2021-2022

University of Colorado Boulder

Student Health Insurance Plan (SHIP)

www.anthem.com/studentadvantage

Anthem Student Advantage

Keeping you at your personal best

A00332COMENABS 05/21

Anthem | STUDENT ADVANTAGE

University of Colorado Boulder

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 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 undergraduate students enrolled in six or more credit hours and graduate students enrolled in one graduate credit hour or more.
- Non-degree seeking Continuing Education students, Study Abroad (including Semester at Sea) students, Evening MBA students and students taking exclusively Be Boulder Anywhere courses, enrolled in six or more credit hours and paying the base student and health fees, may be eligible to enroll in the University of Boulder Colorado Gold SHIP and can do so by contacting the Student Insurance Office at 1-303-492-5107 or studentinsurance@colorado.edu for additional details.
- Students approved for the Leave of Absence Program are eligible to enroll in the University of Boulder Colorado Gold SHIP for one semester that they are not registered for classes and can do so by contacting the Student Insurance Office at 1-303-492-5107 or studentinsurance@colorado.edu for additional details.

Please refer to 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

Semester	Coverage Start Date	Coverage End Date	Premium	Enroll or request a waiver by:
Fall	August 1, 2021	December 31, 2021	$1,948	September 15, 2021
Spring/Summer	January 1, 2022	July 31, 2022	$1,948	February 11, 2022
Summer Only	May 1, 2022	July 31, 2022	$994	May 31, 2022

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

Keep in touch with your benefits information

Student Health Center

Wardenburg Health Center
1900 Wardenburg Drive
119 UCB
Boulder, CO 80309
1-303-492-5101 (24/7 nurse line)
www.colorado.edu/healthcenter/
Please check website for hours.
Saturday and Sunday: Closed

Student Counseling Center

Center for Community, Suite N352
2249 Willard Loop Dr.
104 UCB
Boulder, CO 80309
1-303-492-2277 (24/7 support)
www.colorado.edu/counseling/
Please check website for hours.

Benefits and Claims

Contact AmeriBen at
1-855-639-8676 or visit
MyAmeriben.com.

Eligibility and Enrollment

Wardenburg Health Center
119 18th St, Room 332
Boulder, CO 80305
1-303-492-5107
studentinsurance@colorado.edu

Your CU Boulder Medical services

CU Boulder Medical Services is the primary medical provider for Covered Students enrolled in the Student Health Insurance Plan. These services and benefits are not insured benefits under the Student Health Insurance Plan but are provided by CU Boulder Medical Services to all Covered Students enrolled in the Student Health Insurance Plan.

Most services rendered at CU Boulder Medical Services are not subject to the coinsurance, co-pay or deductible amounts applicable to the Student Health Insurance Plan.

Medical care

Primary and preventive care including:

- Physical exams
- Treatment for illnesses and injuries
- Travel health services (excluding specialty travel immunizations)
- Routine vaccinations
- Allergy shots (antigen not provided by health center)

Nutrition services

- Nutrition counseling for a variety of concerns

Laboratory and X-ray

- Coverage for lab services ordered and managed by a Medical Services provider
- Coverage for X-ray services

Counseling and psychiatry

- 20 counseling and psychiatry visits per policy year including:
  - Individual counseling
  - Couples counseling
  - Medication management
  - Crisis care
- Unlimited group therapy
- 50% coverage of psychological testing (ordered by a Medical Services Provider at CU Boulder Medical Services; subject to availability)

Physical therapy and integrative care

- 25 physical therapy visits per policy year
- 10 chiropractic visits per policy year
- Orthopedic surgeon consultations

Note: CU Sports Medicine at the Champion Center is not part of CU Boulder Medical Services

Continued

Sexual and reproductive health

- Gynecology services
- One annual exam
- Birth control consultations
- Sexually transmitted infection testing and treatment
- Human papillomavirus (HPV) vaccinations
- Transgender patient care and hormone therapy

Annual dental exam

CU Boulder Gold SHIP members are entitled to one dental exam, cleaning and x-ray per policy year at no additional cost. Please see the following link for additional information:

https://www.colorado.edu/health/insurance/student-health-insurance/2021-2022-cu-boulder-gold-health-insurance-plan

Annual eye exam

CU Boulder Gold SHIP members are entitled to one routine eye exam per policy year at no additional cost through College Optical in Boulder. This includes visual fields testing, glaucoma screening, refraction, and a dilated exam if needed.

