2021-2022

University of Louisville
Student Health Insurance Plan

www.anthem.com/studentadvantage

Anthem Student Advantage
Keeping you at your personal best

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Anthem | STUDENT ADVANTAGE

Important notice

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

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Welcome to Anthem Student Advantage

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

What you need to know about Anthem Student Advantage

Who is eligible?

- Health Professional students are automatically charged for the student health insurance on to their student account. Students need to register/ record their choice to enroll or waive the coverage by specified deadlines. There are no exceptions.
- International students are required to maintain insurance coverage throughout enrollment at the University of Louisville. Students need to register/ record their choice to enroll or waive the coverage by specified deadlines. There are no exceptions.
- Graduate Teaching Assistants and Research Assistants (GTA / RA) are automatically enrolled in the plan as part of your benefit package. There is no cost to the student, and this plan cannot be waived.
- Post-Doctoral students are automatically enrolled in the plan as part of your benefit package. There is no cost to the student, and this plan cannot be waived.
- Undergraduate students taking six (6) or more credit hours, all Graduate students taking three (3) or more credit hours, and CO-OP students are eligible to enroll.

Coverage is available for dependents too

If you are covered by Anthem Student Advantage through the University of Louisville, you may enroll your lawful spouse, domestic partner or dependent children under the age of 26. Here is how it works:

- Contact the Insurance Advocate for additional information at stuins@louisville.edu or enroll online at louisville.myahpcare.com.

*Home study, correspondence, and online courses DO NOT fulfill the eligibility requirements that the student actively attend classes.

Coverage periods and rates

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

Costs and dates of coverage

Domestic

Period	Fall 8/1/2021 – 12/31/2021	Spring/Summer 1/1/2022 – 7/31/2022	Summer 5/1/2022 – 7/31/2022
Student	$ 1,544	$ 1,544	$ 778
Spouse	$ 1,544	$ 1,544	$ 778
Each Child	$ 1,544	$ 1,544	$ 778
All Children	$ 3,088	$ 3,088	$ 1,556

International

Period	Fall 8/1/20201 – 12/31/2021	Spring/Summer 1/1/2022 – 7/31/2022	Summer 5/1/2022 – 7/31/2022
Student	$ 1,326	$ 1,326	$ 668
Spouse	$ 1,326	$ 1,326	$ 668
Each Child	$ 1,326	$ 1,326	$ 668
All Children	$ 2,652	$ 2,652	$ 1,336

Health Professionals

Period	Fall 8/1/2021 – 12/31/2021	Spring/Summer 1/1/2022 – 7/31/2022	Summer 5/1/2022 – 7/31/2022	Early Arrival 7/1/2022 – 7/31/2022
Student	$ 1,446	$ 1,446	$ 729	$ 242
Spouse	$ 1,544	$ 1,544	$ 778	$ 259
Each Child	$ 1,544	$ 1,544	$ 778	$ 259
All Children	$ 3,088	$ 3,088	$ 1,556	$ 518

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

Important dates for the coverage period

Open enrollment

International, Voluntary, and Health Professional Students

- **Early Arrival:** 6/15/2021-7/9/2021 (Health Professional Students Only)
- **Fall:** 7/16/21 – 8/31/2021
- **Spring/Summer:** 11/12/2021 – 2/1/22
- **Summer:** 4/15/2022 – 6/3/2022

Graduate Assistants/Teaching Assistants/ Research Assistants

- **Annual:** Ongoing year round 8/1/2021 - 7/31/2022

Must enroll dependents within 7 days of receiving the AHP Email.

Waiver deadlines

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

- **Early Arrival:** 6/15/21-7/9/21 (Health Professional Students Only)
- **Fall:** 8/31/2021
- **Spring/Summer:** 2/1/2022
- **Summer:** 6/3/2022

If you have **questions about enrollment and waiver options,** contact the Insurance Advocate for information at stuins@louisville.edu or visit **louisville.myahpcare.com**.

