

2025-2026

# Anthem

Helping keep you at your personal best



## University of Colorado Boulder

### Student Health Insurance Plan (SHIP)

<https://student.anthem.com/student/schools/cub>







### **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



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# Welcome to Anthem

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

## What you need to know about Anthem Student Advantage



### Who is eligible?

- Degree-seeking undergraduate students enrolled in six or more credit hours and graduate students enrolled in one graduate credit hour or more.
- Non-degree seeking Continuing Education students, Study Abroad (including Semester at Sea) students, Evening MBA students and students taking exclusively Be Boulder Anywhere courses, enrolled in six or more undergraduate credit hours or one or more graduate credit hour and paying the base student and health fees, may be eligible to enroll in the University of Colorado Boulder Gold SHIP and can do so by contacting the Student Insurance Office at **1-303-492-5107** or **<https://www.colorado.edu/health/cu-gold-ship>** for additional details.
- Students approved for the Leave of Absence Program are eligible to enroll in the University of Colorado Boulder Gold SHIP for one semester that they are not registered for classes and can do so by contacting the Student Insurance Office at 1-303-492-5107 or **[studentinsurance@colorado.edu](mailto:studentinsurance@colorado.edu)** for additional details.
- Enrollees in the CU Boulder Gold Plan have the option to add coverage for a spouse and/or eligible dependents. The student must meet the above criteria in order to add spouse and/or dependents.

# 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 (Student)

| Semester      | Coverage Start Date | Coverage End Date | Premium | Enroll or request a waiver by: |
|---------------|---------------------|-------------------|---------|--------------------------------|
| Fall          | August 1, 2025      | December 31, 2025 | \$2442  | September 15, 2025             |
| Spring/Summer | January 1, 2026     | July 31, 2026     | \$2442  | February 16, 2026              |
| Summer Only   | May 1, 2026         | July 31, 2026     | \$1228  | May 31, 2026                   |

## Costs and dates of coverage (Dependents)

| Semester      | Coverage Start Date | Coverage End Date | Premium | Enroll or request a waiver by: |
|---------------|---------------------|-------------------|---------|--------------------------------|
| Fall          | August 1, 2025      | December 31, 2025 | \$2466  | September 15, 2025             |
| Spring/Summer | January 1, 2026     | July 31, 2026     | \$2466  | February 13, 2026              |
| Summer Only   | May 1, 2026         | July 31, 2026     | \$1288  | May 31, 2026                   |

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

\*Rates pending approval with the state and subject to change.

# Keep in touch with your benefits information



## **Student Health Center**

Wardenburg Health Center  
1900 Wardenburg Drive 119 UCB  
Boulder, CO 80309

Phone: 1-303-492-5101

For 24/7 support visit  
Academic Live Care

[www.colorado.edu/healthcenter/](http://www.colorado.edu/healthcenter/)

Please check website for hours.

Saturday and Sunday: Closed



## **Benefits and Claims**

Phone: 844-412-0752

Anthem Blue Cross Blue Shield  
Health Insurance Company



## **Student Counseling Center**

Center for Community, Suite N352  
2249 Willard Loop Dr. 104 UCB  
Boulder, CO 80309

Phone: 1-303-492-2277  
(24/7 support)

[www.colorado.edu/counseling/](http://www.colorado.edu/counseling/)  
Please check website for hours.



## **Eligibility, and enrollment**

Wardenburg Health Center  
1900 Wardenburg Drive 119 UCB  
Boulder, CO 80309

Phone: 1-303-492-5107  
[studentinsurance@colorado.edu](mailto:studentinsurance@colorado.edu)

# Your CU Boulder Medical Services

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

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



## Medical care

Primary and preventive care including:

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



## Health Education and Prevention Services

- Nutrition counseling for a variety of concerns



## Laboratory and X-ray

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



## Counseling and psychiatry

- Up to 12 counseling and psychiatry visits per policy year including:
  - Individual counseling
  - Medication management
  - Crisis care
- Unlimited group therapy



## Physical therapy and integrative care

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

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





### Sexual and reproductive health

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



### Annual eye exam

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

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



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

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



# Easy access to care

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



## Sydney Health app

With the Sydney Health<sup>1</sup> 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<sup>SM</sup> or Google Play<sup>TM</sup> and search for the Sydney Health app to download it today.