Eyeglass frames, lenses, contacts and contact fittings are available with a discount and are the patient's responsibility.

These services are offered at CU Boulder Medical Services, but not covered by CU Boulder Gold SHIP:

- Acupuncture
- Bike fits
- Copies of X-rays and medical records
- Custom knee braces
- Vaccinations for Japanese encephalitis, rabies, yellow fever and typhoid
- Loaned equipment
- Massage therapy
- Missed appointment fees
- Patient-requested lab tests (not medically necessary)
- Replacement of medical supplies

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.

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

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

- www.anthem.com
- www.colorado.edu/health/insurance
- MyAmeriBen.com
- Calling AmeriBen at 1-855-258-2656.

Important tips:

- When you need health care, please access care at the University of Colorado Boulder Health Services first 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 Blue Shield

Student health insurance plan:
University of Colorado Boulder

Your network:
Anthem 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. Plan benefits are pending approval with the state and subject to change.

Student Health Center Benefits: No Charge for Covered Medical Expenses, Deductible Waived, 100% of Usual and Reasonable Charge for Covered RX Expenses

Medical

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible		
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 student	$1,000 student
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.	$5,000 student	$10,000 student
Preventive care/screening/immunization		
In-network preventive care is not subject to deductible, if your plan has a deductible. Deductible does not apply to the following Out-Of-Network services: Immunizations, well woman visits, alcohol and/or drugs counseling office visits, routine cancer screenings.	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	$40 copay per visit deductible does not apply	$40 copay per visit 50% coinsurance deductible does not apply
Specialist Care Office Visit	$40 copay per visit deductible does not apply	$40 copay per visit 50% coinsurance deductible does not apply
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	$40 copay per visit deductible does not apply	$40 copay per visit 50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Other Practitioner Visits:		
Retail Health Clinic	$40 copay per visit deductible does not apply	40 copay per visit, 50% coinsurance deductible does not apply
On-line Visit *Includes Mental/Behavioral Health and Substance Abuse* *Live Health Online is the preferred telehealth solution.* *(www.livehealthonline.com).*	$20 copay per visit deductible does not apply	$20 copay per visit deductible does not apply
Chiropractic	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	$40 copay per visit deductible does not apply	$40 copay per visit, 50% coinsurance deductible does not apply
Chemo/Radiation Therapy	$40 copay per visit deductible does not apply	$40 copay per visit, 50% coinsurance deductible does not apply
Hemodialysis	$40 copay per visit deductible does not apply	$40 copay per visit, 50% coinsurance deductible does not apply
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office *Office Cost Share applies only when Freestanding/Reference Labs are not used.*	20% coinsurance after deductible is met	$40 copay per visit, 50% coinsurance deductible does not apply
Freestanding Lab/Reference Lab	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office	$40 copay per visit, deductible does not apply	$40 copay per visit, 50% coinsurance deductible does not apply
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	$40 copay per visit, deductible does not apply	$40 copay per visit, 50% coinsurance deductible does not apply
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Emergency and Urgent Care		
Urgent Care (Office Setting)	$75 copay per visit, 20% coinsurance deductible does not apply	$75 copay per visit, 50% coinsurance deductible does not apply
Emergency Room Facility Services *Emergency Room copay is waived if directly admitted to the hospital.*	$150 copay per visit, 20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Emergency Ambulance (Air and Ground) *Non-emergency, Non-Network ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$20 copay per visit, 0 coinsurance deductible does not apply	$20 copay per visit, 50% coinsurance deductible does not apply
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery Facility Fees:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) *Rehabilitation services in an inpatient hospital or acute care facility are limited to 60 days combined per benefit period. Limit is combined In- Network and Non-Network.*	$200 copay per visit, 20% coinsurance after deductible is met	$200 copay per visit, 50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 28 hours per week. Limit is combined In-Network and Non-Network. Visit limit does not apply to Home Infusion Therapy or Home Dialysis. Limits are combined for home health care and private duty nursing.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy):		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility)		
	$200 copay per visit, 20% coinsurance after deductible is met	200 copay per visit, 50% coinsurance after deductible is met
Hospice		
	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment		
	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices		
Coverage for hearing aids services is limited to 1 item per ear every 5 years. Covered for children 18 years of age or under. Limit is combined In-Network and Non-Network across all settings.	20% coinsurance after deductible is met	50% coinsurance after deductible is met