Keep in touch with your benefits information

Student Health Center

Cardinal Station
215 Central Avenue, Suite 110
Louisville, KY 40208
502-852-6479

Health Science Center
401 E. Chestnut Street, Suite 110
Louisville, KY 40208
502-852-6446

louisville.edu/campushealth

Benefits and Claims

Anthem Blue Cross and Blue Shield
1-844-412-0752

Download the Sydney Health app on Google Play or the App Store to access claims and coverage information.

Enrollment Information

Academic HealthPlans

louisville.myahpcare.com
help@ahpcare.com

Student Counseling Center

2100 S. Floyd Street, W204
Louisville, KY 40208
502-852-6585

louisville.edu/counseling

Monday - Friday: 8:30am - 4pm

Easy access to care

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

Sydney Health app

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

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

Access the Sydney Health app

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

24/7 NurseLine

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

Provider finder

Use this link to find the right doctor or facility close to where you are.

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

Your summary of benefits

Anthem Blue Cross and Blue Shield

Student health insurance plan:
University of Louisville

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 Evidence of Coverage (EOC), the Evidence of Coverage (EOC) will prevail. Plan benefits are pending approval with the state and subject to change.

Campus Health

Covered Medical Benefits	Cost if you use Campus Health
Deductible **Applies toward In-Network Deductible*	No deductible for Campus Health
Preventive Care Services *(Deductible Waived if In-Network) For more information, please visit healthcare.gov/preventive-care-benefits/*	No charge
Primary Care Office Visits	No charge
Laboratory Procedures	In-House No charge

Medical

Covered Medical Benefits	Cost if you use a Preferred Provider (University of Louisville Physicians)	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible			
See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.	$200 per person	$700 per person	$1,000 per person
Out-of-Pocket Limit			
When you meet your out-of-pocket limit, you will no longer have to pay cost- shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.	$5,000 per person / $10,000 family		

Covered Medical Benefits	Cost if you use a Preferred Provider (University of Louisville Physicians)	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Preventive care/screening/immunization			
In-network preventive care is not subject to deductible, if your plan has a deductible. Non-Network preventive care services for children prior to their 6th birthday have no deductible.	No charge	No charge	25% coinsurance after deductible is met
Doctor Home and Office Services			
Primary Care Office Visit to treat an injury or illness	$30 copay per visit 10% coinsurance	$30 copay per visit 30% coinsurance	$30 copay per visit 35% coinsurance
Specialist Care Office Visit	$30 copay per visit 10% coinsurance	$30 copay per visit 30% coinsurance	$30 copay per visit 35% coinsurance
Prenatal and Post-natal Care *Cost sharing does not apply for preventive services when provided by a preferred provider. Depending on the type of services, a copayment, coinsurance, or deductible may apply.*	$30 copay per visit 0% coinsurance	$30 copay per visit 30% coinsurance	$30 copay per visit 35% coinsurance
Other Practitioner Visits:			
Retail Health Clinic	$50 copay per visit 10% coinsurance	$50 copay per visit 30% coinsurance	$50 copay per visit 35% coinsurance
On-line Visit *Live Health Online is the preferred telehealth solutions (www.livehealthonline.com)*	$30 copay per visit 10% coinsurance	$30 copay per visit 30% coinsurance	$30 copay per visit 35% coinsurance
Manipulation Therapy *Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. Limit is combined In-Network and Non-Network across all outpatient settings.*	$20 copay per visit	30% coinsurance a fter deductible is met	35% coinsurance after deductible is met
Other Services in an Office:			
Allergy Testing	$30 copay per visit 10% coinsurance	$30 copay per visit 30% coinsurance	$30 copay per visit 35% coinsurance
Chemo/Radiation Therapy	10% coinsurance after deductible is met	30% coinsurance after deductible is met	35% coinsurance after deductible is met
Hemodialysis	$20 copay per visit 10% coinsurance	$20 copay per visit 30% coinsurance	$20 copay per visit 35% coinsurance
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met	35% coinsurance after deductible is met
Diagnostic Services			
Lab:			
Office *Office Cost Share applies only when Freestanding/ Reference Labs are not used.*	No charge	No charge	$20 copay per visit 35% coinsurance
Freestanding Lab/Reference Lab	No charge	No charge	$20 copay per visit 35% coinsurance
Outpatient Hospital	No charge	No charge	$20 copay per visit 35% coinsurance