## Provider Finder

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

- [www.anthem.com](http://www.anthem.com)
- [www.colorado.edu/health/insurance](http://www.colorado.edu/health/insurance)
- Sydney Health app

Important tips:

- When you need health care, please access care at the University of Colorado Boulder Health & Wellness Services first. 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.



## Telehealth - Academic LiveCare

From your mobile device or computer with a webcam, you can use Academic LiveCare to visit with a board-certified doctor, psychiatrist or licensed therapist through live video.<sup>2</sup>

To use, go to <https://colorado.myahpcare.com/telehealth>. You can also download the free Academic LiveCare Online app to sign up.



## 24/7 NurseLine

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

<sup>1</sup> Sydney Health is a service mark of CareMarket, Inc.

<sup>2</sup> 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 Colorado Boulder

Your network:  
Anthem PPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC) will prevail. Plan benefits are pending approval with the state and subject to change.

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

### Medical

| Covered Medical Benefits                                                                                                                                                                                                                                                | Cost if you use an In-Network Provider             | Cost if you use an Out-of-Network Provider                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------|
| <b>Overall Deductible</b>                                                                                                                                                                                                                                               |                                                    |                                                                    |
| When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies. Copayments and Coinsurance are separate from and do not apply to the Deductible.                                                    | \$500 student                                      | \$1,000 student                                                    |
| <b>Out-of-Pocket Limit</b>                                                                                                                                                                                                                                              |                                                    |                                                                    |
| 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.                                                      | \$8,700 student                                    | \$10,000 student                                                   |
| <b>Preventive care/screening/immunization</b>                                                                                                                                                                                                                           |                                                    |                                                                    |
| In-network preventive care is not subject to deductible, if your plan has a deductible. Deductible does not apply to the following Out-Of-Network services: Immunizations, well woman visits, alcohol and/or drugs counseling office visits, routine cancer screenings. | No charge                                          | 50% coinsurance after deductible is met                            |
| <b>Doctor Home and Office Services</b>                                                                                                                                                                                                                                  |                                                    |                                                                    |
| Primary Care Visit to treat an injury or illness                                                                                                                                                                                                                        | \$40 copay per visit deductible does not apply     | \$40 copay per visit 50% coinsurance deductible does not apply     |
| Specialist Care Office Visit                                                                                                                                                                                                                                            | \$40 copay per visit deductible does not apply     | \$40 copay per visit 50% coinsurance deductible does not apply     |
| Prenatal and Post-natal Care<br>In-Network preventive prenatal services are covered at 100%.                                                                                                                                                                            | \$40 copay per pregnancy deductible does not apply | \$40 copay per pregnancy 50% coinsurance deductible does not apply |

