Colorado State University - Fort Collins
International Students
Student Health Insurance Plan (SHIP)

Anthem Student Advantage
Keeping you at your personal best
Important notice

This is a brief description of your student health plan underwritten by Anthem Blue Cross and Blue Shield (Anthem). If you would like more details about your coverage and costs, you can get the complete terms in the policy or plan document online at student.anthem.com/welcome.
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Welcome to Anthem Student Advantage
As your new school year begins, it’s important to understand your health care benefits and how they work. Your Anthem Student Advantage plan will help guide you through that process with information about who is eligible, what is covered, how much it costs, and the best ways to access care.

**What you need to know about Anthem Student Advantage**

**Who is eligible?**

› Undergraduate and graduate students enrolled in Continuous Registration or 1 Resident Instruction Credit Hour or more.
› Online students enrolled in 6 credit hours or more.
› Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased.

Please refer to the Anthem policy for additional eligibility provisions.
# Coverage periods and rates

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

## Costs and dates of coverage

<table>
<thead>
<tr>
<th>Semester</th>
<th>Coverage Start Date</th>
<th>Coverage End Date</th>
<th>Premium</th>
<th>Enroll or request a waiver by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall</td>
<td>August 1, 2021</td>
<td>December 31, 2021</td>
<td>$686</td>
<td>September 8, 2021</td>
</tr>
<tr>
<td>Spring/Summer</td>
<td>January 1, 2022</td>
<td>July 31, 2022</td>
<td>$745</td>
<td>February 2, 2022</td>
</tr>
<tr>
<td>Summer Only</td>
<td>May 1, 2022</td>
<td>July 31, 2022</td>
<td>$404</td>
<td>The 1st day of the 1st summer session classes</td>
</tr>
</tbody>
</table>

*The above rates include premiums for the plan and commissions and administrative fees.
*Rates are pending approval with the state and subject to change.
Keep in touch with your benefits information

CSU Health Network (CSUHN)
CSU Health and Medical Center
151 W. Lake Street
(corner of College Ave. and Prospect Rd.)
Fort Collins, CO 80523
Medical Services
1-970-491-7121
health.colostate.edu
Counseling Services
1-970-491-6053
health.colostate.edu/about-counseling-services/

Eligibility and Enrollment
Student Insurance Office
CSU Health and Medical Center - 2nd Floor
151 W. Lake Street
(corner of College Ave. and Prospect Rd.)
Fort Collins, CO 80523
1-970-491-2457
csuhn_insurance@colostate.edu

Benefits and Claims
Contact AmeriBen at
1-855-258-2656 or visit
MyAmeriBen.com
Easy access to care

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

ID Cards and Online Services app

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

LiveHealth Online

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

Provider finder

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

› www.anthem.com
› www.health.colostate.edu
› MyAmeriBen.com
› Calling AmeriBen at 1-855-258-2656

Important tips:

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

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

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.
CSU Health Network (CSUHN) is every student’s on campus home for health and well-being. All CSU students, regardless of their insurance plan, have full access to our wide range of services. All CSUHN services are located under one roof in the on-campus CSU Health and Medical Center, a state-of-the-art facility dedicated to student health and well-being.

Learn more about CSUHN, including location, hours, service charges and more, at health.colostate.edu or by calling 1-970-491-7121.

General medical services
› Primary Care
› Pharmacy
› Immunizations
› Behavioral Health

Health Education and Prevention Services
› Substance Abuse Prevention
› Mental Health Initiatives
› Peer Education (CREWS)
› Resiliency and Well-Being
› Sexual Health Initiatives
› Tobacco Cessation
› Spiritual Care

Laboratory and X-ray
Primary and preventive care including:
› Lab services ordered and managed by a Student Health Center provider
› X-ray services

Counseling Services
› Individuals and Couples
› Groups and Workshops
› Drugs, Alcohol and You (DAY) Programs
› Post-Hospitalization Support (iTEAM)
› Crisis Intervention
› Consultations with Colleagues/Parents/Friends

Specialty Services
› Allergy and Asthma
› Dental
› Men’s Care
› Optometry
› Physical Therapy
› Psychiatry
› Sports Medicine/Orthopedics
› Transgender Care
› Travel Medicine
› Women’s Care
Why use your SHIP at the CSU Health Network?

