2021-2022

Southern New Hampshire University
Student Health Insurance Plan

www.anthem.com/studentadvantage

Anthem Student Advantage
Keeping you at your personal best

A00384NHMENABS 07/21

Anthem STUDENT ADVANTAGE

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 find the complete terms in the policy or plan document online at www.anthem.com.

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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?

- New or continuing campus students will be enrolled in the insurance unless you show you have comparable coverage. You must actively attend classes for at least the first 31 days after your policy begins. Home-study, correspondence, and online courses only do not fulfill this requirement.
- All eligible undergraduate and graduate students will be charged for the insurance plan unless you show proof of other medical insurance and complete the waiver form.
- All international students and scholars are enrolled in the student health insurance plan on a mandatory basis.

Coverage is available for dependents too

If you are covered by Anthem Student Advantage through Southern New Hampshire University, you may enroll your lawful spouse, domestic partner or dependent children under the age of 26.

Here is how it works:

- Eligible students who enroll may also insure their Dependents. Eligible Dependents are the student's legal spouse or Domestic Partner and dependent children under 26 years
  of age. Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and online courses do not fulfill the eligibility requirements that the student actively attend classes. Anthem maintains its right to investigate eligibility or student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever Anthem discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.
- If you have questions, please call 1-603-645-9640 or email sfscampus@snhu.edu.

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

Domestic

Period	Annual 8/30/2021-8/29/2022	Fall 8/30/2021- 12/31/2021	Spring/Summer 1/1/2022-8/29/2022	Summer 5/2/2022-8/29/2022
Student	$1,478.00	$494.00	$984.00	$498.00
Spouse	$1,478.00	$494.00	$984.00	$498.00
Per Child	$1,478.00	$494.00	$984.00	$498.00

International

Period	Annual 8/30/2021-8/29/2022	Fall 8/30/2021- 12/31/2021	Spring 1/1/2022-8/29/2022	Summer 5/2/2022-8/29/2022
Student	$1,478.00	$494.00	$984.00	$498.00
Spouse	$1,478.00	$494.00	$984.00	$498.00
Per Child	$1,478.00	$494.00	$984.00	$498.00

ESL Program

Period	Semester 1 8/30/2021-10/25/2021	Semester 2 10/26/2021-12/31/2021	Semester 3 1/1/2022-2/27/2022	Semester 4 2/28/2022-5/1/2022	Semester 5 5/2/2022-6/27/2022	Semester 6 6/28/2022-8/29/2022
Student	$221.00	$270.00	$266.00	$221.00	$262.00	$229.00
Spouse	$221.00	$270.00	$266.00	$221.00	$262.00	$229.00
Per Child	$221.00	$270.00	$266.00	$221.00	$262.00	$229.00

*The above rates include premiums for the plan and commissions and administrative fees.

Important dates for the coverage period

Waiver deadlines

You can waive your Anthem Student Advantage if you have comparable coverage.

- Fall Waiver Deadline is 8/1/21
- Spring deadline is 1/31/22

If you have **questions about enrollment and waiver options,** visit my.snhu Student Portal or call 1-603-645-9640.

Keep in touch with your benefits information

Student Health Center

2500 North River Road
Manchester, NH 03106
Phone: 1-603-645-9679
Email: wellness@snhu.edu

Claims and coverage

1-844-412-0752
Anthem Blue Cross Life and Health Insurance Company
P.O Box 105370
Atlanta, GA 30348-5370

Benefits, eligibility and enrollment

Gallagher Student Health & Special Risk
1-800-391-9752
www.gallagherstudent.com/snhu
Southern New Hampshire University

Easy access to care

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

Sydney Health app

With the Sydney Health[1] app through Anthem Student Advantage, you have instant access to:

- Your member ID card.
- The Find a Doctor tool.
- More information about your plan benefits.
- Health tips that are tailored to you.
- LiveHealth Online and 24/7 NurseLine.
- Student support specialists (through click-to-chat or by phone).

Access the Sydney Health app

Go to the App Store℠ or Google Play™ and search for the Sydney Health app to download it today.

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 your Sydney Health app or www.livehealthonline.com. You can also download the free LiveHealth Online app to sign up.