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	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *Traditional Drug List* *This product has a 90-day Retail Pharmacy Network available.* *A 90 day supply is available at most retail pharmacies.*		
Tier 1 - Typically Lower Cost Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$25 copay per prescription, deductible does not apply	Covered as In-Network
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$45 copay per prescription, deductible does not apply	Covered as In-Network
Tier 3 - Typically Non-Preferred Brand/Specialty *Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$75 copay per prescription, deductible does not apply	Covered as In-Network

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 student'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 *Limited to covered persons under the age of 19.*		
Child Vision Deductible	$0	$0
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.*		
Single vision lenses	$0 copay	$0 copay (up to $25)
Bifocal lenses	$0 copay	$0 copay (up to $45)
Trifocal lenses	$0 copay	$0 copay (up to $55)
Lenticular lenses	$0 copay	$0 copay (up to $70)
Progressive lenses (standard, premium, select, ultra)	$0 copay	$0 copay (up to $40)
Transitions Lenses	$0 copay	Not covered
Standard polycarbonate	$0 copay	Not covered
Factory Scratch Coating	$0 copay	Not covered
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 *Limited to covered persons under the age of 19.*		
Diagnostic and preventive *Includes cleanings, exams, x-rays, sealants, fluoride*	No charge	50% coinsurance
Basic services *Includes filing and simple extractions*	30% coinsurance	50% coinsurance
Major services/Prosthodontic	50% coinsurance	50% coinsurance
Endodontic, Periodontics, Oral Surgery	50% coinsurance after deductible is met	50% coinsurance
Medically Necessary Orthodontia	50% coinsurance	50% coinsurance
Deductible	Not applicable	Not applicable
Adult Dental (Age 19 and over)	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.

Exclusions

The below exclusions apply. For a full list of exclusions please refer to the certificate of coverage.

1. **Acupuncture Therapy**
   a) Maintenance treatment
   b) Acupuncture when provided for the following conditions:
      Acute low back pain
      Addiction
      AIDS
      Amblyopia
      Allergic rhinitis
      Asthma
      Bell's Palsy
      Burning mouth syndrome
      Cancer-related dyspnea
      Carpal tunnel syndrome
      Chemotherapy-induced leukopenia
      Chemotherapy-induced neuopathic pain
      Chronic pain syndrome (e.g., RSD, facial pain)
      Chronic obstructive pulmonary disease
      Diabetic peripheral neuropathy
      Dry eyes
      Erectile dysfunction
      Facial spasm
      Fetal breech presentation
      Fibromyalgia
      Fibrotic contractures
      Glaucoma
      Hypertension
      Induction of labor
      Infertility (e.g., to assist oocyte retrieval and embryo transfer during IVF treatment cycle)
      Insomnia
      Irritable bowel syndrome
      Menstrual cramps/dysmenorrhea
      Mumps
      Myofascial pain
      Myopia
      Neck pain/cervical spondylosis
      Obesity
      Painful neuropathies
      Parkinson's disease
      Peripheral arterial disease (e.g., intermittent claudication)
      Phantom leg pain
      Polycystic ovary syndrome
      Post-herpetic neuralgia
      Psoriasis
      Psychiatric disorders (e.g., depression)
      Raynaud's disease pain
      Respiratory disorders
      Rheumatoid arthritis
      Rhinitis
      Sensorineural deafness
      Shoulder pain (e.g., bursitis)
      Stroke rehabilitation (e.g., dysphagia)
      Tennis Elbow/epicondylitis
      Tension headache
      Tinnitus
      Tobacco Cessation
      Urinary incontinence
      Uterine fibroids
      Xerostomia
      Whiplash