Covered Medical Benefits	Cost if you use a Preferred Provider (University of Louisville Physicians)	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
X-Ray:			
Office	$25 copay per visit 10% coinsurance	$25 copay per visit 30% coinsurance	$25 copay per visit 35% coinsurance
Freestanding Radiology Center	$25 copay per visit 10% coinsurance	$25 copay per visit 30% coinsurance	$25 copay per visit 35% coinsurance
Outpatient Hospital	$25 copay per visit 10% coinsurance	$25 copay per visit 30% coinsurance	$25 copay per visit 35% coinsurance
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):			
Office	$25 copay per visit 10% coinsurance	$25 copay per visit 30% coinsurance	$25 copay per visit 35% coinsurance
Freestanding Radiology Center	$25 copay per visit 10% coinsurance	$25 copay per visit 30% coinsurance	$25 copay per visit 35% coinsurance
Outpatient Hospital	$25 copay per visit 10% coinsurance	$25 copay per visit 0% coinsurance	$25 copay per visit 35% coinsurance
Emergency and Urgent Care			
Urgent Care (Office Setting)	$50 copay per visit 10% coinsurance	$50 copay per visit 30% coinsurance	$50 copay per visit 35% coinsurance
Emergency Room Facility Services Copay waived if admitted.	$150 copay per visit 30% coinsurance	$150 copay per visit 30% coinsurance	$150 copay per visit 30% coinsurance
Emergency Room Doctor and Other Services	30% coinsurance	30% coinsurance	30% coinsurance
Ambulance (Air and Ground)	Not covered	30% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Mental Health and Substance Use Disorder			
Doctor Office Visit and Online Visit	$30 copay per visit 10% coinsurance	$30 copay per visit 30% coinsurance	35% coinsurance
Facility visit:	10% coinsurance	30% coinsurance	35% coinsurance
Facility Fees	10% coinsurance	30% coinsurance	35% coinsurance
Doctor Services	10% coinsurance	30% coinsurance	35% coinsurance
Outpatient Surgery			
Facility Fees:			
Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met	35% coinsurance after deductible is met
Freestanding Surgical Center	10% coinsurance fter deductible is met	30% coinsurance after deductible is met	35% coinsurance after deductible is met
Doctor and Other Services:			
Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met	35% coinsurance after deductible is met
Freestanding Surgical Center	10% coinsurance after deductible is met	30% coinsurance after deductible is met	35% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a Preferred Provider (University of Louisville Physicians)	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Hospital Stay (all Inpatient stays including Maternity, Mental and Substance Use Disorder):			
Facility fees (for example, room & board) *Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Non-Network Providers combined is limited to 60 days per benefit year.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met	35% coinsurance after deductible is met
Doctor and other services	10% coinsurance after deductible is met	30% coinsurance after deductible is met	35% coinsurance after deductible is met
Recovery & Rehabilitation			
Home Care Visits *Coverage for In-Network Providers and Non-Network Providers combined is limited to 120 visits per benefit period. Visit limit does not apply to Physical, Occupational or Speech Therapy when performed as part of Home Health.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met	35% coinsurance after deductible is met
Rehabilitation services *(for example, physical/speech/occupational therapy)*			
Office *Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. Apply to In-Network Providers and Non- Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	$20 copay per visit	30% coinsurance after deductible is met	25% coinsurance after deductible is met
Outpatient Hospital *Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. Apply to In-Network Providers and Non- Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	$20 copay per visit	30% coinsurance after deductible is met	25% coinsurance after deductible is met
Habilitation services *(for example, physical/speech/occupational therapy):*			
Office *Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. Apply to In-Network Providers and Non- Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	$20 copay per visit	30% coinsurance per visit after deductible is met	25% coinsurance after deductible is met
Outpatient Hospital *Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. Apply to In-Network Providers and Non- Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	$20 copay per visit	30% coinsurance after deductible is met	25% coinsurance after deductible is met
Cardiac rehabilitation			
Office *Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.*	$20 copay per visit	30% coinsurance after deductible is met	25% coinsurance after deductible is met
Outpatient Hospital *Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.*	$20 copay per visit	30% coinsurance after deductible is met	25% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a Preferred Provider (University of Louisville Physicians)	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Skilled Nursing Care (in a facility)			
Coverage for Inpatient rehabilitation and skilled nursing services combined In- Network Providers and Non-Network Providers combined is limited to 60 days per benefit period.	10% coinsurance after deductible is met	30% coinsurance after deductible is met	35% coinsurance after deductible is met
Hospice			
Hospice care benefits are not subject to the Policy Deductible.	Paid at least equal to the Medicare benefits for Hospice Care	Paid at least equal to the Medicare benefits for Hospice Care	Paid at least equal to the Medicare benefits for Hospice Care
Durable Medical Equipment			
Coverage for hearing aids services left ear is limited to 1 unit every 48 months and right ear is limited to 1 unit every 48 months for children 18 years of age or under. Coverage is limited to $3,000 per hearing aid. Apply to In-Network Providers and Non-Network Providers combined.	10% coinsurance after deductible is me	30% coinsurance after deductible is met	35% coinsurance after deductible is met
Prosthetic Devices			
Coverage for wigs needed after cancer treatment In-Network Providers and Non-Network Providers combined is limited to 1 items per benefit period.	10% coinsurance after deductible is met	30% coinsurance after deductible is met	35% coinsurance after deductible is met
Acupuncture in Lieu of Anesthesia *Includes acupuncture therapy when acupuncture is used in lieu of other anesthesia for a surgical or dental procedure covered under this plan. Deductible may apply depending on service.*	Paid as any other sickness.	Paid as any other sickness.	Paid as any other sickness.
Impacted Wisdom Teeth Removal	10% coinsurance after deductible is met	30% coinsurance after deductible is met	30% coinsurance after deductible is met
Dental Care for Dental Injuries	10% coinsurance after deductible is met	30% coinsurance after deductible is met	30% coinsurance after deductible is met