| Covered Medical Benefits                                                                                                                     | Cost if you use an In-Network Provider          | Cost if you use an Out-of-Network Provider                      |
|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------|
| <b>Other Practitioner Visits:</b>                                                                                                            |                                                 |                                                                 |
| Retail Health Clinic                                                                                                                         | \$40 copay per visit deductible does not apply  | \$40 copay per visit 50% coinsurance deductible does not apply  |
| On-line Visit<br>Includes Mental/Behavioral Health and Substance Abuse Academic LiveCare (See page 21) is the preferred telehealth solution. | \$0 copay                                       | \$0 copay                                                       |
| Chiropractic                                                                                                                                 | 20% coinsurance after deductible is met         | 50% coinsurance after deductible is met                         |
| <b>Other Services in an Office:</b>                                                                                                          |                                                 |                                                                 |
| Allergy Testing                                                                                                                              | \$40 copay per visit deductible does not apply  | \$40 copay per visit, 50% coinsurance deductible does not apply |
| Chemo/Radiation Therapy                                                                                                                      | \$40 copay per visit deductible does not apply  | \$40 copay per visit, 50% coinsurance deductible does not apply |
| Hemodialysis                                                                                                                                 | \$40 copay per visit deductible does not apply  | \$40 copay per visit, 50% coinsurance deductible does not apply |
| Prescription Drugs<br>For the drugs itself dispensed in the office through infusion/injection.                                               | 20% coinsurance after deductible is met         | 50% coinsurance after deductible is met                         |
| <b>Diagnostic Services</b>                                                                                                                   |                                                 |                                                                 |
| <b>Lab:</b>                                                                                                                                  |                                                 |                                                                 |
| Office                                                                                                                                       | \$40 copay per visit, deductible does not apply | \$40 copay per visit, 50% coinsurance deductible does not apply |
| Freestanding Lab/Reference Lab                                                                                                               | 20% coinsurance after deductible is met         | 50% coinsurance after deductible is met                         |
| Outpatient Hospital                                                                                                                          | 20% coinsurance after deductible is met         | 50% coinsurance after deductible is met                         |
| <b>X-Ray:</b>                                                                                                                                |                                                 |                                                                 |
| Office                                                                                                                                       | \$40 copay per visit, deductible does not apply | \$40 copay per visit, 50% coinsurance deductible does not apply |
| Freestanding Radiology Center                                                                                                                | 20% coinsurance after deductible is met         | 50% coinsurance after deductible is met                         |
| Outpatient Hospital                                                                                                                          | 20% coinsurance after deductible is met         | 50% coinsurance after deductible is met                         |
| <b>Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):</b>                                                                         |                                                 |                                                                 |
| Office                                                                                                                                       | \$40 copay per visit, deductible does not apply | \$40 copay per visit, 50% coinsurance deductible does not apply |
| Freestanding Radiology Center                                                                                                                | 20% coinsurance after deductible is met         | 50% coinsurance after deductible is met                         |
| Outpatient Hospital                                                                                                                          | 20% coinsurance after deductible is met         | 50% coinsurance after deductible is met                         |



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

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



## Pharmacy

| Covered Prescription Drug Benefits                                                                                                                                                                 | Cost if you use an In-Network Provider                 | Cost if you use an Out-of-Network Provider  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|---------------------------------------------|
| Pharmacy Deductible                                                                                                                                                                                | Not applicable                                         | Not applicable                              |
| Pharmacy Out of Pocket                                                                                                                                                                             | Combined with medical out of pocket maximum            | Combined with medical out of pocket maximum |
| <b>Prescription Drug Coverage</b><br><b>Traditional Drug List</b><br>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<br>Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.            | \$25 copay per prescription, deductible does not apply | Covered as In-Network                       |
| Tier 2 – Typically Preferred Brand<br>Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.               | \$45 copay per prescription, deductible does not apply | Covered as In-Network                       |
| Tier 3 - Typically Non-Preferred Brand/Specialty<br>Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs. | \$75 copay per prescription, deductible does not apply | Covered as In-Network                       |



## Pediatric Vision Limited to covered persons under the age of 19.

| Covered Vision Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|--------------------------------------------|
| <p>This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for student's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail.</p> |                                        |                                            |
| <b>Children's Vision Essential Health Benefits</b><br><b>Limited to covered persons under the age of 19.</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |                                        |                                            |
| Child Vision Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | \$0                                    | \$0                                        |
| Vision exam<br>Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.                                                                                                                                                                                                                                                                                                                                                                                                                    | No charge                              | Reimbursed Up to \$30                      |
| Frames<br>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.                                                                                                                                                                                                                                                                                                                                                                                                                         | No charge                              | Reimbursed Up to \$45                      |
| Lenses<br>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.                                                                                                                                                                                                                                                                                                                                                                                                                         |                                        |                                            |
| Single vision lenses                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | \$0 copay                              | \$0 copay (up to \$25)                     |
| Bifocal lenses                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | \$0 copay                              | \$0 copay (up to \$40)                     |
| Trifocal lenses                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | \$0 copay                              | \$0 copay (up to \$55)                     |
| Progressive lenses (standard, premium, select, ultra)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | \$0 copay                              | \$0 copay (up to \$40)                     |
| Transitions Lenses                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | \$0 copay                              | Not covered                                |
| Standard polycarbonate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | \$0 copay                              | Not covered                                |
| Factory Scratch Coating                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | \$0 copay                              | Not covered                                |
| Elective contact lenses<br>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<br>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.                                                                                                                                                                                                                                                                                                                                                                                                    | No charge                              | Reimbursed up to \$210                     |
| <b>Adult Vision (age 19 and older)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                        |                                            |
| <b>Adult Vision Coverage</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                        |                                            |
| Limited to certain vision screenings required by Federal law and covered under the "Preventive Care" benefit.                                                                                                                                                                                                                                                                                                                                                                                                                          | See "Preventive Care" benefit          | See "Preventive Care" benefit              |



