2020-2021

Regis University

Student Health Insurance Plan

www.anthem.com/studentadvantage

Anthem Student Advantage

Keeping you at your personal best

A00388COMENABS 09/20

Anthem | STUDENT ADVANTAGE

Important notice

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

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Welcome to Anthem Student Advantage

As your new school year begins, it's important to understand your health care benefits and how they work.

Your Anthem Student Advantage plan can help keep you at your personal best. This book will guide you through your plan benefits, with information about who is eligible, what is covered, how to access the right type of care when you need it, and more.

What you need to know about Anthem Student Advantage

Who is eligible?

Eligibility

All students taking 6 or more credit hours, who are enrolled at Regis University in the programs listed below, and who actively attend classes for at least the first 31 days, after the date when coverage becomes effective. Students not enrolled in these programs are ineligible for coverage.

Health insurance coverage is mandatory for the following students enrolled at Regis University:

- Traditional Undergraduate
- All international students regardless of major
- All students enrolled in College for Health Professions
- Undeclared Pre-Nursing Traditional
- Bachelor of Science in Nursing Accelerated
- Bachelor of Science in Nursing Traditional
- Bachelor of Science in Nursing CHOICE
- Bachelor of Science in Nursing Worksite
- MS: Biomedical Sciences
- MS: Nursing, Family Nurse Practitioner
- MS: Nursing, Family Nurse Practitioner Certificate
- MS: Nursing, Neonatal Nurse Practitioner
- MS: Nursing, Neonatal Nurse Practitioner Certificate
- Doctor of Physical Therapy
- Doctor of Pharmacy
- Doctor of Nursing Practice

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. If the eligibility requirements are not met, Anthem's only obligation is to refund the premium.

Enrollment

Eligible students must submit a Waiver Form by the specified deadline dates listed below in the Coverage Period section of this document. Unless students have specifically waived by providing proof of coverage with another plan, all eligible students at Regis University taking 6 or more credit hours will automatically be enrolled on the Student Health Insurance Plan if no waiver was received. There is no voluntary enrollment available for students who are not enrolled in one of the Regis programs listed above. All eligible students MUST complete a waiver annually and provide proof of current insurance coverage. To waive coverage online:

1. Go to gallagherstudent.com/RU.
2. On the left toolbar, click 'Student Waive/Enroll'.
3. Log in by following the instructions on the website (if you haven't already).
4. Click the 'I want to Enroll/Waive' button.
5. Follow the instructions to complete the form.
6. Print or write down your reference number. Receipt of this number only confirms submission, not acceptance, of your form.

Waiver submissions may be audited by Regis University, Anthem, and/or Gallagher Student Health & Special Risk. You may be required to provide, upon request, any coverage documents and/or other records demonstrating that you meet the school's requirements for waiving the student health insurance plan. By submitting the waiver request, you agree that your current insurance plan may be contacted for confirmation that your coverage is in force for the applicable Policy Year and that it meets the school's waiver requirements.

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

The rates below include an administrative fee as well as emergency travel services provided by GeoBlue.

Students rates	Annual 08/13/2020 through 08/19/2021	Fall semester 08/13/2020 through 12/31/2020	Spring/Summer semester 01/01/2021 through 08/19/2021	Accelerated Nursing 05/04/2021 through 08/19/2021
Undergraduate	$2,647	$1,061	$1,586	$729
Graduate	$3,995	$1,582	$2,413	$1,102

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

Important dates for the coverage period

Open enrollment

- **Annual:** September 8, 2020
- **Spring/Summer:** January 22, 2021

Waiver deadlines

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

Annual: September 8, 2020
Spring/Summer: January 22, 2021

If you have **questions about enrollment and waiver options,** visit gallagherstudent.com/RU or call 1-833-255-0742 .

Keep in touch with your benefits information

Student Health Services

Location:
Coors Life Directions Center (F-12)

Academic Year Hours:
Monday–Friday
7:30 a.m. – 5 p.m.

