Xavier University

2019-2020 Student Health Plan

Important notice

This is a brief description of your Student Health Plan underwritten by Anthem Blue Cross and Blue Shield (Anthem). If you'd like more details about your coverage and costs, you can get the complete terms in the policy or plan document online at anthem.com. You'll be able to get a copy of the full Master Policy as soon as it's available.

Anthem | STUDENT ADVANTAGE

anthem.com

1157060HMENASA Rev. 01/20

Who is eligible for the plan

All full-time domestic undergraduate students taking at least 12 or more credit hours are automatically enrolled in this insurance plan, unless proof of comparable coverage is provided. All international students are required to enroll in this insurance plan, unless proof of comparable coverage is provided. International students with F-1 and J-1 Visas are required to have current health insurance coverage with a U.S. claims address. To waive online, log onto: https://xavier.myahpcare.com/waiver

All waiver selections must be made by the waiver periods noted below:

- The Fall online waiver period is **6/18/19 through 9/13/19**.
- The Spring online waiver period is **11/19/19 through 1/31/20**.

If you are covered by the Student Health Insurance Plan for Xavier University, you may also enroll your lawful spouse and/or dependent children under the age of 26. To enroll eligible dependent(s) of a covered student, please visit https://xavier.myahpcare.com/enrollment during the open enrollment period:

- The Fall open enrollment period to enroll Dependents is **6/18/19 through 9/13/19**.
- The Spring open enrollment period to enroll Dependents is **11/19/19 through 1/31/20**.
- The Summer open enrollment period to enroll Dependents is **4/1/2020 through 5/31/2020**.

Coverage period

Coverage under the Plan will become effective at 12:01 a.m. on the later of, but no sooner than:

- The Master Policy effective date;
- The beginning date of the term for which premium has been paid;

The below enrollments will be allowed a **30 day** grace period from the term start date to enroll whereby the effective date will be backdated a maximum of **30 days**. No policy shall ever start prior to the term start date:

- All hard-waiver and mandatory (insurance is required as a condition of enrollment on campus) insurance programs.
- All re-enrollments into the same exact policy if re-enrollment occurs within **30 days** of the prior policy termination date.

Coverage under the plan terminates at 12:01 a.m. on the earlier of:

- Date the Master Policy terminates for all Insured Persons; or
- End of the period of coverage for which premium has been paid; or
- Date the Insured Person ceases to be eligible for the insurance; or
- Date the Insured Person enters military service.

COVERAGE IS **NOT** AUTOMATICALLY RENEWED. Eligible persons must re-enroll when coverage terminates to maintain coverage. No notification of plan expiration or renewal will be sent.

Refunds

Refund of premium will be considered only:

- If you withdraw from school within the first 31 days of a coverage period, you will not be covered under the Policy and the full premium will be refunded, less any claims paid. After 31 days, you will be covered for the full period that you have paid the premium for, and no refund will be allowed.
- For Insured Persons entering the Armed Forces of any country. Such persons will not be covered under the Policy as of the date of his/her entry into the service. A pro rata refund of premium will be made for such person upon written request received by Us within ninety (90) days of withdrawal from school.

Coverage periods and rates

Coverage periods

Coverage for all insured students enrolled for coverage in the Plan for the following Coverage Periods. Coverage will become effective at 12:01 AM on the coverage start date indicated below, and will terminate at 11:59 PM on the coverage end date indicated.

Medical	Annual 8/15/2019 through 8/14/2020	Spring 1/1/2020 through 8/14/2020	Summer 5/15/2020 through 8/14/2020
Student (tuition billed)	$3,106.00	$1,926.00	$781.00
Spouse	$3,106.00	$1,926.00	$781.00
Each child, 2x max	$3,106.00	$1,926.00	$781.00

Emergency travel assistance

As a participant in the student health plan, you have access to the emergency travel services and benefits when you are traveling over 100 miles from home or outside your home country.

To ensure you have immediate access to assistance if you experience a travel related crisis, Academic HealthPlans has included Academic Emergency Services (AES) in your Student Health Insurance Plan coverage. AES offers a wide range of services and benefits to provide everything you need to prepare for your international experience, as well as get the help or information you need in a crisis.

To contact Academic Emergency Services from the U.S or Canada, call: **1-855-873-3555**.

