website below for hours of operation.

1-719-389-6384
www.coloradocollege.edu/offices/studenthealthcenter/

Please note: No policy deductible, copay or coinsurance applies for services received at the Student Health Center.

Benefits and Claims

Contact AmeriBen at 1-855-258-6450 or visit MyAmeriBen.com

Eligibility and enrollment

For more information or for questions, please contact Specialty Insurance Solutions.

1-877-974-7462, ext. 315

Mon. - Fri.: 8:30 AM - 5:00 PM Central time
student-insurance@sis-inc.biz

Your Student Health Center services

The Student Health Center is a student support service that provides a full range of medical, mental health, and health education and prevention services to optimize the health of students and the campus community.

Medical care

Services Available:

- **General Health:** Screenings, evaluation and treatment recommendations for injury, illness or medical conditions on an outpatient basis
- **Physicals:** Athletic and routine physicals are available by appointment at the Center.
- **Women's Health Services:** available during clinic hours.
- **Allergy services:** Allergy shots can be given with medication provided by the student.
- **Travel Medicine:** Optum Travel Medicine is available during regular Optum office hours.

The Student Health Center will host periodic travel clinics. Check with the Center for scheduled clinics.

Scheduled appointments during the week. Walk-ins on the weekends are welcome.

Counseling and psychiatry

The Counseling Center is dedicated to supporting the educational mission of The Colorado College by providing professional mental health services to students.

The Counseling Center is available to all enrolled Colorado College students. There is no fee for the first six sessions of counseling. There is a fee for psychiatrist medication services.

For more information, please contact
the Student Health Center at 1-719-389-6384

Continued

Hours of Operation:
Academic Year: 9 am to 5 pm weekdays.

Summer Session Hours:
9-4 pm weekdays- Call for appointment.

After Hours and weekends:
Call the Counseling Center number, 1-719-389-6093, press one to leave a non-urgent message, press 2 to be connected to a licensed counselor, or press zero to be connected to campus safety.

Contact Information
Address:
Yalich Student Services Building
819 North Tejon Street
Colorado Springs, CO 80903

Phone:
1-719-389-6093

Fax:
1-719-389-6064

Email:
CounselingCenter@coloradocollege.edu
Bill Dove Ph.D.- Director/Clinical Psychologist- wdove@coloradocollege.edu

To make an appointment or ask a question call 1-719-389-6093

For after hours services: In the event of a medical or life threatening emergency, call 911 and/or CC Campus Safety at 1-719-389-6911.

To reach a Counselor after business hours, call the Counseling Center Phone, 1-719-389-6093 and you will be prompted to press 1 to leave a message for the next day, press 2 to be immediately connected with a licensed counselor, or press zero to be connected to campus safety.

Easy access to care

Access the care you need, when you need it, and in the way that works best for you.

ID Cards and Online Services app

For a copy of your insurance ID card, claims status, and information about your Health Benefit Resources, please visit MyAmeriBen.com or download the MyAmeriBen app on your iOS or Android device.

LiveHealth Online

From your mobile device or computer with a webcam, you can use LiveHealth Online to visit with a board-certified doctor, psychiatrist or licensed therapist through live video.[2] To use, go to www.livehealthonline.com. You can also download the free LiveHealth Online app to sign up.

Provider finder

You can find the right doctor or facility close to where you are by visiting:

- www.anthem.com
- www.coloradocollege.edu/offices/studenthealthcenter/insurance/
- MyAmeriBen.com
- Calling AmeriBen at 1-855-258-6450

Important tips:

- When you need health care, please access the Student Health Center first for treatment or to obtain a referral to an In-Network Provider. This can help you save on out-of-pocket costs.
- Networks may change, so make sure you contact the provider before getting care to confirm they are in the network.