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

| Covered Dental Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Cost if you use an In-Network Provider   | Cost if you use an Out-of-Network Provider |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|--------------------------------------------|
| <p>This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's dental services count towards your out of pocket limit.</p> |                                          |                                            |
| <p>Children's Dental Essential Health Benefits<br/>Limited to covered persons under the age of 19.</p>                                                                                                                                                                                                                                                                                                                                                                                                      |                                          |                                            |
| Diagnostic and preventive<br>Includes cleanings, exams, x-rays, sealants, fluoride                                                                                                                                                                                                                                                                                                                                                                                                                          | No Copayment, Deductible, or Coinsurance | No Copayment, Deductible, or Coinsurance   |
| Basic services<br>Includes filing and simple extractions                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 20% coinsurance, Deductible Waived       | 20% coinsurance, Deductible Waived         |
| Major services/Prosthodontic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 50% coinsurance, Deductible Waived       | 50% coinsurance, Deductible Waived         |
| Endodontic, Periodontics, Oral Surgery                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 50% coinsurance, Deductible Waived       | 50% coinsurance, Deductible Waived         |
| Dentally Necessary Orthodontia                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 50% coinsurance, Deductible Waived       | 50% coinsurance, Deductible Waived         |
| Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Not applicable                           | Not applicable                             |
| Adult Dental (Age 19 and over)                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Not covered                              | Not covered                                |

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

#### Emergency Medical Evacuation, Repatriation and Emergency Family Assistance Services

- Emergency Medical Evacuation, Unlimited
- Medically Advisable Repatriation, Unlimited
- Return of Deceased Remains, Unlimited
- Visit by Family Member or Friend, up to \$5,000 with 3 day hospitalization
- Return of Dependent Children, up to \$5,000, if left unattended
- Emergency Return Home, up to \$2,500, in the event of illness or death of family member
- Bereavement Reunion, up to \$2,500, in the event of death of the student
- Return of Personal Belongings, up to \$1,000 in the event of evacuation or death
- Accidental Death and Dismemberment, \$25,000

#### Medical, Travel, Safety, and Legal Assistance

- Pre-travel information portal
- Physician referrals outside of the U.S.
- Medical monitoring during an emergency evacuation to ensure adequate care
- Prescription assistance
- Luggage lost in transit
- Passport replacement assistance
- Emergency travel arrangements
- Emergency translation assistance and/or interpreter referral
- Legal referral

#### Additional Benefits

- Security/Political Evacuation Coverage
- Natural Disaster Evacuation Coverage
- Emergency Reunion 3 Day Threshold

**Academic Emergency Services are available to you 24 hours a day, 7 days a week.**

Simply call the number on the membership card to get access to knowledgeable assistance coordinators who will help you navigate any unfamiliar cultures or circumstances.

**TAKE A SCREENSHOT OF THE CARD OR CUT IT OUT TO KEEP WITH YOU AT ALL TIMES.**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  <b>Academic<br/>Emergency Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>GROUP ID:</b><br>GHS9999AHPCO<br><br><b>MEMBERSHIP TYPE:</b><br>GLOBAL MEDICAL & TRAVEL ASSISTANCE SERVICES |  <b>Academic<br/>Emergency Services</b><br><br>If you need medical or travel assistance, regardless of the nature or severity of your situation, please contact<br><b>AES 24 hours a day / 7 days a week</b><br><br><b>TOLL FREE</b><br>1(855) 873-3555<br><br><b>OUTSIDE THE US</b><br>1(610) 263-4660<br><br><b>EMAIL</b><br>assistance@ahpcare.com |
| <b>ACADEMIC EMERGENCY SERVICES SUPPORT 24/7</b><br><br>To contact Academic Emergency Services from the U.S. or Canada, call toll-free: (855) 873-3555<br>To contact Academic Emergency Services from outside the U.S. or Canada, dial the country access code followed by: 1 (610) 263-4660<br>Country access codes can be found through local directory assistance or <a href="https://www.att.com/support_media/images/pdf/Country_Code_List.pdf">https://www.att.com/support_media/images/pdf/Country_Code_List.pdf</a> .<br>If there is no access code, proceed with calling direct to: 1 (610) 263-4660 |                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                            |

To obtain additional pre-travel information or advice, or in the event of a medical, travel or security crisis, call Academic Emergency Services immediately.