To contact Academic Emergency Services from outside the U.S. or Canada, dial the country access code followed by the collect number: **1-610-263-4660**.

Important contact information

Insurance Company

Anthem Blue Cross Life and Health Insurance Company

Claims & Coverage Questions

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 60007
Los Angeles, CA 90060-0007
1-844-412-0752

Find a Doctor or Preferred Care Provider

Blue Access PPO
1-844-412-0752
Online Provider Finder

General information on Benefits, Eligibility & Enrollment

Academic HealthPlans
1-855-939-9719
https://xavier.myahpcare.com/

Getting started

StudentHealth App

With the StudentHealth app through Anthem Student Advantage, you have instant access to:

- Your member ID card
- Find a Doctor
- More information about your plan benefits
- Health tips that are tailored to you
- LiveHealth Online and 24/7 NurseLine
- Student support specialists; just click to call or chat
- And more!

From your mobile device or tablet go to The App Store℠ or Google Play™ and search for the StudentHealth app to download it today.

LiveHealth Online

Using LiveHealth Online, you can visit with a board-certified doctor, psychiatrist or licensed therapist through live video on your smartphone, tablet or computer with a webcam. It's an easy and convenient way to get the care you need. Go to your StudentHeath app, livehealthonline.com or download the free LiveHealth Online app to sign up on your smartphone or tablet.

24/7 NurseLine

With 24/7 NurseLine , you can call registered nurses to help you with needs such as your fever, allergy relief tips and where to go for care. They can also help you enroll in valuable health management programs for certain health conditions, remind you about scheduling important screenings and exams, and more. Just call 844-545-1429 to speak to a registered nurse today.

Your choice

When you choose preferred providers

You get the highest level of benefits under your health care plan when you use services from preferred providers — which are doctors and hospitals in your plan. They're also called "in-network" providers and when you use them, you're using "in-network" benefits, which give you the best value for your plan. See the charts on the following pages for your share of the cost.

How to find a preferred provider

There are a few ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of the directory, call Member Services at the number on your ID card.
- Visit Online Provider Finder

When you choose non-preferred providers

You can also receive covered services from non-preferred providers, which are doctors and hospitals not in your plan. But you pay more out-of-pocket because the benefits are "out-of-network." See the charts on the following pages for your share of the cost.

Note: If a preferred provider refers you for covered services to other providers, such as labs or specialists, make sure they're preferred providers so you can get in-network benefits, which give you the best value. If you use a non-preferred provider, you pay more out-of-pocket because your benefits are out-of-network even if a preferred provider refers you.

Your out-of-pocket maximum

Your out-of-pocket maximum is the most you could pay during a plan year for copays and coinsurance for covered services. See the charts on the following pages for more details.

Emergency room (ER) services

In an emergency, such as a suspected heart attack, stroke or poisoning, you should go directly to the nearest ER or call 911 (or the local emergency phone number). You pay a copay per visit for in-network or out-of-network ER services. See the charts on the following pages for your share of the cost.

Utilization review requirements

Utilization review is a process of looking at certain types of care, such as hospital admissions, to make sure they're needed, appropriate and efficient. You must follow the requirements of utilization review, including pre-admission review, pre-service approval for certain outpatient services, concurrent review and discharge planning, and individual case management. For more information about utilization review, see your plan document. If you need non-emergency or non-maternity hospitalization, you or someone on your behalf must call the number on your ID card for preapproval.

Pediatric, Vision and Dental benefits

Your medical plan includes a vision and dental policy that covers pediatric essential benefits, for members until the end of the month in which they turn 19.

LiveHealth Online

LiveHealth Online lets you have a video visit with a board-certified doctor using your smartphone, tablet or computer with a webcam. No appointments, no driving and no waiting at an urgent care center. Doctors are available 24/7 to assess your condition.