24/7 NurseLine

Call **1-844-545-1429** to speak to a registered nurse who can help you with health issues like fever, allergy relief, cold and flu symptoms and where to go for care. Nurses can also help you enroll in health management programs if you have specific health conditions, remind you about scheduling important screenings and exams, and more.

Provider finder

Use www.anthem.com/find-care/ to find the right doctor or facility close to where you are.

Anthem Student Advantage Southern New Hampshire University website

Use www.anthem.com/studentadvantage to see your health plan information, including providers, benefits, claims, covered drugs and more.

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

Student health insurance plan:
Southern New Hampshire University

Your network:
BlueChoice
Open Access AltNet

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. Plan benefits are pending approval with the state and subject to change.

Medical

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible		
See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.	$150/person	$450/person
Out-of-Pocket Limit		
When you meet your out-of-pocket limit, you will no longer have to pay cost- shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.	$6,600 person / $13,200 family	$13,200 person / $26,400 family
Preventive care/screening/immunization		
Out Patient preventive care is not subject to deductible.	No charge	40% coinsurance
Doctor Home and Office Services		
Primary Care Office Visit to treat an injury or illness	$20 Copay deductible does not apply	40% coinsurance
Specialist Care Office Visit	$20 Copay deductible does not apply	40% coinsurance
Prenatal and Post-natal Care	No Charge	0% coinsurance after deductible
Other Practitioner Visits:		
Retail Health Clinic	20% coinsurance	40% coinsurance
On-line Visit *Live Health Online is the preferred telehealth solutions (www.livehealthonline.com)*	20% coinsurance	40% coinsurance
Manipulation Therapy *Coverage is limited to 12 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	20% coinsurance	40% coinsurance
Acupuncture	Not covered	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Other Services in an Office:		
Allergy Testing	20% coinsurance	40% coinsurance
Chemo/Radiation Therapy	20% coinsurance	40% coinsurance
Hemodialysis	20% coinsurance	40% coinsurance
Prescription Drugs *For the drug itself dispensed in the office through infusion/injection.*	20% coinsurance	40% coinsurance
Diagnostic Services		
Lab:		
Office *Office Cost Share applies only when Freestanding/Reference Labs are not used.*	20% coinsurance	40% coinsurance
Freestanding Lab/Reference Lab	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
X-Ray:		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Emergency and Urgent Care		
Urgent Care (office setting)	20 Copay deductible does not apply	20% coinsurance
Emergency Room Facility Services	20% coinsurance	20% coinsurance
Emergency Room Doctor and Other Services	20% coinsurance	20% coinsurance
Emergency Ambulance (Air and Ground)	20% coinsurance	20% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit and Online Visit	$20 Copay deductible does not apply	40% coinsurance
Facility visit:	20% coinsurance	40% coinsurance
Facility Fees	20% coinsurance	40% coinsurance
Doctor Services	20% coinsurance	40% coinsurance
Outpatient Surgery		
Facility fees:		
Hospital	20% coinsurance	40% coinsurance
Freestanding Surgical Center	20% coinsurance	40% coinsurance
Doctor and Other Services:	20% coinsurance	40% coinsurance
Hospital	20% coinsurance	40% coinsurance
Freestanding Surgical Center	20% coinsurance	40% coinsurance
Hospital Stay (all Inpatient stays including Maternity, Mental and Substance Use Disorder):		
Facility fees (for example, room & board) *Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Non-Network Providers combined is limited to 60 days per benefit year.*	20% coinsurance	40% coinsurance
Doctor and other services	20% coinsurance	40% coinsurance
Recovery & Rehabilitation		
Home Care Visits *Coverage for In-Network Providers and Non-Network Providers combined is limited to 120 visits per benefit period. Visit limit does not apply to Physical, Occupational or Speech Therapy when performed as part of Home Health.*	20% coinsurance	40% coinsurance
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for physical therapy and occupational therapy combined is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Providers and Non- Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance	40% coinsurance
Outpatient Hospital *Coverage for physical therapy and occupational therapy combined is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Providers and Non- Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance	40% coinsurance