All services must be arranged and paid through the Academic Emergency Services program provider in order for the benefits to apply. There is no claim process for reimbursement of self-paid expenses, unless otherwise noted in program. Terms, limitations and conditions apply to all services and benefits. Academic Emergency Services and AD&D coverage are underwritten by 4 Ever Life International Limited and administered by Worldwide Insurance Services, LLC, separate and independent companies from Academic HealthPlans.



virtual visits 24/7 from a smart phone or computer, or other mobile device

You can see board-certified physical and behavioral health professionals from the comfort of your own home. Safe and secure, it's the on-demand quality care you need, when you need it.

Telehealth is commonly used for:

- coughs & colds
- sinus infections
- allergies
- bronchitis
- headaches
- anxiety & depression
- strep throat
- therapy & counseling
- general wellness
- insomnia





## Designed with you in mind

Offering you healthy support  
and convenient benefits to  
help you stay focused on your  
education and your future.



## Exclusions

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

1. Acupuncture Therapy
  - a) Maintenance treatment
  - b) Acupuncture when provided for the following conditions:
    - Acute low back pain
    - Addiction
    - AIDS
    - Amblyopia
    - Allergic rhinitis
    - Asthma
    - Bell's Palsy
    - Burning mouth syndrome
    - Cancer-related dyspnea
    - Carpal tunnel syndrome
    - Chemotherapy-induced leukopenia
    - Chemotherapy-induced neuropathic pain
    - Chronic pain syndrome (e.g., RSD, facial pain)
    - Chronic obstructive pulmonary disease
    - Diabetic peripheral neuropathy
    - Dry eyes
    - Erectile dysfunction
    - Facial spasm
    - Fetal breech presentation
    - Fibromyalgia
    - Fibrotic contractures
    - Glaucoma
    - Hypertension
    - Induction of labor
    - Infertility (e.g., to assist oocyte retrieval and embryo transfer during IVF treatment cycle)
    - Insomnia
    - Irritable bowel syndrome
    - Menstrual cramps/dysmenorrhea
    - Mumps
    - Myofascial pain
    - Myopia
    - Neck pain/cervical spondylosis
    - Obesity
    - Painful neuropathies
    - Parkinson's disease
    - Peripheral arterial disease (e.g., intermittent claudication) Phantom leg pain
    - Polycystic ovary syndrome
    - Post-herpetic neuralgia
    - Psoriasis
    - Psychiatric disorders (e.g., depression)
    - Raynaud's disease pain
    - Respiratory disorders
    - Rheumatoid arthritis
    - Rhinitis
    - Sensorineural deafness
    - Shoulder pain (e.g., bursitis)
    - Stroke rehabilitation (e.g., dysphagia)
    - Tennis Elbow/epicondylitis
    - Tension headache
    - Tinnitus
    - Tobacco Cessation
    - Urinary incontinence
    - Uterine fibroids
    - Xerostomia
    - Whiplash
2. Acts of War, Disasters, or Nuclear Accidents  
In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff. Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.
3. Administrative Charges
  - a) Charges to complete claim forms,
  - b) Charges to get medical records or reports,
  - c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
4. Alternative / Complementary Medicine  
Services and supplies given by a provider for alternative health care. This includes but is not limited to aromatherapy, naturopathic medicine, herbal remedies, homeopathy, energy medicine, Christian faith-healing medicine, Ayurvedic medicine, yoga, hypnotherapy, and traditional Chinese medicine.
5. Armed Forces  
Services and supplies received from a provider as a result of an injury sustained, or illness contracted, while in the service of the armed forces of any country. When you enter the armed forces of any country, we will refund any unearned pro-rata premium to the policyholder.
6. Applied Behavioral Treatment  
(including, but not limited to, Applied Behavior Analysis and intensive behavior interventions) for all indications except as described under Autism Services in the "Benefits/Coverage (What is Covered)" section.
7. Before Effective Date or After Termination Date  
Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
8. Breasts  
Services and supplies given by a provider for breast reduction or gynecomastia.
9. Certain Providers  
Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet, or which are not recognized by us as an eligible Provider under this Plan.
10. Charges Over the Maximum Allowed Amount  
Charges over the Maximum Allowed Amount for Covered Services, except as written in this Plan.
11. Charges Not Supported by Medical Records  
Charges for services not described in your medical records.
12. Clinically-Equivalent Alternatives  
Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at [www.anthem.com](http://www.anthem.com).