2. **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.

3. **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.

4. **Alternative / Complementary Medicine**
   Services and supplies given by a provider for alternative health care. This includes but is not limited to aromatherapy, naturopathic medicine, herbal remedies, homeopathy, energy medicine, Christian faith-healing medicine, Ayurvedic medicine, yoga, hypnotherapy, and traditional Chinese medicine.

5. **Armed Forces**
   Services and supplies received from a provider as a result of an injury sustained, or illness contracted, while in the service of the armed forces of any country. When you enter the armed forces of any country, we will refund any unearned pro-rata premium to the policyholder.

6. **Applied Behavioral Treatment**
   (including, but not limited to, Applied Behavior Analysis and intensive behavior interventions) for all indications except as described under Autism Services in the "Benefits/Coverage (What is Covered)" section.

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

8. **Breasts**
   Services and supplies given by a provider for breast reduction or gynecomastia.

9. **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.

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

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

12. **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.

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

14. **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.

15. **Cosmetic Services and Plastic Surgery**
Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body. Whether or not for psychological or emotional reasons. Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected. This exclusion does not apply to:
    a) Surgery after an accidental injury when performed as soon as medically feasible.
    b) Coverage that may be provided under the Eligible health services under your plan - Gender reassignment (sex change) treatment section.

16. **Court-ordered Services and Supplies**
Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding other than substance related disorders treatment and mental health treatment described as covered in the "Benefits/Coverage (What is Covered)" section and required by state law.

17. **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.

18. **Custodial Care**
Examples are:
    a) Routine patient care such as changing dressings, periodic turning and positioning in bed
    b) Administering oral medications
    c) Care of a stable tracheostomy (including intermittent suctioning)
    d) Care of a stable colostomy/ileostomy
    e) Care of a bladder catheter (including emptying/changing containers and clamping tubing)
    f) Watching or protecting you
    g) Respite care, adult (or child) day care, or convalescent care except in connection with hospice care
    h) Institutional care. This includes room and board for rest cures, adult day care and convalescent care
    i) Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
    j) Any other services that a person without medical or paramedical training could be trained to perform
    k) Any service that can be performed by a person without any medical or paramedical training

19. **Delivery Charges**
Charges for delivery of Prescription Drugs.

20. **Dental Care for Adults**
    a) Dental services for adults including services related to:
        The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
        Dental services related to the gums
        Apicoectomy (dental root resection)
        Orthodontics
        Root canal treatment
        Soft tissue impactions
        Alveolectomy
        Augmentation and vestibuloplasty treatment of periodontal disease
        False teeth
        Prosthetic restoration of dental implants
        Dental implants

    This exception does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.

21. **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) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
    i) Separate services billed when they are an inherent component of another covered service.
    j) Services to treat Temporomandibular Joint Disorder (TMJ) except as covered under your medical coverage.
    k) Oral hygiene instructions.
    l) Case presentations, office visits and consultations.
    m) Implant services, except as listed in this Booklet.
    n) 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).

o) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
p) Incomplete root canals.
q) Adjunctive diagnostic tests.

22. **Drugs 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.