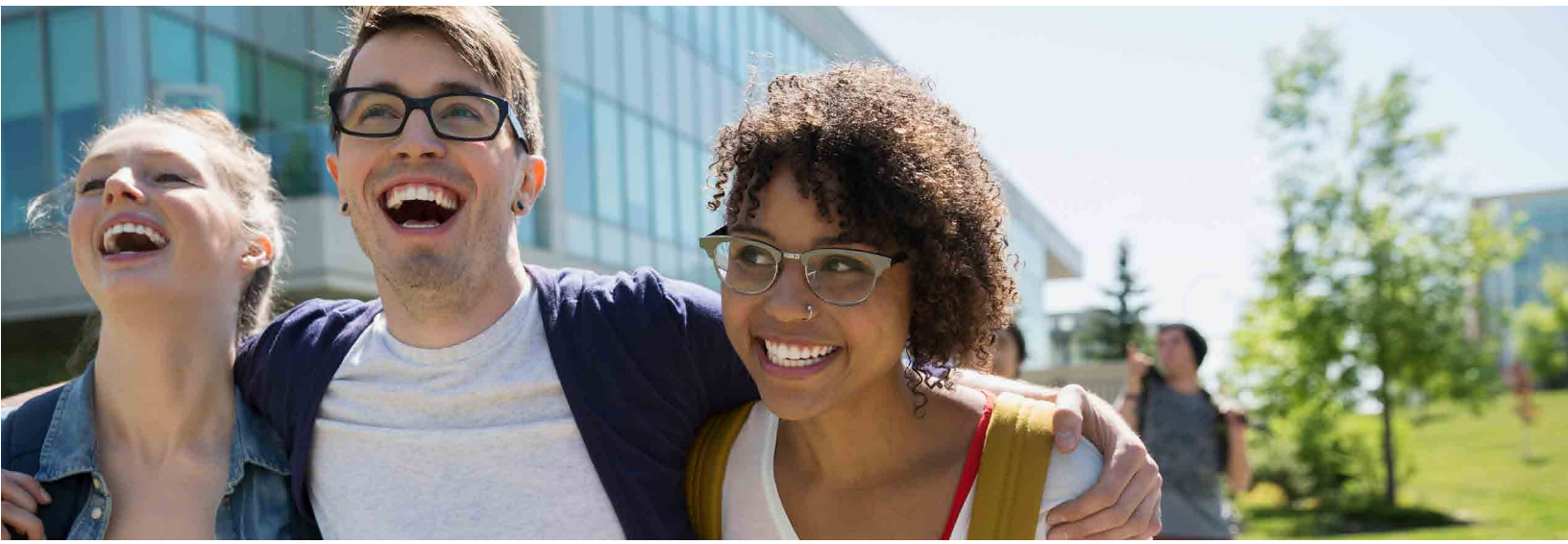
Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Habilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for physical therapy and occupational therapy combined is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Providers and Non- Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance	40% coinsurance
Outpatient Hospital *Coverage for physical therapy and occupational therapy combined is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Providers and Non- Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance	40% coinsurance
Cardiac rehabilitation		
Office	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Skilled Nursing Care (in a facility) *Coverage for Inpatient rehabilitation and skilled nursing services combined In- Network Providers and Non-Network Providers combined is limited to 60 days per benefit period.*	20% coinsurance	40% coinsurance
Hospice	20% coinsurance	40% coinsurance
Durable Medical Equipment *Coverage for hearing aids services left ear is limited to 1 unit every 48 months and right ear is limited to 1 unit every 48 months for children 18 years of age or under. Coverage is limited to $3,000 per hearing aid. Apply to In-Network Providers and Non-Network Providers combined.*	20% coinsurance	40% coinsurance
Prosthetic Devices *Coverage for wigs needed after cancer treatment In-Network Providers and Non-Network Providers combined is limited to 1 items per benefit period.*	20% coinsurance	40% coinsurance