13. Complications of/or Services Related to Non-Covered Services Services, supplies or treatment related to or, for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.
14. Compound Drugs  
Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
15. Cosmetic Services and Plastic Surgery  
Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body. Whether or not for psychological or emotional reasons. Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected. This exclusion does not apply to:
  - a) Surgery after an accidental injury when performed as soon as medically feasible.
  - b) Coverage that may be provided under the Eligible health services under your plan – Gender reassignment (sex change) treatment section.
16. Court-ordered Services and Supplies  
Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding other than substance related disorders treatment and mental health treatment described as covered in the "Benefits/Coverage (What is Covered)" section and required by state law.
17. Crime  
Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
18. Custodial Care  
Examples are:
  - a) Routine patient care such as changing dressings, periodic turning and positioning in bed
  - b) Administering oral medications
  - c) Care of a stable tracheostomy (including intermittent suctioning)
  - d) Care of a stable colostomy/ileostomy
  - e) Care of a bladder catheter (including emptying/ changing containers and clamping tubing)
  - f) Watching or protecting you
  - g) Respite care, adult (or child) day care, or convalescent care except in connection with hospice care
  - h) Institutional care. This includes room and board for rest cures, adult day care and convalescent care
  - i) Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
  - j) Any other services that a person without medical or paramedical training could be trained to perform
  - k) Any service that can be performed by a person without any medical or paramedical training
19. Delivery Charges  
Charges for delivery of Prescription Drugs.
20. Dental Care for Adults
  - a) Dental services for adults including services related to:
    - The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
    - Dental services related to the gums
    - Apicoectomy (dental root resection)
    - Orthodontics
    - Root canal treatment
    - Soft tissue impactions
    - Alveolectomy
    - Augmentation and vestibuloplasty treatment of periodontal disease
    - False teeth
    - Prosthetic restoration of dental implants
    - Dental implants
    - This exception does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.
21. Dental Services
  - a) Dental care for Members age 19 or older, unless listed as covered in the medical benefits of this Booklet.
  - b) Dental services or health care services not specifically covered in this Booklet (including any hospital charges, prescription drug charges and dental services or supplies that do not have an American Dental Association Procedure Code, unless covered by the medical benefits of this Plan).
  - c) Services of anesthesiologists, unless required by law.
  - d) Analgesia, analgesia agents, oral sedation, and anxiolysis nitrous oxide.
  - e) Anesthesia services (such as intravenous conscious sedation, IV sedation and general anesthesia) are not covered when given separate from a covered oral surgery service. EXCEPTION: General anesthesia for dental services for members under age 19 years of age when rendered in a hospital, outpatient surgical facility or other facility licensed pursuant to Section 25-3-101 of the Colorado Revised Statutes if the child, in the opinion of the treating Dentist, satisfies one or more of the following criteria: (a) the child has a physical, mental, or medically compromising condition; (b) the child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; (c) the child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or (d) the child has sustained extensive orofacial and dental trauma.
  - f) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion. Includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
  - g) Dental services or supplies provided solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist,
  - h) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
  - i) Separate services billed when they are an inherent component of another covered service.
  - j) Services to treat Temporomandibular Joint Disorder (TMJ) except as covered under your medical coverage.
  - k) Oral hygiene instructions.
  - l) Case presentations, office visits and consultations.