1 Sydney Health is a service mark of CareMarket, Inc.
2 Appointments subject to availability of a therapist. Psychologists or therapists using LiveHealth Online cannot prescribe medications. Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 1-800-784-2433 (National Suicide Prevention Lifeline) or 911 and ask for help. If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.
LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

Your summary of benefits

Anthem Blue Cross and Blue Shield

Student health insurance plan:
Colorado College Student Health Insurance Plan

Your network:
Blue Classic – PPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Medical

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible		
Per Member The In-Network and Out-of-Network Deductibles are separate and cannot be combined. When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies. *Copayments and Coinsurance are separate from and do not apply to the Deductible.*	$500	$1,000
Out-of-Pocket Limit		
The Out-of-Pocket Limit includes all applicable Deductibles, Coinsurance, and Copayments, including Prescription Drugs Coinsurance/Copayments, you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services. *The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.*	$6,600	$10,000
Acupuncture/Nerve Pathway Therapy	See "Therapy Services".	
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
Ambulance Services (Air and Water)	20% Coinsurance after Deductible	
For Emergency ambulance services from an Out-of-Network Provider you do not need to pay any more than you would have paid for services from an In-Network Provider. ***Important Note:*** *Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through Precertification. Please see the section "How to Access Your Services and Obtain Approval of Benefits" in the Policy for details.*		
Ambulance Services (Ground)	20% Coinsurance after Deductible	
For Emergency ambulance services from an Out-of-Network Provider you do not need to pay any more than you would have paid for services from an In-Network Provider. ***Important Note:*** *All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through Precertification. Please see the section "How to Access Your Services and Obtain Approval of Benefits" in the Policy for details.*	$100 Copay per trip, 0% Coinsurance, Deductible Waived	

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Autism Services Includes Applied Behavioral Analysis Services	Benefits are based on the setting in which Covered Services are received.	
The limits for physical, occupational, and speech therapy will not apply to children between age 3 and 6 with Autism Spectrum Disorders, if part of a Member's Autism Treatment Plan, and determined Medically Necessary by Us.		
Behavioral Health Services	See "Mental Health, Alcohol and Substance Abuse Services".	
Cardiac Rehabilitation	See "Therapy Services".	
Chemotherapy	See "Therapy Services".	
Chiropractic Care	See "Therapy Services".	
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	
Diabetes Equipment, Education, and Supplies Screenings for gestational diabetes are covered under "Preventive Care."	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	
Dialysis	See "Therapy Services".	
Durable Medical Equipment (DME), Medical Devices, Medical and Surgical Supplies (Received from a Supplier)	0% Coinsurance after Deductible	40% Coinsurance after Deductible
Prosthetics	0% Coinsurance after Deductible	40% Coinsurance after Deductible
The cost-shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received.		
Replacement hearing aids will be supplied every 5 years. New hearing aid will be a covered service when alterations to your existing hearing aid cannot adequately meet your needs or be repaired.	In-Network: 0% Coinsurance after Deductible Out-of-Network: 40% Coinsurance after Deductible	
Emergency Room Services		
Emergency Room Facility Charge	$50 Copay per visit, 0% Coinsurance, Deductible Waived Copayment waived if admitted	
Emergency Room Doctor Charge		
Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)		
Advanced Diagnostic Imaging (including MRIs, CAT scans)		
Habilitative Services	Benefits are based on the setting in which Covered Services are received. See "Inpatient Services" and "Therapy Services"	

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Home Care		
Home Care Visits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Skilled Nursing Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Services (Precertification Required)		
Facility Room & Board Charge:		
Hospital / Acute Care Facility	$400 Copay per Hospital Confinement, 20% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Skilled Nursing Facility	$200 Copay per Hospital Confinement, 20% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Doctor Services for:		
General Medical Care / Evaluation and Management (E&M)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Bariatric Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Services (Delivery)	See "Inpatient Services".	
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Infertility *Cover based on Anthem medical policy. Treatment to include artificial insemination, including related prescription drugs, that satisfies Anthem's medical policy. Donor eggs, donor semen, or services related to their procurement or storage are not covered.*	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.
Massage Therapy	See "Therapy Services".	
Mental Health, Biologically Based Mental Illness, Alcohol and Substance Abuse Services		
Inpatient Facility Services	$400 Copay per Hospital Confinement, 20% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Residential Treatment Center Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Inpatient Doctor Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Facility Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Doctor Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Partial Hospitalization Program / Intensive Outpatient Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Office Visits (Including Online Visits and Intensive In-Home Behavioral Health Programs)	$25 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Mental Health, Biologically Based Mental Illness, Alcohol and Substance Abuse Services will be covered as required by state and federal law. Please see "Mental Health Parity and Addiction Equity Act" in the "Additional Federal Notices" section in the Policy for details.		
Occupational Therapy	**See "Therapy Services".**	
Office Visits		
Primary Care Physician / Provider (PCP)	$25 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Specialty Care Physician / Provider (SCP)	$25 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Retail Health Clinic Visit	$25 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Counseling – Includes Family Planning and Nutritional Counseling (Other than Eating Disorders)	$25 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Nutritional Counseling for Eating Disorders	$25 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Allergy Testing	0% Coinsurance after Deductible	40% Coinsurance after Deductible
Allergy Shots / Injections (other than allergy serum)	0% Coinsurance after Deductible	40% Coinsurance after Deductible
Preferred Diagnostic Labs (i.e., reference labs)	0% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Lab (non-preventive)	0% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic X-ray (non-preventive)	0% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Tests (non-preventive; including hearing and EKG)	0% Coinsurance after Deductible	40% Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	0% Coinsurance after Deductible	40% Coinsurance after Deductible
Office Surgery	0% Coinsurance after Deductible	40% Coinsurance after Deductible