Pharmacy

Covered Medical Benefits	Cost if you use a Preferred Provider (University of Louisville Physicians)	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Pharmacy Deductible	Not applicable	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	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). $30 copay per Prescription deductible does not apply (home delivery only).	$15 copay per Prescription deductible does not apply (retail only). $30 copay per Prescription deductible does not apply (home delivery only).	25% coinsurance
Tier 2 – Typically Preferred Brand Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy).	$30 copay per Prescription deductible does not apply (retail only). $60 copay per Prescription deductible does not apply (home delivery only).	$30 copay per Prescription deductible does not apply (retail only). $60 copay per Prescription deductible does not apply (home delivery only).	25% coinsurance
Tier 3 – Typically Non-Preferred Brand Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy).	$50 copay per Prescription deductible does not apply (retail only). $100 copay per Prescription deductible does not apply (home delivery only).	$50 copay per Prescription deductible does not apply (retail only). $100 copay per Prescription deductible does not apply (home delivery only).	25% coinsurance

Pediatric Vision *Limited to covered persons under the age of 21*.

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Children's Vision Essential Health Benefits (up to age 21)		
Child Vision Deductible	$0 person	Not Applicable
Vision exam Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.	No charge	Reimbursed Up to $30
Frames Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.	No charge, formulary	Reimbursed Up to $45
Lenses Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.	No charge	$25 Reimbursement for Single, $40 Reimbursement for Bifocal and $55 Reimbursement for Trifocal Vision Lens
Elective contact lenses Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.	No charge	Reimbursed Up to $60
Non-Elective Contact Lenses Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.	No charge	Reimbursed Up to $210
Adult Vision (age 21 and older)		
Adult Vision Coverage		
Limited to certain vision screenings required by Federal law and coveredunder the "Preventive Care" benefit.	See "Preventive Care" benefit	See "Preventive Care" benefit

Pediatric Dental *Limited to covered persons under the age of 21.*

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Children's Dental Essential Health		
Benefits Diagnostic and preventive *Includes cleanings, exams, x-rays, sealants, fluoride*	No charge	No charge
Basic services *Includes fillings and simple extractions*	20% coinsurance	20% coinsurance
Major services/Prosthodontic	50% coinsurance	50% coinsurance
Endodontic, Periodontics, Oral Surgery	50% coinsurance	50% coinsurance
Medically Necessary Orthodontia	50% coinsurance	50% coinsurance
Deductible	Not applicable	Not applicable
Adult Dental	Not covered	Not covered

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.