- m) Implant services, except as listed in this Booklet.
  - n) non-resorbable filling materials, nor the procedures used to prepare and place material(s) in the canals (tooth roots). Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or
  - o) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
  - p) Incomplete root canals.
  - q) Adjunctive diagnostic tests.
22. Drugs Contrary to Approved Medical and Professional Standards Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
23. Drugs Over Quantity or Age Limits  
Drugs which are over any quantity or age limits set by the Plan or us.
24. Drugs Over the Quantity Prescribed or Refills After One Year  
Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
25. Drugs Prescribed by Providers Lacking Qualifications/ Registrations/Certifications  
Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by us.
26. Drugs That Do Not Need a Prescription  
Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
27. Durable Medical Equipment (DME)  
Examples of these items are:
- a) Whirlpools
  - b) Portable whirlpool pumps
  - c) Sauna baths
  - d) Massage devices
  - e) Over bed tables
  - f) Elevators
  - g) Communication aids
  - h) Vision aids
  - i) Telephone alert systems
  - j) Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician.
28. Educational Services  
Except as described as covered services for autism spectrum disorders, therapies for congenital defects and birth abnormalities and early intervention services in the Benefits/coverage (what is covered) section, examples of these services are:
- a) Any service or supply for education, training or retraining services or testing. This includes:
    - Special education
    - Remedial education
    - Wilderness treatment program
    - Job training
    - Job hardening programs
  - b) Services provided by a governmental school district.
29. Emergency Room Services for non-Emergency Care  
Services provided in an emergency room for conditions that do not meet the definition of Emergency. This includes, but is not limited to, suture removal, routine pregnancy test, sore throat, ear ache/infection, rashes, sprains/strains, constipation, diarrhea, upper respiratory illness, abrasions, sleep disorder, conjunctivitis/pink eye, back pain that is not sudden and severe in onset, or dental caries/cavity in an emergency room. For non-emergency care please use the closest network Urgent Care Center or your Primary Care Physician.
30. Experimental or Investigational Services  
Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs). See the "Benefits/Coverage (What is Covered)" section.
31. The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental /Investigational.
32. Eyeglasses and Contact Lenses  
Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.
33. Eye Exercises  
Orthoptics and vision therapy.
34. Eye Surgery  
Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
35. Family Members  
Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
36. Foot Care  
Services and supplies for:
- a) The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches
  - b) The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - c) Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
  - d) Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet unless specifically required for treatment or to prevent complications of diabetes.
37. Foot Surgery  
Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
38. Free Care  
Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.
39. If Workers' Compensation benefits are not available to you, this Exclusion does not apply.  
This Exclusion will apply if you get the benefits in whole or in part.
40. Health Club Memberships and Fitness Services  
Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
41. Hearing Aids and Exams  
The following services or supplies:
- a) A replacement of:
    - A hearing aid that is lost, stolen or broken
    - A hearing aid installed within the prior 12 month period



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

#### 42. Infertility Treatment

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

#### 43. Lost or Stolen Drugs

Refills of lost or stolen Drugs.

#### 44. Medical Equipment, Devices, and Supplies

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

Allowable Amount for the standard item which is a Covered Service is your responsibility.

#### 45. Medical Supplies: Outpatient Disposable

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

#### 46. Medicare

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

#### 47. Missed or Cancelled Appointments

Charges for missed or cancelled appointments.

#### 48. Non-approved Drugs

Drugs not approved by the FDA.

#### 49. Non-Medically Necessary Services

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

#### 50. Nutritional Support

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

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

#### 51. Off label use

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

#### 52. Personal Care, Comfort or Convenience Items

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

#### 53. Private Duty Nursing

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

#### 54. Prosthetics Devices

- a) Services covered under any other benefit
- b) Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace.

- c) Trusses, corsets, and other support items.
  - d) Repair and replacement due to loss, misuse, abuse or theft
  - e) Communication aids
55. Residential accommodations  
Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:
- a) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
  - b) Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
  - c) Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
  - d) Wilderness camps.
56. Riot  
Services and supplies that you receive from providers as a result of an injury from your "participation in a riot". This means when you take part in a riot in any way such as inciting, or conspiring to incite, the riot. It does not include actions that you take in self-defense as long as they are not against people who are trying to restore law and order.
57. Routine Physicals  
Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.
58. Sexual Dysfunction and Enhancement  
Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
- a) Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ.
  - b) Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services. Not eligible for coverage are prescription drugs in 60 day supplies.
59. Stand-By Charges  
Stand-by charges of a Doctor or other Provider.
60. Surrogate Mother Services  
Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
61. Temporomandibular Joint Dysfunction Treatment (TMJ) and Craniomandibular Joint Dysfunction Treatment (CMJ)
- a) Dental implants
62. Travel Costs  
Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
63. Vein Treatment  
Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

#### 64. Vision Services

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

#### Adult Vision Care

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

#### Adult Vision Care Services and Supplies

Your plan does not cover adult vision care services and supplies, except as described in the Benefits/coverage (what is covered) section.