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Therapy Services:		
Chiropractic Care / Manipulation Therapy (regardless of the Provider type rendering the service)	$25 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Acupuncture/Nerve Pathway Therapy & Massage Therapy	Not covered except for in lieu of anesthesia	Not covered except for in lieu of anesthesia
Physical, Speech, & Occupational Therapy	$25 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Dialysis / Hemodialysis	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Radiation / Chemotherapy / Non-Preventive Infusion & Injection	0% Coinsurance after Deductible	40% Coinsurance after Deductible
Cardiac Rehabilitation & Pulmonary Therapy	$25 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Prescription Drugs Administered in the Office (includes allergy serum)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Orthotics	See "Durable Medical Equipment (DME), Medical Devices, Medical and Surgical Supplies".	
Outpatient Facility Services		
Facility Surgery Charge	$300 Copay per date of service, 20% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Doctor Surgery Charges	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Other Facility Charges (for procedure rooms or other ancillary services)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Lab	0% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic X-ray	0% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Tests: Hearing, EKG, etc. (Non-Preventive)	0% Coinsurance after Deductible	40% Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Therapy:		
Chiropractic Care / Manipulation Therapy (regardless of the Provider type rendering the service)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Physical, Speech, & Occupational Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Radiation / Chemotherapy / Non-Preventive Infusion & Injection	0% Coinsurance after Deductible	40% Coinsurance after Deductible

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Dialysis / Hemodialysis	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Cardiac Rehabilitation & Pulmonary Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Prescription Drugs Administered in an Outpatient Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Physical Therapy	See "Therapy Services".	
Preventive Care/screening/immunization *Preventive care from an Out-of-Network Provider is not subject to the Maximum Allowed Amount.*	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible
Prosthetics	See "Prosthetics" under "Durable Medical Equipment (DME), Medical Devices, Medical and Surgical Supplies".	
Pulmonary Therapy	See "Therapy Services".	
Radiation Therapy	See "Therapy Services".	
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received. See "Inpatient Services" for details on Benefits.	
Respiratory Therapy	See "Therapy Services".	
Skilled Nursing Facility	$200 Copay per Hospital Confinement, 20% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Speech Therapy	See "Therapy Services".	
Surgery	Benefits are based on the setting in which Covered Services are received.	
Telehealth visit through Live Health Online	$25	Not covered
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Therapy Services	Benefits are based on the setting in which Covered Services are received.	
Physical Therapy (Rehabilitative)	Unlimited	
Physical Therapy (Habilitative)	Unlimited	
Occupational Therapy (Rehabilitative)	Unlimited	
Occupational Therapy (Habilitative)	Unlimited	
Speech Therapy (Rehabilitative)	Unlimited	
Speech Therapy (Habilitative)	Unlimited Other than as provided for Habilitative Services, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from injury, trauma, stroke, surgery, cancer, or vocal nodules.	