Pharmacy

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	$2500 combined with medical out of pocket maximum	$2500 combined with medical out of pocket maximum
Prescription Drug Coverage *Traditional Open Drug List*		
Tier 1 - Typically Lower Cost Generic *Covers up to a 30 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).* **Mail Order**	$20 copay per Prescription deductible does not apply (retail only). $50 copay per Prescription deductible does not apply (home delivery only)	$20 copay per Prescription deductible does not apply (retail only). 40% coinsurance
Tier 2 - Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).* **Mail Order**	$30 copay per Prescription deductible does not apply (retail only). $75 copay per Prescription deductible does not apply (home delivery only)	$30 copay per Prescription deductible does not apply (retail only). 40% coinsurance
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).* **Mail Order**	$60 copay per Prescription deductible does not apply (retail only). $150 copay per Prescription deductible does not apply (home delivery only)	$60 copay per Prescription deductible does not apply (retail only). 40% coinsurance
Tier 4 - Specialty *Covers up to a 30 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).* **Mail Order**	$60 copay per Prescription deductible does not apply (retail only). $150 copay per Prescription deductible does not apply (home delivery only)	$60 copay per Prescription deductible does not apply (retail only). 40% 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
This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail.		
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	$0 person	Not Applicable
Vision exam *Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Frames *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $45
Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$25 Reimbursement for Single, $40 Reimbursement for Bifocal and $55 Reimbursement for Trifocal Vision Lens
Elective contact lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $60
Non-elective contact lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $210
Adult Vision (age 19 and older)		
Adult Vision Coverage *Limited to certain vision screenings required by Federal law and covered under the "Preventive Care" benefit.*	See "Preventive Care" benefit	See "Preventive Care" benefit



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
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's dental services count towards your out of pocket limit.		
Children's Dental Essential Health Benefits (up to age 19)		
Diagnostic and preventive *Coverage for In-Network Providers and Non-Network Providers combined is limited to 2 visits per benefit period.*	No charge	No charge
Basic services	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Major services/Prosthodontics	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Endodontic, Periodontics, Oral Surgery	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Medically Necessary Orthodontia services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Not applicable	Not applicable
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not Applicable	Not Applicable
Annual maximum	Not covered	Not covered

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.

Notes

- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- The family deductible and out-of-pocket maximum are embedded indicating the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; additionally, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- All medical and pharmacy deductibles, copayments and coinsurance apply to the out of pocket maximum.
- To view your prescription formulary list log on to www.anthem.com/health-insurance/customer-care/forms-library

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.

Anthem determines whether services or supplies are Medically Necessary based on the definition of Medical Necessity found in the "Definitions" section.

1. **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.
2. **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 Anthem.
3. **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 (**except** when a Doctor of naturopathic medicine furnishes services that are Covered Services),
   k) Thermography,
   l) Orthomolecular therapy,
   m) Contact reflex analysis,
   n) Bioenergial 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.
4. **Autopsies.**
   Autopsies and post-mortem testing when requested by an entity other than Anthem.
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. Examples include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
7. **Charges over the Maximum Allowed Amount.**
   Charges over the Maximum Allowed Amount for Covered Services.
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 Member Services at 1-844-412-0752 or visit our website at www.anthem.com.

   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.
10. **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 for non-Investigational treatments.
11. **Complications of / or Services Related to Non-Covered Services.**
    Services, supplies, or treatment related to, or for problems directly resulting from, 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. **Compound Drugs.**
    Compound Drugs unless all of the ingredients are FDA approved as designated in the FDA's Orange Book: "Approved Drug Products with Therapeutic Equivalence Evaluations", 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.
13. **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 "Reconstructive Surgery" as stated under "Surgery" in the "What's Covered" section.
14. **Custodial Care.**
    Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
15. **Delivery Charges.**
    Charges for delivery of Prescription Drugs.]

16. **Dental Devices for Snoring.**
Oral appliances for snoring.