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

24. **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.

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

26. **Drugs That Do Not Need a Prescription**
Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.

27. **Durable Medical Equipment (DME)**
Examples of these items are:
a) Whirlpools
b) Portable whirlpool pumps
c) Sauna baths
d) Massage devices
e) Over bed tables
f) Elevators
g) Communication aids
h) Vision aids
i) Telephone alert systems
j) Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician.

28. **Educational Services**
Except as described as covered services for autism spectrum disorders, therapies for congenital defects and birth abnormalities and early intervention services in the Benefits/coverage (what is covered) section, examples of these services are:
a) Any service or supply for education, training or retraining services or testing. This includes:
Special education
Remedial education
Wilderness treatment program
Job training
Job hardening programs
b) Services provided by a governmental school district.

29. **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, but is not limited to, suture removal, routine pregnancy test, sore throat, ear ache/infection, rashes, sprains/strains, constipation, diarrhea, upper respiratory illness, abrasions, sleep disorder, conjunctivitis/pink eye, back pain that is not sudden and severe in onset, or dental caries/cavity in an emergency room. For non-emergency care please use the closest network Urgent Care Center or your Primary Care Physician.

30. **Experimental or Investigational Services**
Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs). See the "Benefits/Coverage (What is Covered)" section.

31. **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.**

32. **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.

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

34. **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.

35. **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.

36. **Foot Care**
Services and supplies for:
a) The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches
b) The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
c) Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
d) Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet unless specifically required for treatment or to prevent complications of diabetes.

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

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

39. **If Workers' Compensation benefits are not available to you, this Exclusion does not apply.**
This Exclusion will apply if you get the benefits in whole or in part.

40. **Health Club Memberships and Fitness Services**
Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.

41. Hearing Aids and Exams

The following services or supplies:

a) A replacement of:
   A hearing aid that is lost, stolen or broken
   A hearing aid installed within the prior 12 month period
b) Replacement parts or repairs for a hearing aid
c) Batteries or cords
d) A hearing aid that does not meet the specifications prescribed for correction of hearing loss
e) Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist
f) Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay
g) Any tests, appliances and devices to:
   Improve your hearing. This includes hearing aid batteries, amplifiers, and auxiliary equipment
   Enhance other forms of communication to make up for hearing loss or devices that simulate speech.

42. Infertility Treatment

a) Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
b) All charges associated with:
   Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father.
   Cryopreservation (freezing) of eggs, embryos or sperm.
   Storage of eggs, embryos, or sperm.
   Thawing of cryopreserved (frozen) eggs, embryos or sperm.
   The care of the donor in a donor egg cycle which includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers.
   The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which the person is not genetically related.
   Obtaining sperm from a person not covered under this plan for ART services.
c) Home ovulation prediction kits or home pregnancy tests.
d) The purchase of donor embryos, donor oocytes, or donor sperm.
e) Reversal of a voluntary sterilizations, including follow-up care.
f) Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures.
g) In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or precedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery).
h) ART services are not provided for out-of-network care.

43. Lost or Stolen Drugs

Refills of lost or stolen Drugs.

44. 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.

45. Medical Supplies: Outpatient Disposable

a) Any outpatient disposable supply or device. Examples of these are:
   Sheaths
   Bags
   Elastic garments
   Support hose
   Bandages
   Bedpans
   Syringes
   Blood or urine testing supplies
   Other home test kits
   Splints
   Neck braces
   Compresses
   Other devices not intended for reuse by another patient

46. Medicare

Services and supplies available under Medicare, if you are entitled to premium-free Medicare Part A or enrolled in Medicare Part B, or if you are not entitled to premium-free Medicare Part A or enrolled in Medicare Part B because you refused it, dropped it, or did not make a proper request for it.

47. Missed or Cancelled Appointments

Charges for missed or cancelled appointments.

48. Non-approved Drugs

Drugs not approved by the FDA.