Academic Emergency Services Numbers	
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**

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

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

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

1. **Abortion Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery.**
   This Exclusion does not apply to abortions performed to preserve the life of the female upon whom the abortion is performed.
2. **Administrative Charges**
   a) Charges to complete claim forms,
   b) Charges to get medical records or reports,
   c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include fees for educational brochures or calling you to give you test results.
3. **Aids for Non-verbal Communication Devices and computers to assist in communication and speech except for speech aid devices and trachea-esophageal voice devices approved by Anthem.**
4. **Alternative / Complementary Medicine Services or supplies for alternative or complementary medicine. This includes:**
   a) Acupuncture,
   b) Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body,
   c) Holistic medicine,
   d) Homeopathic medicine,
   e) Hypnosis,
   f) Aroma therapy,
   g) Massage and massage therapy,
   h) Reiki therapy,
   i) Herbal, vitamin or dietary products or therapies,
   j) Naturopathy,
   k) Thermography,
   l) Orthomolecular therapy,
   m) Contact reflex analysis,
   n) Bioenergial synchronization technique (BEST),
   o) Iridology-study of the iris,
   p) Auditory integration therapy (AIT),
   q) Colonic irrigation,
   r) Magnetic Innervation therapy,
   s) Electromagnetic therapy,
   t) Neurofeedback / Biofeedback.
5. **Autopsies and post-mortem testing.**
6. **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.
7. **Certain Providers**
   Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
8. **Charges Over the Maximum**
   Allowed Amount Charges over the Maximum Allowed Amount for Covered Services.
9. **Charges**
   Not Supported by Medical Records Charges for services not described in your medical records.
10. **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.
    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.
11. **Clinical Trial**
    Non-Covered Services Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
12. **Complications of/or Services Related to Non-Covered Services**
    Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.
13. **Compound 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.
14. **Cosmetic Services Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services.**
    Cosmetic services are meant to preserve, change, or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).
    This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy or to surgery to correct congenital defects and birth abnormalities.
15. **Court Ordered Testing**
    Court ordered testing or care unless Medically Necessary.

16. **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. This Exclusion also does not apply unless the Member is incarcerated in a local penal institution or in the custody of a local law enforcement officer as a result of a conviction for a felony.

17. **Cryopreservation**

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

18. **Custodial Care**

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

19. **Delivery Charges**

Charges for delivery of Prescription Drugs.

20. **Dental**

Devices for Snoring Oral appliances for snoring.

21. **Dental Services:**

a) Dental care for Members age 21 or older except for those services covered under the "Dental Services (All Members / All Ages)" benefit or those services covered under the "Oral Surgery" section of the "Surgery" benefit.
b) Oral hygiene instructions.
c) Case presentations.
d) Enamel microabrasion and odontoplasty.
e) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes tooth whitening agents or tooth bonding and veneer covering of the teeth.
f) Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
g) Pulp vitality tests.
h) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
i) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
j) Incomplete root canals.
k) Bacteriologic tests for determination of periodontal disease or pathologic agents.
l) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
m) Services of anesthesiologists, except for those services covered under the "Dental Services (All Members / All Ages)" benefit or services covered under the "Oral Surgery" section of the "Surgery" benefit.
n) Anesthesia Services (such as intravenous or non-intravenous conscious sedation and general anesthesia) are not covered when given separate from complex surgical services.
o) Additional, elective or enhanced prosthodontic procedures including connector bar(s), stress breakers and precision attachments.
p) Separate services billed when they are an inherent component of another Covered Service.
q) Cone beam images.
r) Sinus augmentation.