Your summary of benefits

Anthem Blue Cross and Blue Shield

Student Health Plan: Xavier University

Your Network: Blue Access 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 Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	In-Network Coverage	Out-of-Network Coverage
Student Health Center (SHC) Benefits The Deductible will be waive and benefits will be paid at 100% of billed charges after a $30 copay per visit for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center.		
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.*	$500 person $1000 family	$500 person $1000 family
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.*	$7,150 person $14,300 family	$7,150 person $14,300 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Out-of-Network preventive care services for children prior to their 6th birthday have no deductible.*	No charge	50% coinsurance after deductible is met
Doctor home and office services:		
Primary care visit to treat an injury or illness	$25 copay per visit 20% coinsurance	$25 copay per visit 50% coinsurance
Specialist care visit	$25 copay per visit 20% coinsurance	$25 copay per visit 50% coinsurance
Prenatal and post-natal Care	Based on setting where service is performed	Based on setting where service is performed

Your summary of benefits

Covered Medical Benefits	In-Network Coverage	Out-of-Network Coverage
Other practitioner visits:		
Retail health clinic	$25 copay per visit 20% coinsurance	$25 copay per visit 50% coinsurance
On-line medical visit *Live Health Online is the preferred telehealth solutions*	$25 copay per visit 20% coinsurance	$25 copay per visit 50% coinsurance
Acupuncture	Based on setting where service is performed	Based on setting where service is performed
Other services in an office:		
Allergy testing	Based on setting where service is performed	Based on setting where service is performed
Chemo/radiation therapy	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hemodialysis	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription drugs *For the drug 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	50% coinsurance after deductible is met
Freestanding lab/reference lab	No charge	50% coinsurance after deductible is met
Outpatient hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-ray		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
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

Your summary of benefits

Covered Medical Benefits	In-Network Coverage	Out-of-Network Coverage
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
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
Emergency and urgent care		
Urgent care (office setting)	$25 copay per visit 20% coinsurance	$25 copay per visit 50% coinsurance
Emergency room facility services *Copay waived if admitted.*	$250 copay per visit and 20% coinsurance	Covered as in-network
Ambulance (air and ground)	20% coinsurance after deductible is met	Covered as in-network
Outpatient mental/behavioral health and substance abuse disorder		
Doctor office visit and online visit	Based on setting where service is performed	Based on setting where service is performed
Facility visit		
Facility fees	Based on setting where service is performed	Based on setting where service is performed
Doctor services	Based on setting where service is performed	Based on setting where service is performed
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

Your summary of benefits

Covered Medical Benefits	In-Network Coverage	Out-of-Network Coverage
Hospital stay (all inpatient stays including maternity, mental/behavioral health, and substance abuse disorder)		
Facility fees (for example, room and board) *Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Out-of-Network Providers combined is limited to 60 days per benefit year.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Recovery and rehabilitation		
Home care visits	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office	$25 copay per visit 20% coinsurance	$25 copay per visit 50% coinsurance
Outpatient hospital	$25 copay per visit 20% coinsurance	$25 copay per visit 50% coinsurance
Habilitation services (for example, physical/speech/occupational therapy):		
Office	$25 copay per visit 20% coinsurance	$25 copay per visit 50% coinsurance
Outpatient hospital	$25 copay per visit 20% coinsurance	$25 copay per visit 50% coinsurance
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per benefit period. Applies to In-Network Providers and Out-of-Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient hospital *Coverage is limited to 36 visits per benefit period. Applies to In-Network Providers and Out-of-Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	$25 copay per visit 20% coinsurance after deductible is met	$25 copay per visit 50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	In-Network Coverage	Out-of-Network Coverage
Skilled nursing care (in a facility)	20% coinsurance after deductible is met	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 wigs needed after cancer treatment In-Network Providers and Out-of-Network Providers combined is limited to 1 items per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Prescription Drug Benefits	In-Network Coverage	Out-of-Network Coverage
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 Open 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 a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy).*	$15 copay per Prescription deductible does not apply (retail only). $37.50 copay per Prescription deductible does not apply (home delivery only).	50% coinsurance after deductible is met
Tier 2 — Typically preferred brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy).*	$25 copay per Prescription deductible does not apply (retail only). $62.50 copay per Prescription deductible does not apply (home delivery only).	50% coinsurance after deductible is met
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). Covers up to 90 day supply (retail maintenance pharmacy).*	$25 copay per Prescription deductible does not apply (retail only). $62.50 copay per Prescription deductible does not apply (home delivery only).	50% coinsurance after deductible is met