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Chiropractic Care / Manipulation Therapy (regardless of the Provider type rendering the service)	Unlimited	
Acupuncture/Nerve Pathway Therapy & Massage Therapy	Acupuncture: Exclusion, except when used in lieu of anesthesia	
Cardiac Rehabilitation	Unlimited	
Note: *The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.*		
Transgender Services Precertification required	Benefits are based on the setting in which Covered Services are received.	
Transplant Services Precertification required	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services".	
Urgent Care Services (Office Visits)		
Urgent Care Office Visit Charge	$35 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Allergy Shots / Injections (other than allergy serum)	$35 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Preferred Diagnostic Labs (i.e., reference labs)	$35 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Other Charges (e.g., diagnostic x-ray and lab services, medical supplies)	$35 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	$35 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Office Surgery	$35 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Prescription Drugs Administered in the Office (includes allergy serum)	$35 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
If you get urgent care at a Hospital or other outpatient Facility, please refer to "Outpatient Facility Services" for details on what you will pay.		

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

To best understand your benefits, you may call our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. We suggest you do this before you have an evaluation and/or work-up for a transplant, so that we can assist you in maximizing your benefits. To learn more or to find out which Hospitals are In-Network Transplant Providers, you may contact the Member Services telephone number on the back of Your Identification Card and ask for the transplant coordinator. In addition, you or your Provider must call our Transplant Department for Precertification prior to the transplant, whether this is performed in an Inpatient or Outpatient setting.

The requirements described below do not apply to the following:

- Cornea and kidney transplants, which are covered as any other surgery; and
- Any Covered Services related to a Covered Transplant Procedure, that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the collection and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received.

Covered Medical Benefits	In-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers	Out-of-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers
Transplant Benefit Period	**In-Network Transplant Provider**	**Out-of-Network Transplant Provider**
	Starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	Starts one day before a Covered Transplant Procedure and continues to the date of discharge at an Out-of-Network Transplant Provider Facility.
Covered Transplant Procedure during the Transplant Benefit Period	**In-Network Transplant Provider Facility**	**Out-of-Network Transplant Provider Facility**
Precertification required	During the Transplant Benefit Period, 20% Coinsurance after Deductible Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.	During the Transplant Benefit Period, 40% Coinsurance after Deductible. During the Transplant Benefit Period, Covered Transplant Procedure charges at an Out-of-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also an In-Network Provider for this Plan (for services other than Covered Transplant Procedures), then you will not have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. If the Provider is an Out-of-Network Provider for this Plan, you will have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.
Covered Transplant Procedure during the Transplant Benefit Period	20% Coinsurance after Deductible	40% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging	0% Coinsurance	0% Coinsurance
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services		
Transportation and Lodging Limit	Covered, as approved by Anthem, up to $10,000 per transplant. In- and Out-of-Network combined	
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Donor Search Limit	Covered, as approved by Anthem, up to $30,000 per transplant. In- and Out-of-Network combined	
Live Donor Health Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Donor Health Service Limit	Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure, for up to six weeks from the date of procurement.	

Pharmacy

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
At least one product in all 18 approved methods of contraception is covered under this policy without cost sharing as required by Federal and state law. Otherwise, each Prescription Drug will be subject to a cost share (e.g., Copayment/Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.		
Prescription Drug Co-Payment (0% Coinsurance, Deductible Waived)	$15 copay for generic $25 copay for brand name $60 copay for non-preferred brand / specialty Mail order covered for 90 days at 2.5 times the copay	
Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.		
Retail Pharmacy (In-Network and Out-of-Network)	30 days	
Home Delivery (Mail Order) Pharmacy	90 days	
Specialty Pharmacy	30 days* *See additional information in the "Specialty Drug Copayments / Coinsurance" section below.	

Specialty Drug Copayments / Coinsurance:

Please note that certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When you get Specialty Drugs from the Specialty Pharmacy, you will have to pay the same Copayments/Coinsurance you pay for a 30-day supply at a Retail Pharmacy.

Note: *Prescription Drugs will always be dispensed as ordered by your Doctor. You may ask for the Brand Name Drug. However, if a Generic Drug is available, you will have to pay the difference in the cost between the Generic and Brand Name Drug. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet gives the same quality. For certain higher cost generic drugs, we reserve the right, in our sole discretion, to make an exception and not require you to pay the difference in cost between the Generic and Brand Name Drug.*

Note: *No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.*

Pediatric Vision *Limited to covered persons under the age of 19*.