There is $0 cost share (no copay, deductible or coinsurance) for most services provided to SHIP (Student Health Insurance Plan) enrolled students at the CSU Health Network (CSUHN). Students should access services at the CSUHN before seeking medical care in the community.

A portion of the amount outlined in the Schedule of Costs are allocated for the additional benefits shown below.

### What is covered?

| CSUHN Medical Benefit | › Medical, Psychiatry and Counseling Services  
| (in-house services only) | › X-Ray and Lab Tests (processed at CSUHN)  
| › No cost share or deductible | › Medical Tests and Procedures  
| | › Minor Surgical procedures  
| | › Infirmary/IV  
| | › Physical Therapy including braces/casting  
| | › Orthopedic consults  
| | › Immunizations  
| | — Childhood/Adult immunizations as recommended by the CDC  
| | — Travel immunizations when required by a CSU degree research/internship or study program  
| CSUHN Prescription Drug Benefit | › No cost share at the CSU Health Network Pharmacy for generic or brand-name medications.  
| | › Specialty medications are not available at the Health Network Pharmacy.  
| Flex Services | › Optometry Services  
| ($250 plan year maximum benefit) | › Dental Services  
| | › Travel Clinic  
| | › Counseling Fee (part-time students only)  
| | › Health Access Fee (part-time students only)  
| | › Medical Records  
| | › Voluntary or other services not medically necessary for the diagnosis or treatment of an illness or injury  
| Inclusions | › No Show and Late Appointment Fees  
| | › Services or supplies not rendered at CSU Health Network  
| | › Elective and/or over-the-counter medications  
| | › Services not listed above  

Medical expenses incurred at the CSUHN do not require a claim form and are not subject to deductible and/or cost share. Any ineligible expense not payable under the plan will be charged to your student account.

A referral from a CSUHN Provider is encouraged for services received outside of the CSUHN.
What is covered?

CSUHN Medical Benefit (in-house services only)

- Medical, Psychiatry and Counseling Services
- X-Ray and Lab Tests (processed at CSUHN)
- Medical Tests and Procedures
- Minor Surgical procedures
- Infirmary/IV
- Physical Therapy including braces/casting
- Orthopedic consults
- Immunizations
  - Childhood/Adult immunizations as recommended by the CDC
  - Travel immunizations when required by a CSU degree research/internship or study program

CSUHN Prescription Drug Benefit

- No cost share at the CSU Health Network Pharmacy for generic or brand-name medications.
- Specialty medications are not available at the Health Network Pharmacy.

Flex Services ($250 plan year maximum benefit)

May be used for health-related services not otherwise covered at CSU Health Network.

Inclusions

- Optometry Services
- Dental Services
- Travel Clinic
- Counseling Fee (part-time students only)
- Health Access Fee (part-time students only)
- Medical Records
- Voluntary or other services not medically necessary for the diagnosis or treatment of an illness or injury

Exclusions

- No Show and Late Appointment Fees
- Services or supplies not rendered at CSU Health Network
- Elective and/or over-the-counter medications
- Services not listed above
Your summary of benefits

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 and applies to services provided outside of the CSU Health Network. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail. Plan benefits are pending approval with the state and subject to change.

Medical

<table>
<thead>
<tr>
<th>Covered Medical Benefits</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use an Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Deductible</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Per Member Per Plan Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The In-Network and Out-of-Network Deductibles are separate and cannot be combined. When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies. Copayments and Coinsurance are separate from and do not apply to the Deductible.</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Out-of-Pocket Limit</td>
<td>$6,850</td>
<td>$13,700</td>
</tr>
<tr>
<td>The Out-of-Pocket Limit includes all applicable Deductibles, Coinsurance, and Copayments, including Prescription Drugs Coinsurance/Copayments, you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services. The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.</td>
<td>$6,850</td>
<td>$13,700</td>
</tr>
<tr>
<td>Acupuncture/Nerve Pathway Therapy</td>
<td>See “Therapy Services”.</td>
<td></td>
</tr>
<tr>
<td>Allergy Services</td>
<td>Benefits are based on the setting in which Covered Services are received.</td>
<td></td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>20% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Ambulance Services (Ground)</td>
<td></td>
<td>20% Coinsurance after Deductible</td>
</tr>
</tbody>
</table>

For emergency ambulance services from an Out-of-Network Provider you do not need to pay any more than you would have paid for services from an In-Network Provider.