- a) Special supplies such as non-prescription sunglasses
  - b) Special vision procedures, such as orthoptics or vision therapy.
  - c) Eye exams during your stay in a hospital or other facility for health care.
  - d) Eye exams for contact lenses or their fitting.
  - e) Eyeglasses or duplicate or spare eyeglasses or lenses or frames.
  - f) Replacement of lenses or frames that are lost or stolen or broken.
  - g) Acuity tests.
  - h) Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures.
  - i) Services to treat errors of refraction.
65. Waived Cost-Shares Out-of-Network  
For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.
66. Weight Loss Programs  
Programs, whether or not under medical supervision, unless listed as covered in this Booklet.  
This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

67. Weight Loss Surgery

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

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

- a) Administration Charges - Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
  - b) Charges Not Supported by Medical Records - Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
  - c) Clinically-Equivalent Alternatives - Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at [www.anthem.com](http://www.anthem.com).
  - d) Compound Drugs - Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
  - e) Contrary to Approved Medical and Professional Standards - Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
  - f) Delivery Charges - Charges for delivery of Prescription Drugs.
  - g) Drugs Given at the Provider's Office / Facility - Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
  - h) Drugs Not on the Anthem Prescription Drug List (a formulary) - You can get a copy of the list by calling us or visiting our website at [www.anthem.com](http://www.anthem.com). If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to "Prescription Drug List" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception.
  - i) Drugs Over Quantity or Age Limits - Drugs which are over any quantity or age limits set by the Plan or us.
  - j) Drugs Over the Quantity Prescribed or Refills After One Year - Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
  - k) Drugs Prescribed by Providers Lacking Qualifications/ Registrations/ Certifications - Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by Anthem.
  - l) Drugs That Do Not Need a Prescription - Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
  - m) Family Members - Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
  - n) {Option to remove: [Gene Therapy - Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.]}
  - o) Infertility Drugs - Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT), except as listed in this booklet.
  - p) Items Covered as Durable Medical Equipment (DME) - Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.
  - q) Items Covered Under the "Allergy Services" Benefit - Allergy desensitization products or allergy serum. While not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.
  - r) Lost or Stolen Drugs - Refills of lost or stolen Drugs.
  - s) Mail Order Providers other than the PBM's Home Delivery Mail Order Provider - Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
  - t) Non-approved Drugs - Drugs not approved by the FDA.
  - u) Non-Medically Necessary Services - Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
  - v) Nutritional or Dietary Supplements - Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
  - w) Off label use - Off label use, unless we must cover the use by law or if we, or the PBM, approve it.
  - x) Onychomycosis Drugs - Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
  - y) Over-the-Counter Items - Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product may not be covered, even if written as a Prescription. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
69. This Exclusion does not apply to over-the-counter products that we must cover as a "Preventive Care" benefit under federal law with a Prescription.
- a) Sexual Dysfunction Drugs - Drugs to treat sexual or erectile problems.
  - b) Syringes - Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
  - c) Weight Loss Drugs - Any Drug mainly used for weight loss.



# Access help in your language

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

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

## Arabic

تادخ مقرب لصلتا. إن اناجم لتغلب تدعاسل او تداول عمل اذه ىلع لوصول ال لكل قحي تدعاسل لكب تصاخلا (TTY/TDD: 711) فيرعتلا قاطب ىلع دوجوملا ءاضعلا

## Armenian

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

## Chinese

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

## French

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

## Haitian

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

## Italian

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

## Japanese

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

## Korean

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

## Navajo

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

## 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 ਮੁਫਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

## Russian

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

## Spanish

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

## Tagalog

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

## Vietnamese

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

## It 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  
<https://student.anthem.com/student/schools/cub>



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