17. **Dental Services.**
Coverage is not provided for the following Dental-related services:
   a) Dental care for members age 19 and older, unless covered by the medical benefits of this plan.
   b) Dental services or health care services not specifically covered under the plan (including any hospital charges, prescription drug charges and] dental services or supplies that do not have an American Dental Association Procedure Code).
   c) Services of anesthesiologist, unless required by law.
   d) Anesthesia services (such as intravenous or non-intravenous conscious sedation, and general anesthesia) are not covered when given separate from a covered oral surgery service, except as required by law.
   e) Analgesia, analgesia agents, oral sedation and anxiolysis nitrous oxide.
   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 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) Case presentations, office visits.
   i) Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
   j) Enamel microabrasion and odontoplasty.
   k) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.
   l) Biological tests for determination of periodontal disease or pathologic agents, unless covered by the medical benefits of this plan.
   m) Collection of oral cytology samples 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) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
   q) Provisional splinting, temporary procedures or interim stabilization.
   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) Repair or replacement of lost or broken appliances.
   bb) Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials, nor the procedures used to prepare and place materials in the canals (tooth roots).
   cc) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
   dd) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
   ee) For dental services received prior to the effective date of this plan or received after the coverage under this plan has ended.
   ff) Dental services given by someone other than a licensed provider (dentist or physician) or their employees.
   gg) Services to treat temporomandibular joint disorder (TMJ), unless covered by the medical benefits of this plan.
   hh) Dental services for which you would have no legal obligation to pay in the absence of this or like coverage.
   ii) 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.

18. **Disease or Injury Sustained as a Result of War or Participation in Riot or Insurrection.**
No Benefits are available for care required to diagnose or treat any illness or injury that is a result of war or participation in a riot or an insurrection.

19. **Drugs Contrary to Approved Medical and Professional Standards.**
Drugs given or prescribed in a way that is against approved medical and professional standards of practice.

20. **Drugs Over Quantity or Age Limits.**
Drugs which are over any quantity or age limits based upon FDA labeling.

21. **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.

22. **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.

23. **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.

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

25. **Emergency Room Services for non-Emergency Care.**
Services provided in an emergency room for conditions that do not meet the definition of Emergency. This includes services such as suture removal in an emergency room. For non-Emergency Care please use the closest In-Network Urgent Center or your Primary Care Physician.

26. **Experimental or Investigational Services.**
Services or supplies that are Experimental / Investigational as defined in the "Definitions" section of this Booklet. Except as stated under "Clinical Trials" in the "What's Covered" section, this exclusion 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 it is Experimental / Investigational.

27. **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.

28. **Eye Exercises.**
Orthoptics and vision therapy.

29. **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.

30. **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.

31. **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:
    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.

32. **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.

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

34. **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 Workers' Compensation benefits are not available to you, for whatever reason, 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.

35. **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.

    This exclusion does not include Self-administered human growth hormones to treat children with short stature who have an absolute deficiency in natural growth hormone. Benefits are also available to treat children with short stature who have chronic renal insufficiency and who do not have a functioning renal transplant.

36. **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.

37. **Home 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) Private duty nursing.
    c) Food, housing, and home delivered meals.
    d) Homemaker services, except for the homemaker visits described in the "What's Covered" section under "Home Care" (prenatal and postpartum visits) and under "Hospice."

38. **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.

39. **Hyperhidrosis Treatment.**
Medical and surgical treatment of excessive sweating (hyperhidrosis).

40. **Infertility Treatment.**
which is considered Experimental / Investigational, non-medical costs related to third party reproduction. For surrogates or gestational carriers there is no coverage for the preparation or introduction of embryos, oocytes, or donor sperm.

41. **Lost or Stolen Drugs.**
Refills of lost or stolen Drugs.

42. **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.

43. **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 "What's Covered" section.

44. **Missed or Cancelled Appointments.**
Charges for missed or cancelled appointments.

45. **Non-approved Drugs.**
Drugs not approved by the FDA.

46. **Non-Medically Necessary Services.**
Services that are not Medically Necessary as defined in the "Definitions" section of this Booklet.

47. **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.

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

49. **Private Duty Nursing.**
    Private Duty Nursing Services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the "Home Care Services" benefit.

50. **Prosthetics.**
    Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics except as required by law.

51. **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.

52. **Routine Physicals.**
    Physical exams 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.

53. **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 lists or other exclusion / sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to Emergency Care.

54. **Services Received Outside of the United States.**
    Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care, Emergency Ambulance or Covered Services approved in advance by Anthem.

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

56. **Smoking Cessation Programs.**
    Programs to help you stop smoking. Please note: Preventive screenings, counseling and other Preventive Care services for tobacco use and tobacco cessation are covered as required by law under the "Preventive Care" benefit in the "What's Covered" section and in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

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

58. **Reversal of Elective Sterilization.**

59. **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).