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, based upon FDA labeling.

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 Anthem.

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. **Educational Services**

Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

28. **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 suture removal in an emergency room. For non-emergency care please use the closest network Urgent Care Center or your Primary Care Physician.

29. **Experimental or Investigational Services**

Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply. The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational. Please see "Additional Information about Experimental / Investigational Services" at the end of this section for more details.

30. **Eyeglasses and Contact Lenses**

Eyeglasses and contact lenses to correct your eyesight except those covered under the "Vision Services For Members Through Age 20" or those services covered under the "Prosthetics" benefit in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.

31. **Eye Exercises**

Orthoptics and vision therapy. This Exclusion does not apply to Members through age 20.

32. **Eye Surgery**

Eye surgery to fix errors of refraction, such as near-sightedness. This includes LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

33. Family Members

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

34. Foot Care

Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including:

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

35. Foot Orthotics

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

36. Foot Surgery

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

37. Free Care

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

If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

This Exclusion does not apply to a Member incarcerated in a local penal institution or in the custody of a local law enforcement officer prior to conviction for a felony.

38. Growth Hormone Treatment

Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

39. 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.

40. Home Care

a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
b) Food, housing, homemaker services and home delivered meals.

41. Hospital Services

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

42. Hyperhidrosis Treatment

Medical and surgical treatment of excessive sweating (hyperhidrosis). 44) Infertility Treatment Testing or treatment related to infertility.

43. Intercollegiate Sports

Medical treatment for injuries sustained in practice for, or participation in, Intercollegiate Sports in excess of the benefit maximum in the "Schedule of Benefits" section of this Booklet.

44. Lost or Stolen Drugs

Refills of lost or stolen Drugs.

45. Maintenance Therapy

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

46. Medical Equipment, Devices, and Supplies

a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
c) Non-Medically Necessary enhancements to standard equipment and devices.
d) Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum 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.
e) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section.

47. Medicare

For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, as described in the "Medicare" section in "General Provisions." If you do not enroll in Medicare Part B, 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.

48. Missed or Cancelled Appointments

Charges for missed or cancelled appointments.

49. Non-approved Drugs

Drugs not approved by the FDA.

50. 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.

51. Nutritional or Dietary Supplements

Nutritional and/or dietary supplements. This Exclusion includes 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. This Exclusion does not apply to therapeutic food, formulas, supplements, and low-protein modified food products covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit or to the newborn diet covered under the "Inpatient Services" benefit.

52. Off label use

Off label use unless we approve it.

53. Oral Surgery

Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.

54. Personal Care, Convenience and Mobile/Wearable Devices

a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs.
b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads).
c) Home workout or therapy equipment, including treadmills and home gyms.
d) Pools, whirlpools, spas, or hydrotherapy equipment.
e) Hypo-allergenic pillows, mattresses, or waterbeds.
f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
g) Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

55. Private Duty Nursing

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

56. Prosthetics

Prosthetics for sports or cosmetic purposes.

57. 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.

58. Routine Physicals and Immunizations

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

59. Sanctioned or Excluded Providers

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

60. Services Received Outside the United States

Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care and Emergency Ambulance.

61. Sexual Dysfunction Services or supplies for male or female sexual problems.

62. Sport, Contest, or Competition

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.

63. Sport, Contest, or Competition Injury sustained while:

a) Participating in any intercollegiate or professional sport, contest or competition.
b) Traveling to or from such sport, contest or competition as a participant.
c) Participating in any practice or conditioning program for such sport, contest or competition.] 67) Stand-By Charges Stand-by charges of a Doctor or other Provider.

64. Sterilization

Services to reverse an elective sterilization.

65. Surrogate Mother Services

Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including the bearing of a child by another woman for an infertile couple).

66. Temporomandibular Joint Treatment

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

67. Travel Costs

Mileage, lodging, meals, and other Member-related travel costs. This Exclusion does not apply to the travel and lodging services covered under the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services" benefit.