Note: All scheduled ground ambulance services for non-emergency transfers, except transfers from one acute facility to another, must be approved through precertification.

Please see the section “How to Access your Services and Obtain Approval of Benefits” in the Plan document for details.

Autism Services

Includes Applied Behavioral Analysis Services

Benefits are based on the setting in which Covered Services are received.

The limits for physical, occupational, and speech therapy will not apply to children between age 3 and 6 with Autism Spectrum Disorders, if part of a Member’s Autism Treatment Plan, and determined Medically Necessary by Anthem.
<table>
<thead>
<tr>
<th>Covered Medical Benefits</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use an Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Services</td>
<td>See “Mental Health, Alcohol and Substance Abuse Services”.</td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>See “Therapy Services”.</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>See “Therapy Services”.</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>See “Therapy Services”.</td>
<td></td>
</tr>
<tr>
<td>Clinical Trials</td>
<td>Benefits are based on the setting in which Covered Services are received.</td>
<td></td>
</tr>
<tr>
<td>Diabetes Equipment, Education, and Supplies</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Screenings for gestational diabetes are covered under “Preventive Care.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>Benefits are based on the setting in which Covered Services are received.</td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>See “Therapy Services”.</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (DME), Medical Devices, Medical and Surgical Supplies (Received from a Supplier)</td>
<td>20% Coinsurance after Deductible</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Prosthetics</td>
<td>20% Coinsurance after Deductible</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>The cost-shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial and replacement hearing aids will be supplied every 5 years.</td>
<td>20% Coinsurance after Deductible</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>New hearing aid will be a covered service when alterations to your existing hearing aid cannot adequately meet your needs or be repaired.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Facility Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Doctor Charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)</td>
<td>$100 Copayment per visit plus 20% Coinsurance after Deductible Copayment waived if admitted</td>
<td></td>
</tr>
<tr>
<td>Advanced Diagnostic Imaging (including MRIs, CAT scans)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Habilitative Services</td>
<td>Benefits are based on the setting in which Covered Services are received. See “Inpatient Services” and “Therapy Services” in the Plan document</td>
<td></td>
</tr>
<tr>
<td>Home Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· Home Care Visits</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>· Skilled Nursing Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Services (Precertification Required)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Facility Room &amp; Board Charge:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· Hospital / Acute Care Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· Skilled Nursing Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Covered Medical Benefits

### Doctor Services for:
- General Medical Care / Evaluation and Management (E&M)
- Surgery
- Bariatric Surgery

### Doctor Services for:
- Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services)

### Inpatient Services (Delivery)

### Newborn / Maternity Stays:
If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.

### Infertility

### Massage Therapy
- See “Therapy Services”.

### Mental Health, Biologically Based Mental Illness, Alcohol and Substance Abuse Services
- Inpatient Facility Services
- Residential Treatment Center Services
- Inpatient Doctor Services
- Outpatient Facility Services
- Outpatient Doctor Services
- Partial Hospitalization Program / Intensive Outpatient Services
- Office Visits (Including Online Visits and Intensive In-Home Behavioral Health Programs)

*Mental Health, Biologically Based Mental Illness, Alcohol and Substance Abuse Services will be covered as required by state and federal law. Please see “Mental Health Parity and Addiction Equity Act” in the “Additional Federal Notices” section in the Plan document for details.*

### Occupational Therapy
- See “Therapy Services”.

### Office Visits
- Primary Care Physician / Provider (PCP)
- Specialty Care Physician / Provider (SCP)
- Retail Health Clinic Visit
- Counseling – Includes Family Planning and Nutritional Counseling (Other than Eating Disorders)
- Nutritional Counseling for Eating Disorders
- Allergy Testing