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Children's Vision Essential Health Benefits *Limited to covered persons under the age of 19.* **Note:** *Benefits for Vision Services are not subject to any Deductible stated in this Plan. Any amount the Member pays in Copayment for Vision Services does not apply to any Deductible stated in this Plan.*		
Routine Eye Exam *Limited to one exam per school year per Member.*	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Standard Plastic Lenses		
Single Vision	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Bifocal	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Trifocal	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Standard Progressive	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Additional lens options: Covered lenses include factory scratch coating, UV coating, standard polycarbonate, and standard photochromic.	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Frames *Limited to 1 per year.*	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Contact Lenses *Elective or non-elective contact lenses from the Anthem Formulary are covered every Benefit Period per Member. Limited to 1 per year.*	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Elective Contact Lenses (Conventional or Disposable)	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Non-Elective Contact Lenses	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.	Benefits are based on the setting in which Covered Services are received.	

Pediatric Dental *Limited to covered persons under the age of 19*.

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Children's Dental Essential Health Benefits (up to age 19) *Limited to covered persons under the age of 19.*		
Diagnostic and Preventive Services	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Basic Restorative Services	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Endodontic Services	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Periodontal Services	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Oral Surgery Services	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Major Restorative Services	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Prosthodontic Services	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Dentally Necessary Orthodontic Care	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Dental Injuries Benefits paid on Injury to Sound, Natural Teeth only.	20% Coinsurance after Deductible	

Benefits that go with you

You can count on medical coverage anywhere worldwide with GeoBlue.[1] Easily access international doctors by phone or video and use our 24/7 help center for emergency health questions. Anthem Student Advantage and GeoBlue provides the right support and services when you need them the most.

Visit https://www.geobluestudents.com to learn more.

GeoBlue benefits for the 2021-2022 school year

Use of benefits must be coordinated and approved by GeoBlue.

International telemedicine services[2]	
Global TeleMD™	Confidential access to international doctors by telephone or video call.
Coverage outside the U.S., excluding student's home country.	
Medical Expenses	Maximum benefit up to $250,000 per coverage year, no deductibles or copays. Consult coverage certificate for benefit limitations and exclusions.[3]
Coverage worldwide except within 100 miles of primary residence for U.S. students. Coverage worldwide, excluding home country for international students.	
Emergency medical evacuation	Unlimited
Repatriation of remains	Unlimited
Emergency family travel arrangements	Maximum benefit up to $5,000 per coverage year
Political emergency and natural disaster evacuation (Available only when traveling outside the United States)[4]	Covered 100% up to $100,000 per person. Subject to a combined $5,000,000 limit per any one covered event for all people covered under the plan.
Accidental death and dismemberment	Maximum benefit up to $10,000 per coverage year

GeoBlue

1 GeoBlue is the trade name of Worldwide Insurance Services, LLC (Worldwide Services Insurance Agency, LLC in California and New York), an independent licensee of the Blue Cross and Blue Shield Association. GeoBlue is the administrator of coverage provided under insurance policies issued by 4 Ever Life International Limited, Bermuda, an independent licensee of the Blue Cross Blue Shield Association. Coverage is not available in all states. Some restrictions apply.

2 Telemedicine services are provided by Teladoc Health, directly to members. GeoBlue assumes no liability and accepts no responsibility for information provided by Teladoc Health and the performance of the services by Teladoc Health. Support and information provided through this service does not confirm that any related treatment or additional support is covered under a member's health plan.

3 These medical expenses are limited and are subject to limitations and exclusions. See full certificate of insurance for a full description of services and coverage of what is and isn't covered.

4 The Political, Military and Natural Disaster Evacuation Services (PEND) are provided through Crisis24, an independent third party, non-affiliated service provider. Crisis24 does not supply Blue Cross or Blue Shield products or other benefits, and is therefore solely responsible for PEND and other collateral services it provides. GeoBlue makes no warranty, express or implied, and accepts no responsibility resulting from the provision or use of Crisis24 PEND or other Crisis24 services.

Designed with you in mind

Offering you healthy support and easy-to-use benefits to help you stay focused on your education and your future.