68. Vein Treatment

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

69. Vision Services

a) Vision services for Members age 21 or older, except those services covered under the "Vision Services for Members Age 21 and Older"

benefit and those services covered under the "Vision Services (All Members / All Ages)" benefit.

b) Safety glasses and accompanying frames.
c) For two pairs of glasses in lieu of bifocals.
d) Plano lenses (lenses that have no refractive power)
e) Lost or broken lenses or frames if the Member has already received benefits during a Benefit Period. This Exclusion does not apply, however, to one set of replacement lenses or frames if they are Medically Necessary.
f) Vision services not listed as covered in this Booklet.
g) Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, except as listed under "Vision Services for Members Through Age 20" in the Schedule of Benefits.
h) Blended lenses.
i) Oversize lenses.
j) Sunglasses and accompanying frames.
k) For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
l) For Members through age 20, no benefits are available for frames or contact lenses not on the Anthem formulary.

70. **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.

71. **Weight Loss Programs**

Weight loss programs, whether or not under medical supervision. This Exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

72. **Weight Loss Surgery Bariatric surgery.**

This includes Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.

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

1. **Administration Charges**
   Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2. **Charges Not Supported by Medical Records**
   Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
3. **Clinical Trial Non-Covered Services**
   Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
4. **Compound Drugs**
   Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
5. **Contrary to Approved Medical and Professional Standards**
   Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
6. **Delivery Charges**
   Charges for delivery of Prescription Drugs.
7. **Drugs Given at the Provider's Office / Facility**
   Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Hearing Aids and Related Services Benefits include Medically Necessary hearing aids, including bone-anchored hearing aids. Benefits also include Medically Necessary services to assess, select, adjust or fit the hearing aid. You can get Covered Services from a licensed audiologist or a licensed hearing instrument specialist.
8. **Medical and Surgical Supplies" benefit – they are Covered Services.**
9. **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.
10. **Drugs Over Quantity or Age Limits**
    Drugs which are over any quantity or age limits set by the Plan, based upon FDA labeling.
11. **Drugs Over the Quantity Prescribed or Refills After One Year**
    Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Drugs Prescribed by Providers**

    Lacking Qualifications/Registrations/Certifications Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by Anthem.
13. **Drugs That Do Not Need a Prescription**

    Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
14. **Family Members**

    Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
15. **Gene Therapy**

    Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, benefits may be available under the "Gene Therapy" benefit. Please see that section for details.

16. **Growth Hormone Treatment**
    Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
17. **Hyperhidrosis Treatment**
    Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
18. **Infertility Drugs**
    Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
19. **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.
20. **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.
21. **Lost or Stolen Drugs**
    Refills of lost or stolen Drugs.
22. **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.
23. **Non-approved Drugs**
    Drugs not approved by the FDA.
24. **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.
25. **Nutritional or Dietary Supplements**
    Nutritional and/or dietary supplements. This Exclusion includes 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. This Exclusion does not apply to therapeutic food, formulas, supplements, and low-protein modified food products covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit or to the newborn diet covered under the "Inpatient Services" benefit.
26. **Off label use**
    Off label use, unless we must cover the use by law or if we, or the PBM, approve it.
27. **Onychomycosis Drugs**
    Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
28. **Over-the-Counter Items**
    Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product may not be covered, even if written as a Prescription. This includes Prescription Legend Drugs when any version or strength becomes available over the counter. This Exclusion does not apply to over-the-counter products that we must cover as a "Preventive Care" benefit under state or federal law with a Prescription.
29. **Sanctioned or Excluded Providers**
    Any Drug, Drug regimen, treatment, or supply that is furnished, ordered or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/ Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies.
30. **Sexual Dysfunction Drugs**
    Drugs to treat sexual or erectile problems.
31. **Syringes**
    Hypodermic syringes except when given for use with insulin and other covered self injectable Drugs and medicine.
32. **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 **1-844-412-0752**.