### Covered Services
- Covered services are for:
  - Doctor services
  - Hospital services
  - Ambulatory surgical and professional services
  - Inpatient health care to the extent that it is covered under the plan
  - Outpatient health care to the extent that it is covered under the plan

### Cost if you use an In-Network Provider

### Cost if you use an Out-of-Network Provider

<table>
<thead>
<tr>
<th>Service Category</th>
<th>In-Network Cost</th>
<th>Out-of-Network Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor Services for:</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Maternity Visits</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Inpatient Services (Delivery)</td>
<td>See “Inpatient Services.”</td>
<td></td>
</tr>
<tr>
<td>Infertility</td>
<td>Benefits are based on the setting in which Covered Services are received.</td>
<td>Benefits are based on the setting in which Covered Services are received.</td>
</tr>
<tr>
<td>Massage Therapy</td>
<td>See “Therapy Services”.</td>
<td></td>
</tr>
<tr>
<td>Mental Health, Biologically Based Mental Illness, Alcohol and Substance Abuse Services</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Office Visits</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>See “Therapy Services”.</td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician / Provider (PCP)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Specialty Care Physician / Provider (SCP)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Retail Health Clinic Visit</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Counseling – Includes Family Planning and Nutritional Counseling (Other than Eating Disorders)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Nutritional Counseling for Eating Disorders</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Covered Medical Benefits</td>
<td>Cost if you use an In-Network Provider</td>
<td>Cost if you use an Out-of-Network Provider</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Allergy Shots / Injections (other than allergy serum)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Preferred Diagnostic Labs (i.e., reference labs)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Diagnostic Lab (non-preventive)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Diagnostic X-ray (non-preventive)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Diagnostic Tests (non-preventive; including hearing and EKG)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Advanced Diagnostic Imaging (including MRIs, CAT scans)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Office Surgery</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
</tbody>
</table>

**Therapy Services:**

<table>
<thead>
<tr>
<th>Therapy Services</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use an Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Care / Manipulation Therapy (regardless of the Provider type rendering the service)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Acupuncture/Nerve Pathway Therapy &amp; Massage Therapy</td>
<td>Not covered except for in lieu of anesthesia</td>
<td>Not covered except for in lieu of anesthesia</td>
</tr>
<tr>
<td>Physical, Speech, &amp; Occupational Therapy</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Dialysis / Hemodialysis</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Radiation / Chemotherapy / Non-Preventive Infusion &amp; Injection</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Cardiac Rehabilitation &amp; Pulmonary Therapy</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Prescription Drugs Administered in the Office (includes allergy serum)</td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Orthotics</th>
<th>See “Durable Medical Equipment (DME), Medical Devices, Medical and Surgical Supplies”.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Facility Services</td>
<td></td>
</tr>
<tr>
<td>Facility Surgery Charge</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies)</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Doctor Surgery Charges</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Other Doctor Charges (Including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Other Facility Charges (for procedure rooms or other ancillary services)</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Diagnostic Lab</td>
<td>20% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Diagnostic X-ray</td>
<td>20% Coinsurance after Deductible</td>
</tr>
</tbody>
</table>
### Covered Medical Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic Tests:</strong> Hearing, EKG, etc. (Non-Preventive)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td><strong>Advanced Diagnostic Imaging (including MRIs, CAT scans)</strong></td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td><strong>Therapy:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care / Manipulation Therapy (regardless of the Provider type rendering the service)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td>Physical, Speech, &amp; Occupational Therapy</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td>Radiation / Chemotherapy / Non-Preventive Infusion &amp; Injection</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td>Dialysis / Hemodialysis</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td>Cardiac Rehabilitation &amp; Pulmonary Therapy</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td>Prescription Drugs Administered in an Outpatient Facility</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
<tr>
<td><strong>Physical Therapy</strong></td>
<td>See “Therapy Services”.</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive care from an Out-of-Network Provider is not subject to the Maximum Allowed Amount.</td>
<td>No Copayment, Deductible, or Coinsurance</td>
<td>40% Coinsurance of Deductible</td>
</tr>
<tr>
<td><strong>Prosthetics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>See “Prosthetics” under “Durable Medical Equipment (DME), Medical Devices, Medical and Surgical Supplies”.</td>
<td></td>
</tr>
<tr>
<td><strong>Pulmonary Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>See “Therapy Services”.</td>
<td></td>
</tr>
<tr>
<td><strong>Radiation Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>See “Therapy Services”.</td>
<td></td>
</tr>
<tr>
<td><strong>Rehabilitation Services</strong></td>
<td>Benefits are based on the setting in which Covered Services are received. See “Inpatient Services” for details on Benefits.</td>
<td></td>
</tr>
<tr>
<td><strong>Respiratory Therapy</strong></td>
<td>See “Therapy Services”.</td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>See “Inpatient Services”.</td>
<td></td>
</tr>
<tr>
<td><strong>Speech Therapy</strong></td>
<td>See “Therapy Services”.</td>
<td></td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td>Benefits are based on the setting in which Covered Services are received.</td>
<td></td>
</tr>
<tr>
<td><strong>Temporomandibular and Craniomandibular Joint Treatment</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Covered Medical Benefits