49. Non-Medically Necessary Services

Services and supplies which are not medically necessary for the diagnosis, care, or treatment of an illness or injury or the restoration of physiological functions. This includes behavioral health services that are not primarily aimed at the treatment of illness, injury, restoration of physiological functions or that do not have a physiological or organic basis. This applies even if they are prescribed, recommended, or approved by your physician, dental provider, or vision care provider. This exception does not apply to Preventive care and wellness benefits.

50. Nutritional Support

Except as covered in the "Benefits/Coverage (What is Covered)" section - Nutritional support benefit, the following are not covered services:

a) Any food item, including:
   Infant formulas
   Nutritional supplements
   Vitamins
   Other nutritional items even if it is the sole source of nutrition.

51. Off label use

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

52. Personal Care, Comfort or Convenience Items

Any service or supply primarily for your convenience and personal comfort or that of a third party.

53. Private Duty Nursing

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

54. Prosthetics Devices

a) Services covered under any other benefit
b) Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices

to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace.
c) Trusses, corsets, and other support items.
d) Repair and replacement due to loss, misuse, abuse or theft
e) Communication aids

55. 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.
d) Wilderness camps.

56. Riot
Services and supplies that you receive from providers as a result of an injury from your "participation in a riot". This means when you take part in a riot in any way such as inciting, or conspiring to incite, the riot. It does not include actions that you take in self-defense as long as they are not against people who are trying to restore law and order.

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

58. Sexual Dysfunction and Enhancement
Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
a) Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ.
b) Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services.

Not eligible for coverage are prescription drugs in 60 day supplies.

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

60. 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).

61. Temporomandibular Joint Dysfunction Treatment (TMJ) and Craniomandibular Joint Dysfunction Treatment (CMJ)
a) Dental implants

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

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

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

Adult Vision Care
a) Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses.
b) Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes.

Adult Vision Care Services and Supplies
Your plan does not cover adult vision care services and supplies, except as described in the Benefits/coverage (what is covered) section.
a) Special supplies such as non-prescription sunglasses
b) Special vision procedures, such as orthoptics or vision therapy.
c) Eye exams during your stay in a hospital or other facility for health care.
d) Eye exams for contact lenses or their fitting.
e) Eyeglasses or duplicate or spare eyeglasses or lenses or frames.
f) Replacement of lenses or frames that are lost or stolen or broken.
g) Acuity tests.
h) Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures.
i) Services to treat errors of refraction.

65. 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.

66. 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.

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

68. **Pharmacy:** In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:
    a) Administration Charges - Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
    b) Charges Not Supported by Medical Records - Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
    c) 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.
    d) 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.
    e) 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.
    f) Delivery Charges - Charges for delivery of Prescription Drugs.
    g) 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.
    h) 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.
    i) Drugs Over Quantity or Age Limits - Drugs which are over any quantity or age limits set by the Plan or us.
    j) 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.
    k) Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications - Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by Anthem.
    l) 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.
    m) 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.
    n) {Option to remove: [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.]
    o) Infertility Drugs - Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT), except as listed in this booklet.
    p) 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.
    q) 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.
    r) Lost or Stolen Drugs - Refills of lost or stolen Drugs.
    s) 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.
    t) Non-approved Drugs - Drugs not approved by the FDA.
    u) 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.
    v) 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.
    w) Off label use - Off label use, unless we must cover the use by law or if we, or the PBM, approve it.
    x) Onychomycosis Drugs - Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
    y) 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.

69. **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.**
    a) Sexual Dysfunction Drugs - Drugs to treat sexual or erectile problems.
    b) Syringes - Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
    c) 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 بقسم خدمات الأعضاء الموجود على بطاقة هويتك 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 کمکهای به صورت به زبان خودتان دریافت کنید. برای کمک دریافت به زبان خودتان به کارمند خدمات اعضاء که روی کارت شناسایی خود درج شده است، مراجعه کنید. (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' áaji' 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.

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