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 مجاناً. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة.(TTY/TDD: 711)

Armenian

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

Chinese

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

Farsi

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

French

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

Haitian

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

Italian

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

Japanese

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

Korean

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

Navajo

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

Polish

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

Punjabi

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

Russian

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

Spanish

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

Tagalog

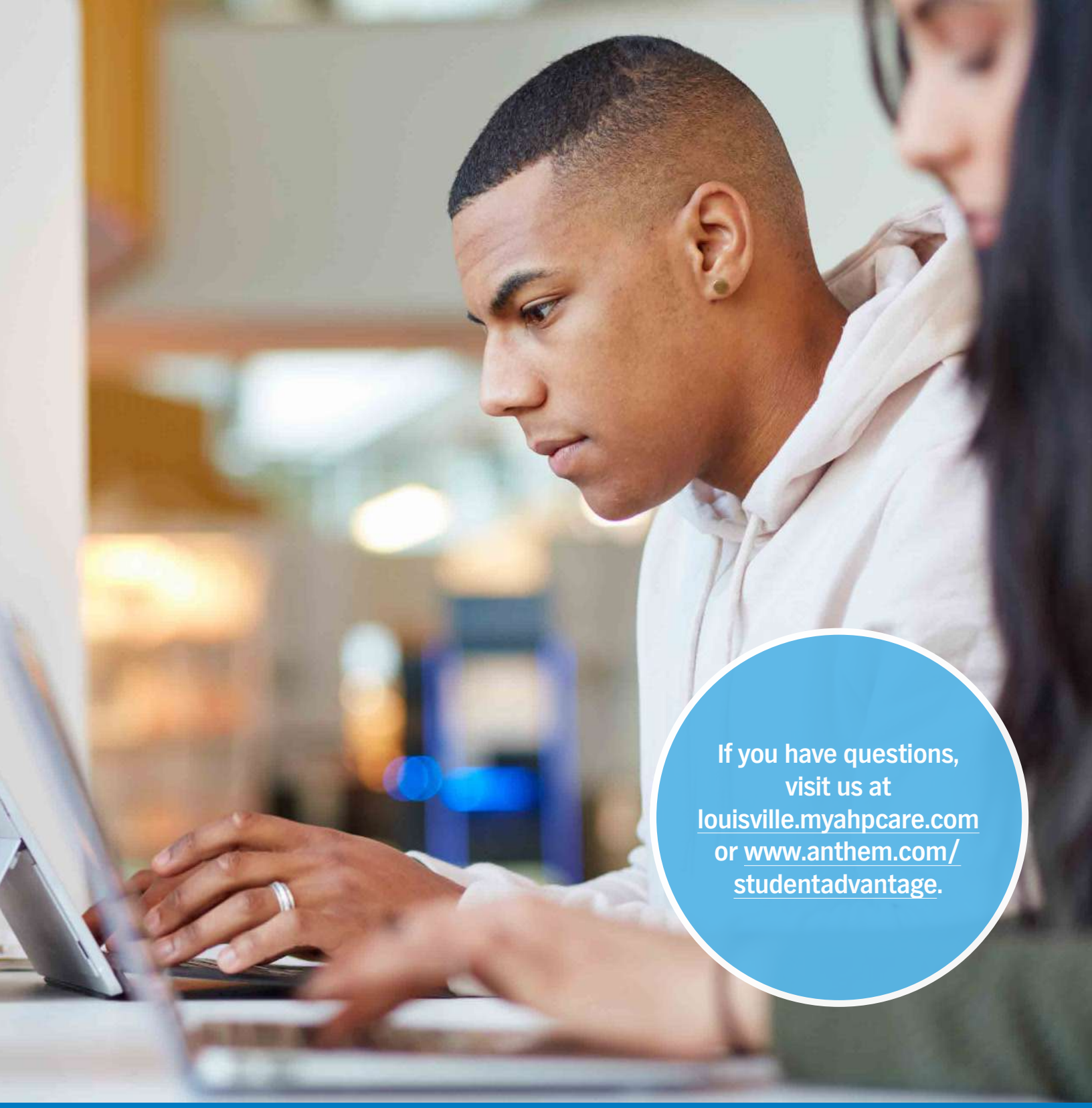
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Vietnamese

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

It is important we treat you fairly

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



If you have questions, visit us at louisville.myahpcare.com or www.anthem.com/studentadvantage.

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