Exclusions

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. We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

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. **Alternative / Complementary Medicine**

   Services or supplies for alternative or complementary medicine, regardless of the Provider rendering such services or supplies.This includes, but is not limited to:

   a) Holistic medicine,
   b) Homeopathic medicine,
   c) Hypnosis,
   d) Aroma therapy,
   e) Reiki therapy,
   f) Herbal, vitamin or dietary products or therapies,
   g) Naturopathy,
   h) Thermography,
   i) Orthomolecular therapy,
   j) Contact reflex analysis,
   k) Bioenergial synchronization technique (BEST),
   l) Iridology-study of the iris,
   m) Auditory integration therapy (AIT),
   n) Colonic irrigation,
   o) Magnetic innervation therapy,
   p) Electromagnetic therapy,
   q) Neurofeedback / Biofeedback.

4. **Applied Behavioral Treatment**

   (including, but not limited to, Applied Behavior Analysis and intensive behavior interventions) for all indications except as described under Autism Services.

5. **Before Effective Date or After Termination Date**

   Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

6. **Certain Providers**

   Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet, or which are not recognized by us as an eligible Provider under this Plan.

7. **Charges Over the Maximum Allowed Amount**

   Charges over the Maximum Allowed Amount for Covered Services, except as written in this Plan.

8. **Charges Not Supported by Medical Records**

   Charges for services not described in your medical records.

9. **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.

10. **Collegiate Sports**

    Charges for services related to injuries or illness sustained while participating in, practicing for or, travelling to or from, an intercollegiate sport or competition. Additionally, Covered Services do not include expenses covered or eligible for coverage under any separate NCAA-sponsored or sanctioned insurance policy for student athletes.

11. **Complications of Non-Covered Services**

    Care 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.

12. **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 psychiatric, psychological, or 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).

13. **Court Ordered Testing**

    Court ordered testing or care unless the testing or care is Medically Necessary and otherwise a Covered Service under this Booklet.

14. **Crime**

    Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.

15. **Custodial Care**

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

16. **Delivery Charges**

    Charges for delivery of Prescription Drugs.

17. Dental Services

a) Dental care for Members age 19 or older, unless listed as covered in the medical benefits of this Booklet.
b) Dental services or health care services not specifically 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, unless required by law.
d) Analgesia, analgesia agents, oral sedation, and anxiolysis nitrous oxide.
e) Anesthesia services (such as intravenous conscious sedation, IV sedation and general anesthesia) are not covered when given separate from a covered oral surgery service. EXCEPTION: General anesthesia for dental services for members under age 19 years of age when rendered in a hospital, outpatient surgical facility or other facility licensed pursuant to Section 25-3-101 of the Colorado Revised Statutes if the child, in the opinion of the treating Dentist, satisfies one or more of the following criteria: (a) the child has a physical, mental, or medically compromising condition; (b) the child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; (c) the child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or (d) the child has sustained extensive orofacial and dental trauma.
f) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion. Includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
g) Dental services or supplies provided solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
h) Occlusal or athletic mouth guards.
i) Prosthodontic services (such as dentures or bridges) and periodontal services such as scaling and root planing.
j) For members through age 18, prosthodontic services (such as dentures or bridges) and periodontal services (such as scaling and root planing).
k) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
l) Separate services billed when they are an inherent component of another covered service.
m) Services to treat Temporomandibular Joint Disorder (TMJ) except as covered under your medical coverage.
n) Oral hygiene instructions.
o) Case presentations, office visits and consultations.
p) Implant services, except as listed in this Booklet.
q) Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling materials, nor the procedures used to prepare and place material(s) in the canals (tooth roots).
r) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
s) Incomplete root canals.
t) Adjunctive diagnostic tests.

18. 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.

19. Drugs Prescribed by Providers Lacking Qualifications/Certifications

Prescription drugs prescribed by a Provider that does not have the necessary qualifications, including certifications, as determined by Anthem.

20. Educational Services

Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.

21. 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.

22. Eyeglasses and Contact Lenses

Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.

23. Eye Exercises

Orthoptics and vision therapy.

24. 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.

25. 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.

26. Foot Care

Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

a) Cleaning and soaking the feet.
b) Applying skin creams to care for skin tone.
c) Other services that are given when there is not an illness, injury or symptom involving the foot.

27. Foot Orthotics

Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes.

28. Foot Surgery

Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

29. Free Care

Services you would not have to pay for if you did not 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.

30. Gene Therapy

Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

31. **Hearing Aids**

Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

32. **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.

33. **Infertility Treatment**

Infertility procedures not specified in this Booklet.