<table>
<thead>
<tr>
<th>Therapy Services</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use an Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy (Rehabilitative)</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy (Habilitative)</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy (Rehabilitative)</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy (Habilitative)</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td>Speech Therapy (Rehabilitative)</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td>Speech Therapy (Habilitative)</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care / Manipulation Therapy</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td>Acupuncture/Nerve Pathway Therapy &amp; Massage Therapy</td>
<td>Acupuncture: Exclusion, except when used in lieu of anesthesia</td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>Unlimited</td>
<td></td>
</tr>
</tbody>
</table>

Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.

### Transgender Services
- Precertification required

### Transplant Services
- Precertification required
  - See “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services”.

### Urgent Care Services (Office Visits)

<table>
<thead>
<tr>
<th>Urgent Care Office Visit Charge</th>
<th>$50 Copayment per visit plus 20% Coinsurance after Deductible</th>
<th>$50 Copayment per visit plus 40% Coinsurance after Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Shots / Injections (other than allergy serum)</td>
<td>$50 Copayment per visit plus 20% Coinsurance after Deductible</td>
<td>$50 Copayment per visit plus 40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Preferred Diagnostic Labs (i.e., reference labs)</td>
<td>$50 Copayment per visit plus 20% Coinsurance after Deductible</td>
<td>$50 Copayment per visit plus 40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Other Charges (e.g., diagnostic x-ray and lab services, medical supplies)</td>
<td>$50 Copayment per visit plus 20% Coinsurance after Deductible</td>
<td>$50 Copayment per visit plus 40% Coinsurance after Deductible</td>
</tr>
</tbody>
</table>
### Covered Medical Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use an Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Diagnostic Imaging (including MRIs, CAT scans)</td>
<td>$50 Copayment per visit plus 20% Coinsurance after Deductible</td>
<td>$50 Copayment per visit plus 40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Office Surgery</td>
<td>$50 Copayment per visit plus 20% Coinsurance after Deductible</td>
<td>$50 Copayment per visit plus 40% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Prescription Drugs Administered in the Office (includes allergy serum)</td>
<td>$50 Copayment per visit plus 20% Coinsurance after Deductible</td>
<td>$50 Copayment per visit plus 40% Coinsurance after Deductible</td>
</tr>
</tbody>
</table>

*If you get urgent care at a Hospital or other outpatient Facility, please refer to “Outpatient Facility Services” for details on what you will pay.*

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

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

*The requirements described below do not apply to the following:*
- Cornea and kidney transplants, which are covered as any other surgery; and
- Any Covered Services related to a Covered Transplant Procedure, that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the collection and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