Your summary of benefits

Covered Vision Benefits	In-Network Coverage	Out-of-Network Coverage
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	None	None
Vision exam *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.*	$20 copay per visit	Reimbursed up to $30
Frames *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed up to $45
Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	$25 reimbursement for Single Vision Lens $40 reimbursement for Bifocal Vision Lens $55 reimbursement for Trifocal Vision Lens
Elective contact lenses *Coverage for In-Network Providers and Out-of-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 Out-of-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 for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	$20 copay per visit	50% coinsurance

Your summary of benefits

Covered Dental Benefits	In-Network Coverage	Out-of-Network Coverage
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		
Diagnostic and preventive *Coverage for In-Network Providers and Out-of-Network Providers combined is limited to 2 visits per benefit period.*	Covered in full	Covered in full
Basic services	40% coinsurance	40% coinsurance
Major services	50% coinsurance	50% coinsurance
Medically necessary orthodontia services	50% coinsurance	50% coinsurance
Cosmetic orthodontia services	Not covered	Not covered
Deductible	No deductible	No deductible
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

Your summary of benefits

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 and Limitations:

  The services listed below are not covered by this plan. Complete details on exclusions and limitations are stated in the Subscriber Certificate.

  - Any service that is not medically necessary
  - Any service required by a third party (court ordered services are covered if all of the other terms of the plan are met)
  - Cosmetic surgery
  - Custodial or convalescent care
  - Educational testing and therapy
  - Experimental and/or investigational services except as required by law for clinical trials
  - Hospitalization for conditions that are not covered
  - Human organ transplants other than those listed in the Subscriber Certificate as Covered Services
  - Miscellaneous devices, materials, and supplies, including, but not limited to, dentures and support devices for the feet and corrective shoes
  - Permanent dental restoration, most oral surgery (general anesthesia, hospital or surgical day care facility charges for dental procedures are covered for certain individuals only to the extent required by law)
  - Personal comfort items
  - Radial keratotomy or other surgery to correct vision
  - Routine podiatry
  - Services covered by government programs to the extent permitted by law
  - Services for work-related illness or injury
  - Sex changes
  - Services, treatments, procedures or programs for weight or appetite control, weight loss, weight management or control of obesity, except for diabetes education, nutrition counseling, and medically necessary surgical and non-surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity.

Exclusions

What's Not Covered

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

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

We do not provide benefits for procedures, equipment, services, supplies or charges:

1. Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.
2. Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples of non-Covered Providers include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.
4. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
5. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
6. For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
7. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
8. For court ordered testing or care unless Medically Necessary.
9. For which you have no legal obligation to pay in the absence of this or like coverage.
10. For the following
    - Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member except as otherwise described in this Booklet.
    - Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with Providers not directly responsible for your care.
    - Charges that are not documented in Provider records.

- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

11. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group. This exclusion does not apply to Covered Services that have not been exhausted and are not paid for by another source.

12. Prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

13. For completion of claim forms or charges for medical records or reports unless otherwise required by law.

14. For missed or canceled appointments.

15. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

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

17. Charges in excess of Our Maximum Allowable Amounts.

18. Incurred prior to your Effective Date.

19. Incurred after the termination date of this coverage except as specified elsewhere in this Booklet.

20. For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Booklet. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.

21. For maintenance therapy, which is 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.

22. For Custodial Care, convalescent care or rest cures.

Exclusions

23. For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:

    - cleaning and soaking the feet.
    - applying skin creams in order to maintain skin tone.
    - other services that are performed when there is not a localized illness, injury or symptom involving the foot.

24. For foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.

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

26. For dental treatment, under the medical portion of this Plan, regardless of origin or cause, except as specified elsewhere in this Booklet. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to:

    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

    This exclusion does not apply to covered dental services for Members through age 18.