34. **Intractable Pain and/or Chronic Pain**

Charges for a pain state in which the cause of the pain cannot be removed and which in the course of medical practice no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts. It is pain that lasts more than 6 months, is not life threatening, and may continue for a lifetime, and has not responded to current treatment.

35. **Lost or Stolen Drugs**

Refills of lost or stolen Drugs.

36. **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".

37. **Medical Equipment, Devices, and Supplies**

a) Replacement or repair of purchased or rental equipment because of misuse, or loss.
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 Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.

38. **Medicare**

For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in "General Provisions". If you do not enroll in Medicare Part B, Anthem will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.

39. **Missed or Cancelled Appointments**

Charges for missed or cancelled appointments.

40. **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.

41. **Nutritional or Dietary Supplements**

Nutritional and/or dietary supplements, except as described in 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.

42. **Off label use**

Off label use, unless we must cover it by law or if we approve it.

43. **Personal Care and Convenience**

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, cottontipped 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) Hypo-allergenic 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).

44. **Private Duty Nursing**

Private Duty Nursing Services, except as specifically stated in this Booklet.

45. **Prosthetics**

Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics, unless medically necessary.

46. **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.

47. **Services Received From Student Health Center**

Services provided normally without charge by the Student Health Center of the Policyholder. Services covered or provided by the student health fee.

48. **Sexual Dysfunction**

Services or supplies for male or female sexual problems.

49. **Stand-By Charges**

Stand-by charges of a Doctor or other Provider.

50. **Sterilization**

Services to reverse an elective sterilization.

51. **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).

52. **Temporomandibular Joint Treatment**

Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

53. **Travel Costs**

Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.

54. **Vein Treatment**

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

55. **Vision Services**

a) Vision services not specifically listed as covered in this Booklet.

b) For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacture does not allow discounts.
c) Safety glasses and accompanying frames.
d) For two pairs of glasses in lieu of bifocals.
e) Plano lenses (lenses that have no refractive power).
f) Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
g) Blended lenses.
h) Oversize lenses.
i) Sunglasses.
j) For Members through age 18, no benefits are available for frames and contact lenses purchased outside of our formulary.
k) Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically stated as covered in this Booklet.
l) Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.

56. 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.

57. Weight Loss Programs

Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

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

58. Weight Loss Surgery

Services and supplies related to bariatric surgery, or surgical treatment of obesity, unless listed as covered in the Booklet.

What is 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. 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.

3. Compound Drugs

Compound Drugs unless all of the ingredients are FDA-approved and 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.

4. 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.

5. Delivery Charges

Charges for delivery of Prescription Drugs.

6. 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.

7. 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 section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception.

8. Drugs Over Quantity or Age Limits

Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.

9. 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.

10. Drugs Prescribed by Providers Lacking Qualifications/Certifications

Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, including certifications, as determined by Anthem.

11. 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.

12. Gene Therapy

Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

13. Infertility Drugs

Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT), except as listed in this Booklet.

14. Items Covered as Durable Medical Equipment (DME)

Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood 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 and Medical Devices" benefit. Please see that section for details.

15. 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.

16. Lost or Stolen Drugs

Refills of lost or stolen Drugs.

17. 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.

18. **Non-approved Drugs**
    Drugs not approved by the FDA.
19. **Off label use**
    Off label use, unless we must cover the use by law or if we, or the PBM, approve it.
20. **Onychomycosis Drugs**
    Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
21. **Over-the-Counter Items**
    Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes 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.
22. **Sexual Dysfunction Drugs**
    Drugs to treat sexual or erectile problems.
23. **Syringes**
    Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
24. **Weight Loss Drugs**
    Any Drug mainly used for weight loss.

Access help in your language

If you have any questions about this document, you have the right to help and information in your language at no cost. To talk to an interpreter, call **1-855-330-1098**.