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

<table>
<thead>
<tr>
<th>Covered Transplant Procedure during the Transplant Benefit Period</th>
<th>In-Network Transplant Provider Facility</th>
<th>Out-of-Network Transplant Provider Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transplant Benefit Period</strong></td>
<td>Starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.</td>
<td>Starts one day before a Covered Transplant Procedure and continues to the date of discharge at an Out-of-Network Transplant Provider Facility.</td>
</tr>
<tr>
<td><strong>Precertification required</strong></td>
<td>During the Transplant Benefit Period, 20% Coinsurance after Deductible. Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.</td>
<td>During the Transplant Benefit Period, 40% Coinsurance after Deductible. During the Transplant Benefit Period, Covered Transplant Procedure charges at an Out-of-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also an In-Network Provider for this Plan (for services other than Covered Transplant Procedures), then you will not have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. If the Provider is an Out-of-Network Provider for this Plan, you will have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.</td>
</tr>
<tr>
<td><strong>Transportation and Lodging</strong></td>
<td>0% Coinsurance</td>
<td>0% Coinsurance</td>
</tr>
<tr>
<td><strong>Transportation and Lodging Limit</strong></td>
<td>Covered, as approved by Anthem, up to $10,000 per transplant. In- and Out-of-Network combined</td>
<td>Covered, as approved by Anthem, up to $10,000 per transplant. In- and Out-of-Network combined</td>
</tr>
<tr>
<td><strong>Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services</strong></td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td><strong>Donor Search Limit</strong></td>
<td>Covered, as approved by Anthem, up to $30,000 per transplant. In- and Out-of-Network combined</td>
<td>Covered, as approved by Anthem, up to $30,000 per transplant. In- and Out-of-Network combined</td>
</tr>
<tr>
<td><strong>Live Donor Health Services</strong></td>
<td>20% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
</tr>
<tr>
<td><strong>Donor Health Service Limit</strong></td>
<td>Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure, for up to six weeks from the date of procurement.</td>
<td></td>
</tr>
</tbody>
</table>
At least one product in all 18 approved methods of contraception is covered under this policy without cost sharing as required by Federal and state law. Otherwise, each Prescription Drug will be subject to a cost share (e.g., Copayment/Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.

<table>
<thead>
<tr>
<th>Prescription Drug Co-Payment</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use an Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Member Retail Co-Payment</td>
<td>$10 copay for generic</td>
<td>$10 copay for generic</td>
</tr>
<tr>
<td></td>
<td>$35 copay for brand name</td>
<td>$35 copay for brand name</td>
</tr>
<tr>
<td></td>
<td>$60 copay for non-preferred brand / specialty</td>
<td>$60 copay for non-preferred brand / specialty</td>
</tr>
<tr>
<td></td>
<td>Mail order covered for 90 days at 3 times the copay</td>
<td>Mail order covered for 90 days at 3 times the copay</td>
</tr>
</tbody>
</table>

**Day Supply Limitations** – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Pharmacy (In-Network and Out-of-Network)</td>
<td>30 days</td>
</tr>
<tr>
<td>Home Delivery (Mail Order) Pharmacy</td>
<td>90 days</td>
</tr>
<tr>
<td>Specialty Pharmacy</td>
<td>30 days*</td>
</tr>
</tbody>
</table>

*SSee additional information in the “Specialty Drug Copayments / Coinsurance” section below.

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

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

**Note:** No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.
**Pediatric Vision** *Limited to covered persons under the age of 19.*

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

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

<table>
<thead>
<tr>
<th>Covered Dental Benefits</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use an Out-of-Network Provider</th>
</tr>
</thead>
</table>
| **Children’s Dental Essential Health Benefits (up to age 19)**
  *Limited to covered persons under the age of 19.* | Deductible waived, subject to 0% Coinsurance | Deductible waived, subject to 0% Coinsurance |
| Diagnostic and Preventive Services | Deductible waived, subject to 0% Coinsurance | Deductible waived, subject to 0% Coinsurance |
| Basic Restorative Services | Deductible waived, subject to 0% Coinsurance | Deductible waived, subject to 0% Coinsurance |
| Endodontic Services | Deductible waived, subject to 0% Coinsurance | Deductible waived, subject to 0% Coinsurance |
| Periodontal Services | Deductible waived, subject to 0% Coinsurance | Deductible waived, subject to 0% Coinsurance |
| Oral Surgery Services | Deductible waived, subject to 0% Coinsurance | Deductible waived, subject to 0% Coinsurance |
| Major Restorative Services | Deductible waived, subject to 0% Coinsurance | Deductible waived, subject to 0% Coinsurance |
| Prosthodontic Services | Deductible waived, subject to 0% Coinsurance | Deductible waived, subject to 0% Coinsurance |
| Dentally Necessary Orthodontic Care | Deductible waived, subject to 0% Coinsurance | Deductible waived, subject to 0% Coinsurance |

**Dental Injuries**

Benefits paid on Injury to Sound, Natural Teeth only.