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

61. **Travel Costs.**
    Mileage, lodging, meals, and other Member-related travel costs except as described under "Human Organ and Tissue Transplants"

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

63. **Vision Services.**
    We will not pay for services incurred for, or in connection with, any of the items below.
    a) For safety glasses and accompanying frames.
    b) For two pairs of glasses in lieu of bifocals.
    c) For Plano lenses (lenses that have no refractive power).
    d) Blended lenses.
    e) Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
    f) Vision services not listed as covered in this Booklet.
    g) Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically stated as covered in this Booklet.
    h) 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.
    i) For Members through age 18, no benefit is available for frames or contact lenses purchased outside of Anthem's formulary.
    j) 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.
    k) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
    l) For which the member has no legal obligation to pay in the absence of this or like coverage.

m) For services or supplies prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse or Domestic Partner, child, brother, sister or parent.
n) For completion of claim forms or charges for medical records or reports.
o) For missed or cancelled appointments.
p) Visual therapy, such as orthoptics or vision training and any associated supplemental testing, unless covered by the medical benefits of this Booklet.
q) For medical or surgical treatment of the eyes, including inpatient or outpatient hospital vision care, except as covered under the medical benefits of this plan.
r) Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed provider.

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

This Exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This Exclusion does not apply to the "Diabetes Management" or "Preventive Care" benefits or to "Surgery for conditions caused by obesity" under "Surgery" in the "What's Covered" section.

65. **Wilderness or other outdoor camps and/or programs.**

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 Anthem 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 for non-Investigational treatments.
4. **Compound Drugs.**
Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: "Approved Drug Products with Therapeutic Equivalence Evaluations", 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.
5. **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.
6. **Cosmetic Drugs Agents or medications.**
used for cosmetic purposes.
7. **Delivery Charges.**
Charges for delivery of Prescription Drugs.
8. **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 in the "What's Covered" section - they are Covered Services.
9. **Drugs Not on the Anthem Prescription Drug List (formulary).**
You can get a copy of the list by calling us at 1-844-412-0752 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 "Prior Authorization" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception.
10. **Drugs over Quantity or Age Limits.**
Drugs which are over any limits quantity or age limits based upon FDA labeling.
11. **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.
12. **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.
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. Please see "Over-the-Counter Items" below for information about coverage required by law for over-the-counter items purchased at an In-Network Pharmacy with a Prescription from your Doctor.
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. **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 "Gene Therapy" benefit. Please see the "What's Covered" section for details.
16. **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.
17. **Hyperhidrosis Treatment.**
Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
18. **Items Covered as Durable Medical Equipment (DME).**
Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors and contraceptive devices. Items not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order)

Pharmacy" may be covered under the "Durable Medical Equipment and Medical Supplies" benefit in the "What's Covered" section. Please see that section for details.

19. **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 in the "What's Covered" section. Please see that section for details.

20. **Lost or Stolen Drugs.**
Refills of lost or stolen Drugs.

21. **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.

22. **Non-approved Drugs.**
Drugs not approved by the FDA.

23. **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.

24. **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.

25. **Onychomycosis Drugs.**
Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.

26. **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 may not be covered, even if written as a prescription. 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 by law under "Preventive Care" in the "What's Covered" section when you purchase them from an In-Network Pharmacy with a Prescription from your Doctor. These include over-the-counter contraceptive products for women and over-the-counter smoking cessation / nicotine replacement products (limited to nicotine patches and gum), low-dose aspirin and colonoscopy prep medications.

27. **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 the 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.

28. **Sexual Dysfunction Drugs.**
Drugs to treat sexual or erectile problems.