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card. (TTY/TDD: 711)

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة.(TTY/TDD: 711)

Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi

شما این حق را دارید که این اطلاعات و کمک را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Navajo

Bee ná ahóót'i' t'áá ni nizaad k'ehjí níká a'doowoł t'áá jíík'e. Naaltsoos bee atah nílínígíí bee néého' dólzingo nanitinígíí béésh bee hane' í bikáá' áajį' hodíílnih. (TTY/TDD: 711)

Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵੱਚਿ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵੱਚਿ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਕਿਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਸਿਜ਼਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Tagalog

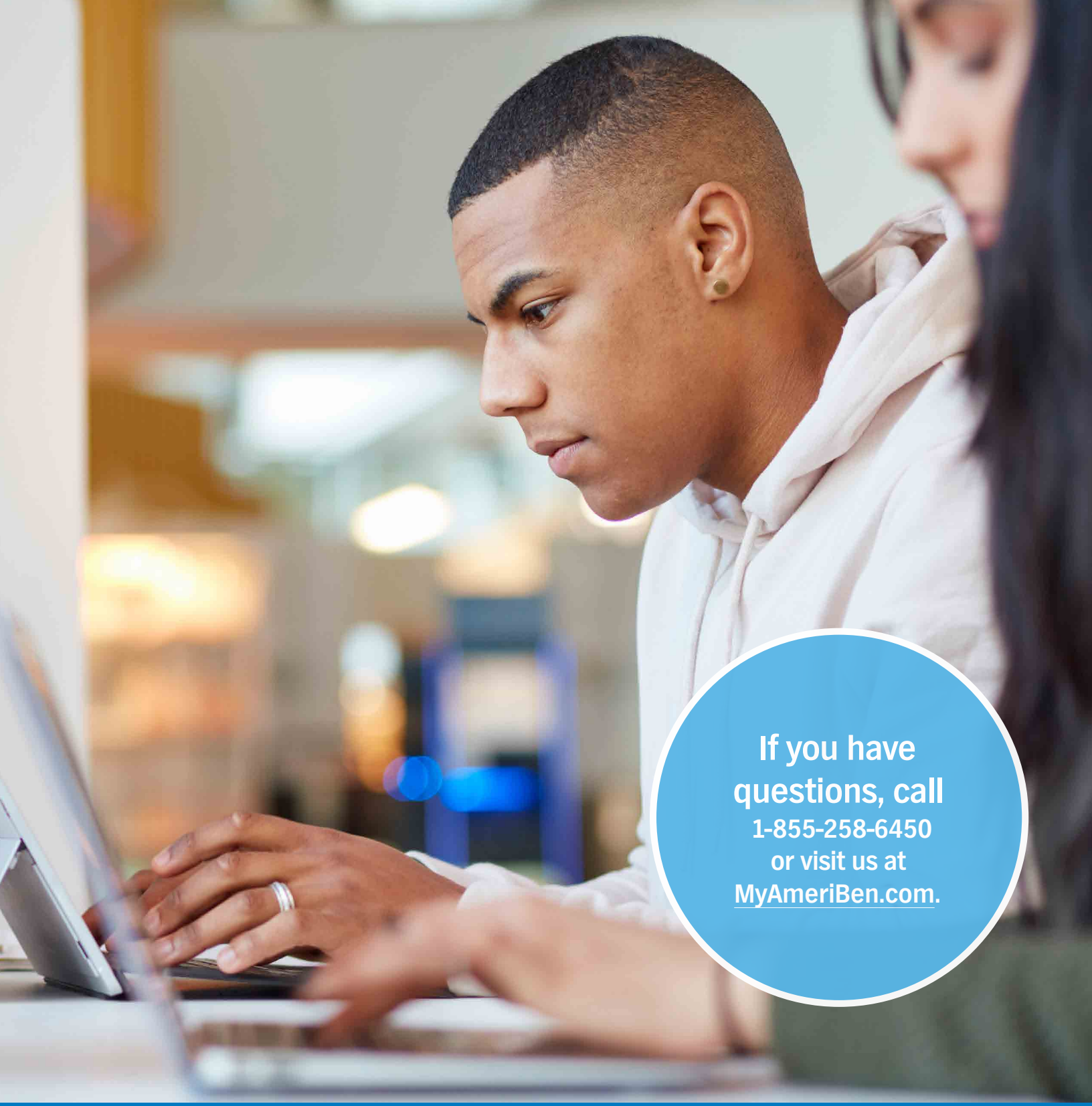
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

It is important we treat you fairly

That is why we follow federal civil rights laws in our health programs and activities. We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language is not English, we offer free language assistance services through interpreters and other written languages. If you are interested in these services, call the Customer Service number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.



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