0% Coinsurance after Deductible
Benefits that go with you

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

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

<table>
<thead>
<tr>
<th>GeoBlue benefits for the 2021-2022 school year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Use of benefits must be coordinated and approved by GeoBlue.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>International telemedicine services²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global TeleMD™</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage outside the U.S., excluding student’s home country.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Expenses</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage worldwide except within 100 miles of primary residence for U.S. students.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage worldwide, excluding home country for international students.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage worldwide except within 100 miles of primary residence for U.S. students. Coverage worldwide, excluding home country for international students.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency medical evacuation</td>
</tr>
<tr>
<td>Repatriation of remains</td>
</tr>
<tr>
<td>Emergency family travel arrangements</td>
</tr>
<tr>
<td>Political emergency and natural disaster evacuation (Available only when traveling outside the United States)⁴</td>
</tr>
<tr>
<td>Accidental death and dismemberment</td>
</tr>
</tbody>
</table>

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

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1. GeoBlue is the trade name of Worldwide Insurance Services, LLC, Worldwide Services Insurance Agency, LLC in California and New York, an independent licensee of the Blue Cross and Blue Shield Association. GeoBlue is the administrator of coverage provided under insurance policies issued by Aetna Life International Limited, Bermuda, an independent licensee of the Blue Cross Blue Shield Association. Coverage is not available in all states. Some restrictions apply.
2. Telemedicine services are provided by Teladoc Health, directly to members. GeoBlue assumes no liability and accepts no responsibility for information provided by Teladoc Health. Support and information provided through this service does not confirm that any related treatment or additional support is covered under a member’s health plan.
3. These medical expenses are limited and are subject to limitations and exclusions. See full certificate of insurance for a full description of services and coverage of what is and isn’t covered.
4. The Political, Military and Natural Disaster Evacuation Services (PEND) are provided through Crisis24, an independent third-party, nonaffiliated service provider. Crisis24 does not supply Blue Cross or Blue Shield products or other benefits, and is therefore solely responsible for PEND and other collateral services it provides. GeoBlue makes no warranty, express or implied, and accepts no responsibility resulting from the provision or use of Crisis24 PEND or other Crisis24 services.
Designed with you in mind
Offering you healthy support and easy-to-use benefits to help you stay focused on your education and your future.
In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan. We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

1. Acts of War, Disasters, or Nuclear Accidents
   In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.
   Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

2. Administrative Charges
   a) Charges to complete claim forms,
   b) Charges to get medical records or reports,
   c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

3. Alternative / Complementary Medicine
   Services or supplies for alternative or complementary medicine, regardless of the Provider rendering such services or supplies. This includes, but is not limited to:
   a) Holistic medicine,
   b) Homeopathic medicine,
   c) Hypnosis,
   d) Aroma therapy,
   e) Reiki therapy,
   f) Herbal, vitamin or dietary products or therapies,
   g) Naturopathy,
   h) Thermography,
   i) Orthomolecular therapy,
   j) Contact reflex analysis,
   k) Bioenergial synchronization technique (BEST),
   l) Iridology-study of the iris,
   m) Auditory integration therapy (AIT),
   n) Colonic irrigation,
   o) Magnetic innervation therapy,
   p) Electromagnetic therapy,
   q) Neurofeedback / Biofeedback.

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

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

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

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

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

9. Clinically-Equivalent Alternatives
   Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

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

11. Complications of Non-Covered Services
    Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

12. Cosmetic Services
    Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

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

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

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

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

18. **Drugs That Do Not Need a Prescription**

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

19. **Drugs Prescribed by Providers Lacking Qualifications/Certifications**

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

20. **Educational Services**

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

21. **Experimental or Investigational Services**

Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply. The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational.