27. For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

28. For the following dental services:

    - Dental care for members age 19 and older, unless covered by the medical benefits of this Certificate.
    - 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.
    - Dental services or health care services not specifically covered under the Certificate (including any hospital charges, prescription drug charges and dental services or supplies that do not have an American Dental Association Procedure Code).
    - For dental services received prior to the effective date of this Certificate or received after the coverage under this Certificate has ended.
    - Anesthesia services, (such as intravenous or non-intravenous conscious sedation, analgesia, nitrous oxide, and general anesthesia) are not covered when given separate from a covered oral surgery service, except as required by law.
    - Analgesia, analgesia agents, oral sedation and anxiolysis nitrous oxide.
    - Services of anesthesiologist, unless required by law.
    - Dental services given by someone other than a licensed provider (dentist or physician) or their employees.
    - Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

Exclusions

- Dental services provided by dentists 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.
- Case presentations, office visits.
- Enamel microabrasion and odontoplasty.
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Provisional splinting.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Temporomandibular Joint Disorder (TMJ), unless covered by the medical benefits of this Certificate.
- Oral hygiene instructions.
- Repair or replacement of lost or broken appliances.
- 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).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Separate services billed when they are an inherent component of another covered service.
- Dental services for which you would have no legal obligation to pay in the absence of this or like coverage.
- Additional treatment necessary to correct or relieve the results of treatment previously benefited under the Certificate.
- Biological tests for determination of periodontal disease or pathologic agents, unless covered by the medical benefits of this Certificate.
- Collection of oral cytology samples via scraping of the oral mucosa, unless covered by the medical benefits of this Certificate.
- Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannon satisfactorily restore the case.
- Pulp vitality tests.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Oral appliances for snoring.

Exclusions

29. For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or as specified elsewhere in this Booklet. The only exceptions to this are for any of the following:

    - transplant preparation.
    - initiation of immunosuppresives.
    - treatment related to an accidental injury, cancer or cleft palate.

30. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly except as specified elsewhere in this Booklet.

31. Weight loss programs whether or not they are pursued under medical or Physician supervision, unless specifically 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. This Exclusion does not apply to weight management programs required under federal law as part of the "Preventive Care" benefit.

32. For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous Anthem plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Booklet. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

33. For marital counseling.

34. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service for Member's through age 18. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.

35. For vision orthoptic training.

36. For hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

37. For services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based., except as otherwise specified herein.

38. For services to reverse voluntarily induced sterility.

39. For diagnostic testing or treatment related to infertility except as otherwise stated as covered in the Schedule of Benefits.

Exclusions

40. For personal hygiene, environmental control, or convenience items including but not limited to:

    - Air conditioners, humidifiers, air purifiers;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;
    - Safety helmets for Members with neuromuscular diseases; or
    - Sports helmets.
    - Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

41. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

42. For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by Us, or as otherwise described in this Booklet.

43. For care received in an emergency room which is not Emergency Care, except as specified in this Certificate. For non-Emergency Care please use the closest Network Urgent Care Center and/or your Primary Care Physician for services. As required by Ohio law, please note that coverage for Emergency Care will be provided as described in "Emergency Care Services" in the Covered Services section. Examples of non-Emergency Care may include, but are not limited to: suture removal, routine pregnancy test, sore throat, ear ache/infection, rashes, sprains/strains, constipation, diarrhea, abrasions, sleep disorder, conjunctivitis/pink eye, back pain that is not sudden and severe in onset, and dental caries/cavity.

44. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK radial keratotomy or keratomileusis or excimer laser refractive keratectomy.

45. For self-help training and other forms of non-medical self-care, except as otherwise provided in this Booklet.

46. For examinations relating to research screenings.

47. For stand-by charges of a Physician.

48. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes. This exclusion does not apply to Covered Services that have not been exhausted and are not paid for by another source.

49. For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.

50. For Manipulation Therapy services rendered in the home as part of Home Care Services.

51. Services and supplies related to male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

Exclusions

52. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

53. For any services or supplies provided to a person not covered under the Plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

54. For surgical treatment of gynecomastia.

55. For medical and surgical treatment of hyperhidrosis (excessive sweating).

56. For any service for which you are responsible under the terms of this Booklet to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of- Network Provider.

57. 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.

58. Complications of/or services directly related to services, supplies, or treatment related to or for problems that is a non-Covered Service under this Booklet because it was determined by Us to be Experimental/Investigational or non-Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.

59. For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply. This exclusion does not apply to Preventive Services and over-the-counter products that We must cover under federal law with a Prescription.

60. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

61. Treatment of telangiectatic dermal veins (spider veins) by any method.

62. Reconstructive services except as specifically stated in the "What's Covered" section of this Booklet, or as required by law.

63. Nutritional and/or dietary supplements, except as provided in this Booklet or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist. This exclusion does not apply to Covered Services received for Home Infusion Therapy under the "Home Care Services" benefit.