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

30. **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

ىلع دوجوملا ءاضعلأا تامدخ مقرب لصتا .ًاناجم كتغلب ةدعاسملاو تامولعملا هذه ىلع لوصحلا كل قحي
ةقاطب فيرعتلا ةصاخلا كب ةدعاسملل.(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

تروص هب ار اهکمک و تاعلاطا نیا هک دیراد ار قح نیا امش
هب کمک تفایرد یارب .دینک تفایرد ناتدوخ نابز هب ناگیار
جرد ناتیاسانش تراک یور رب هک ءاضعا تامدخ زکرم هرامش
دیریگب سامت ،تسا (TTY/TDD: 711). هدش

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 ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ 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

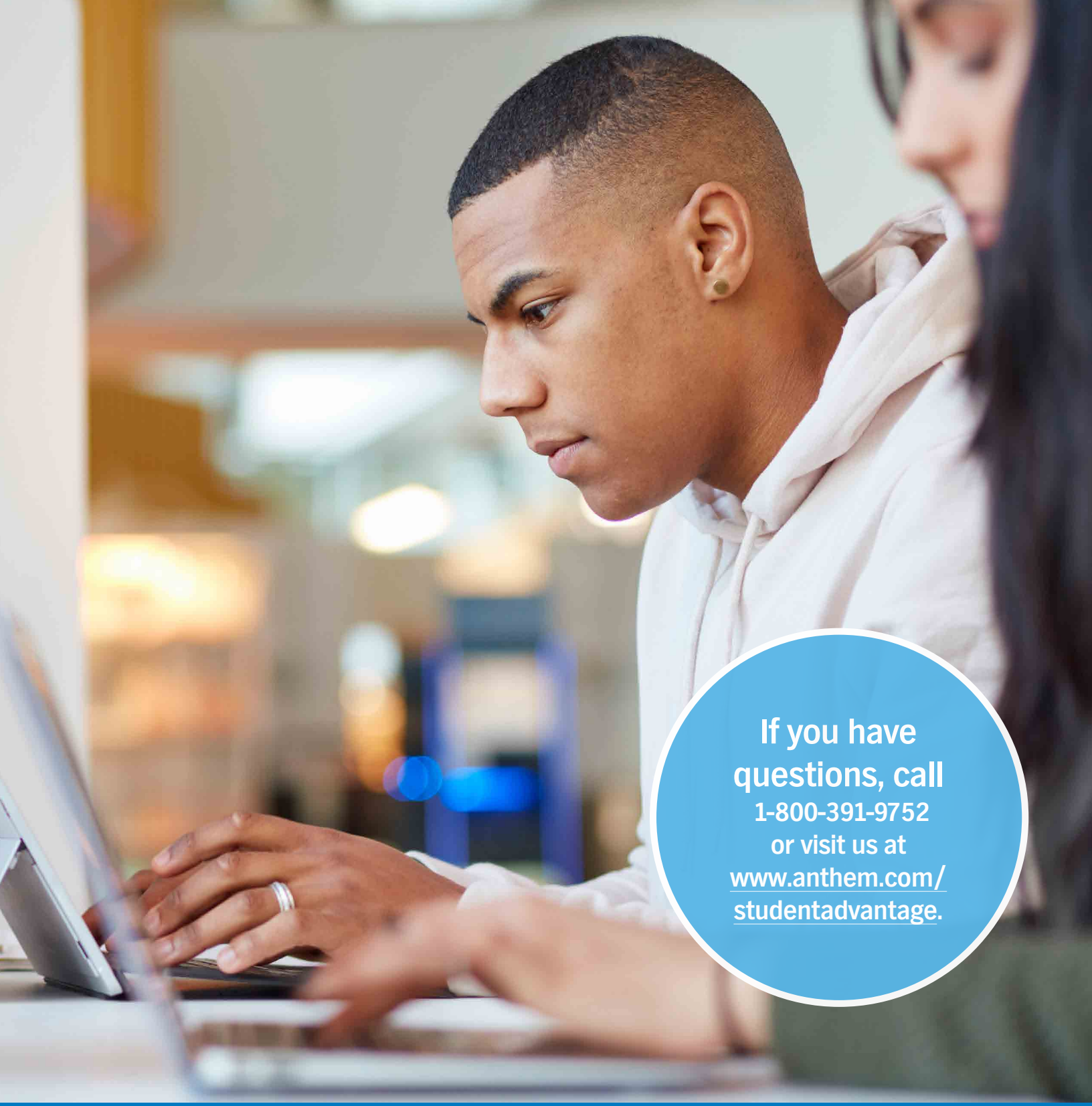
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

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.



If you have questions, call 1-800-391-9752 or visit us at www.anthem.com/studentadvantage.

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