22. **Eyeglasses and Contact Lenses**

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

23. **Eye Exercises**

Orthoptics and vision therapy.

24. **Eye Surgery**

Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

25. **Family Members**

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

26. **Foot Care**

Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
   a) Cleaning and soaking the feet.
   b) Applying skin creams to care for skin tone.
   c) Other services that are given when there is not an illness, injury or symptom involving the foot.

27. **Foot Orthotics**

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

28. **Foot Surgery**

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

29. **Free Care**

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

30. **Gene Therapy**

Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
31. **Hearing Aids**
Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

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

33. **Infertility Treatment**
Infertility procedures not specified in this Booklet.

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

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

36. **Maintenance Therapy**
Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to “Habilitative Services”.

37. **Medical Equipment, Devices, and Supplies**
   a) Replacement or repair of purchased or rental equipment because of misuse, or loss.
   b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
   c) Non-Medically Necessary enhancements to standard equipment and devices.
   d) Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.

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

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

40. **Non-Medically Necessary Services**
Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

41. **Nutritional or Dietary Supplements**
Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.

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

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

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

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

46. **Residential Accommodations**
Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center.

47. **Services Received From Student Health Center**
Services covered or provided by the CSU Health Network if covered by the on campus benefits.

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

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

50. **Sterilization**
Services to reverse an elective sterilization.

51. **Surrogate Mother Services**
Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

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

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

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

55. **Vision Services**
   a) Vision services not specifically listed as covered in this Booklet.
b) For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.

c) Safety glasses and accompanying frames.

d) For two pairs of glasses in lieu of bifocals.

e) Plano lenses (lenses that have no refractive power).

f) Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.

g) Blended lenses.

h) Oversize lenses.

i) Sunglasses.

j) For Members through age 18, no benefits are available for frames and contact lenses purchased outside of our formulary.

k) Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically stated as covered in this Booklet.

l) Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.

56. Waived Cost-Shares Out-of-Network

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

57. Weight Loss Programs

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

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

58. Weight Loss Surgery

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

What is Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

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

1. Administration Charges

Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.

2. Clinically-Equivalent Alternatives

Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

3. Compound Drugs

Compound Drugs unless all of the ingredients are FDA-approved and require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

4. Contrary to Approved Medical and Professional Standards

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

5. Delivery Charges

Charges for delivery of Prescription Drugs.

6. Drugs Given at the Provider’s Office/Facility

Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the “Prescription Drugs Administered by a Medical Provider” section, or Drugs covered under the “Medical and Surgical Supplies” benefit – they are Covered Services.

7. Drugs Not on the IngenioRx Prescription Drug List (a formulary)

You can get a copy of the list by calling us or visiting our website at www.anthem.com. If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to “Prescription Drug List” in the section “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception.

8. Drugs Over Quantity or Age Limits

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

9. Drugs Over the Quantity Prescribed or Refills After One Year

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

10. Drugs Prescribed by Providers Lacking Qualifications/Certifications

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

11. Drugs That Do Not Need a Prescription

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

12. Gene Therapy

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

13. Infertility Drugs

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

14. Items Covered as Durable Medical Equipment (DME)

Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the “Durable Medical Equipment and Medical Devices” benefit. Please see that section for details.

15. Items Covered Under the “Allergy Services” Benefit

Allergy desensitization products or allergy serum. While not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit, these items may be covered under the “Allergy Services” benefit. Please see that section for details.

16. Lost or Stolen Drugs

Refills of lost or stolen Drugs.

17. Mail Order

Providers other than the PBM’s Home Delivery Mail Order Provider. Prescription Drugs dispensed by any Mail Order Provider other than the PBM’s Home Delivery Mail Order Provider, unless we must cover them by law.

18. Non-approved Drugs

Drugs not approved by the FDA.
19. **Off label use**
   Off label use, unless we must cover the use by law or if we, or the PBM, approve it.

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

21. **Over-the-Counter Items**
   Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
   This Exclusion does not apply to over-the-counter products that we must cover as a “Preventive Care” benefit under Federal law with a Prescription.

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

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

24. **Weight Loss Drugs**
   Any Drug mainly used for weight loss.
Access help in your language

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

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

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 (TTY: 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 MyAmeriBen.com