64. For 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.

65. For Applied Behavioral Treatment (including, but not limited to, Applied Behavior Analysis and Intensive Behavior Interventions) for all indications except as described under Habilitative Services in the "What's Covered" section unless otherwise required by law.

Exclusions

66. For expenses incurred for the treatment of accidents or injuries resulting from the participation in interscholastic, intercollegiate, or professional sport, contest or competition; traveling to or from such sport, contest or competition as a participant; or while participating in any practice or conditioning program for such sport, contest, or competition to the extent such accidents or injuries are covered by an NCAA, NAIA, or student athletic department accident or injury policy. In combination with insurance/benefits provided by these sources, students will not incur any more out-of-pocket costs than they, or any other student, would if covered solely by this Plan.

67. For Student Health Plan Services provided normally without charge by the health service of the University or School. This includes services covered or provided by the student health fee.

68. For certain Prescription Drugs 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.

69. 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.

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

71. For drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.

72. For 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.

73. For Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by us.

74. For drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

75. For 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.

76. For refills of lost or stolen Drugs.

77. For residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center.

78. For physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes, which are not required by law under the "Preventive Care" benefit.

Exclusions

79. For 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:

    - 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.
    - 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.
    - 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.

80. For 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.

81. Drugs not approved by the FDA.

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

83. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.

84. For autopsies and post-mortem testing.

85. For 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.

86. For charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.

87. 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.

88. 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.

89. For wilderness or other outdoor camps and/or programs.

90. Services from a Facility or Residential Treatment Center / Facility that do not fall within the definitions of "Facility" or "Residential Treatment Center / Facility" listed in the "Definitions" section.

91. For elective abortions. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "What's Covered" section.

Exclusions

92. For the following vision services:

- Eyeglass lenses, frames, or contact lenses for Members age 19 and older, unless listed as covered in this booklet.
- Visual therapy, such as orthoptics or vision training, and any associated supplemental testing, unless covered under the medical benefits in this Booklet.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, including inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Booklet.
- Lost or broken lenses or frames, unless the member has reached the member's normal interval for service when seeking replacements.
- Cosmetic lens options, such as special lens coatings or non-prescription lenses, unless specifically stated as covered in this Booklet.
- Safety glasses and accompanying frames.
- Vision services not listed as covered in this Booklet.
- 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.
- For Members through age 18, no benefits are available for frames or contact lenses not on the Anthem formulary.
- Certain benefits may be covered under the "Preventive Care" benefit. Please see that section for further details.

Your summary of benefits

Notes:

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the Ohio Department of Insurance.
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and Ohio laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to 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 services subject to a coinsurance are also subject to the annual medical deductible.
- Annual out-of-pocket maximums include deductible, copays, coinsurance and prescription drug.
- In network and out-of-network deductible and out-of-pocket maximum are exclusive of each other.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (for example, X-ray, lab, surgery), after any applicable deductible.
- Preventive care services include physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For medical emergency care rendered by a non-participating provider or non-contracting hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- If your plan includes out-of-network benefit and you use a out-of-network provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- Non-emergency, out-of-network air ambulance services are limited to Anthem maximum payment of $50,000 per trip.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
- 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.

Your summary of benefits

- 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
- Additional visits may be authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- If your plan includes out-of-network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.
- Bariatric surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- Skilled nursing facility day limit does not apply to mental health and substance abuse.
- Respite care limited to five consecutive days per admission.
- Freestanding lab and radiology center is defined as services received in a non-hospital based facility.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense.
- Supply limits for certain drugs may be different; go to Anthem's website or call Customer Service.
- Certain drugs require preauthorization approval to obtain coverage.
- This plan includes custom benefits that may supersede some of the information included in the Limitations and Exclusions list provided here. Please see your EOC for full details on your covered benefits.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

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

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

Arabic

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

Armenian

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

Chinese

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

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 n1 ahoot'i' t'11 ni nizaad k'ehj7 n7k1 a'doowo[t'11 j77k'e. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. (TTY/TDD: 711)

Get help in your language

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 makakuha 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's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't 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 isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services 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. Or you can 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.

Questions: 1-855- 330-1098 or visit us at www.anthem.com