Summer Hours:
Monday–Friday
8:30 a.m. – 5 p.m.
Closed for lunch from 12-1 p.m.

Contact Us:
Phone: 1-303-458-3558
Email: rushs@regis.edu

Claims and coverage

1-844-412-0752
Anthem Blue Cross and Blue Shield
PO Box 5747
Denver, CO 80217

Eligibility and Enrollment

Gallagher Student Health & Special Risk
500 Victory Road
Quincy, MA 02171
1-833-255-0742
gallagherstudent.com/RU

Your Student Health Services

Regis University Student Health Services

Student Health Services offers students coordinated health care services, provides routine ambulatory medical care, GYN services, treats minor emergencies, prescribes medication and makes medical referrals. Students on the Regis University Student Health Insurance Plan in need of medical care should, except in the case of a medical emergency, consider first seeking treatment at Regis University Student Health Services.

Students in the Traditional Undergraduate, Undeclared Pre-Nursing Traditional, Bachelor of Science in Nursing Accelerated, Bachelor of Science in Nursing Traditional, Bachelor of Science in Nursing CHOICE, Doctor of Pharmacy, and Doctor of Physical Therapy and MS Biomedical Sciences programs may utilize Student Health Services.

Easy access to care

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

Sydney Health app

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

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

Access the Sydney Health app

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

LiveHealth Online

From your mobile device or computer with a webcam, you can use LiveHealth Online to visit with a board-certified doctor, psychiatrist or licensed therapist through live video.[2] To use, go to your Sydney Health app or **www.livehealthonline.com**. You can also download the free LiveHealth Online app to sign up.

24/7 NurseLine

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

Provider finder

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

Anthem Student Advantage Regis University website

Use **www.anthem.com/studentadvantage** to see your health plan information, including providers, benefits, claims, covered drugs and more.

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

Gallagher Student Health & Special Risk complements

Exclusively from Gallagher Student Health & Special Risk, the following menu of products is provided to all students currently enrolled in this plan. For more information on all of the products & services listed below, visit your school's page at gallagherstudent.com/RU under the "Discounts and Wellness" tab.

EyeMed Vision Care

The discount vision plan is available through EyeMed Vision Care. EyeMed's provider network offers access to over 45,000 independent providers and retail stores nationwide, including LensCrafters, Sears Optical, Target Optical, JC Penney Optical, and most Pearle Vision locations. You can purchase prescription eyeglasses, conventional contact lenses or even non-prescription sunglasses at savings between 15% and 45% off regular retail pricing. In addition, you can receive discounts off laser correction surgery at some of the nation's most highly-qualified laser correction surgeons. You can take advantage of the savings immediately using your EyeMed ID card, which can be printed from the "Discounts and Wellness" tab on your school's page at gallagherstudent.com/RU.

Basix Dental Savings

Maintaining good health extends to taking care of your teeth, gums and mouth. The Basix Dental Savings program provides a wide range of dental services at reduced costs for students enrolled in a Gallagher Student Health & Special Risk Insurance plan. It is important to understand the Dental Savings Program is not dental insurance. Basix contracts with dentists that agree to charge a negotiated fee to students covered under the Gallagher Student Health & Special Risk plan.

Savings vary but can be as high as 50% depending upon the type of service received and the contracted dentist providing the service. To use the program, simply:

- Find a contracted dentist from the Basix website.
- Make an appointment with a contracted dentist — be sure to tell the dental office that you have access to the Basix Dental Savings program. You do not need a separate identification card for the Basix program, but you will need to show your student health insurance ID card to confirm your eligibility.
- Payment must be made at the time of service in order to receive the negotiated rate. Full details of the program including lists of contracted dentists and fee schedules can found at basixstudent.com.

Your summary of benefits

Anthem Blue Cross and Blue Shield

Student health insurance plan:
Regis University

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.

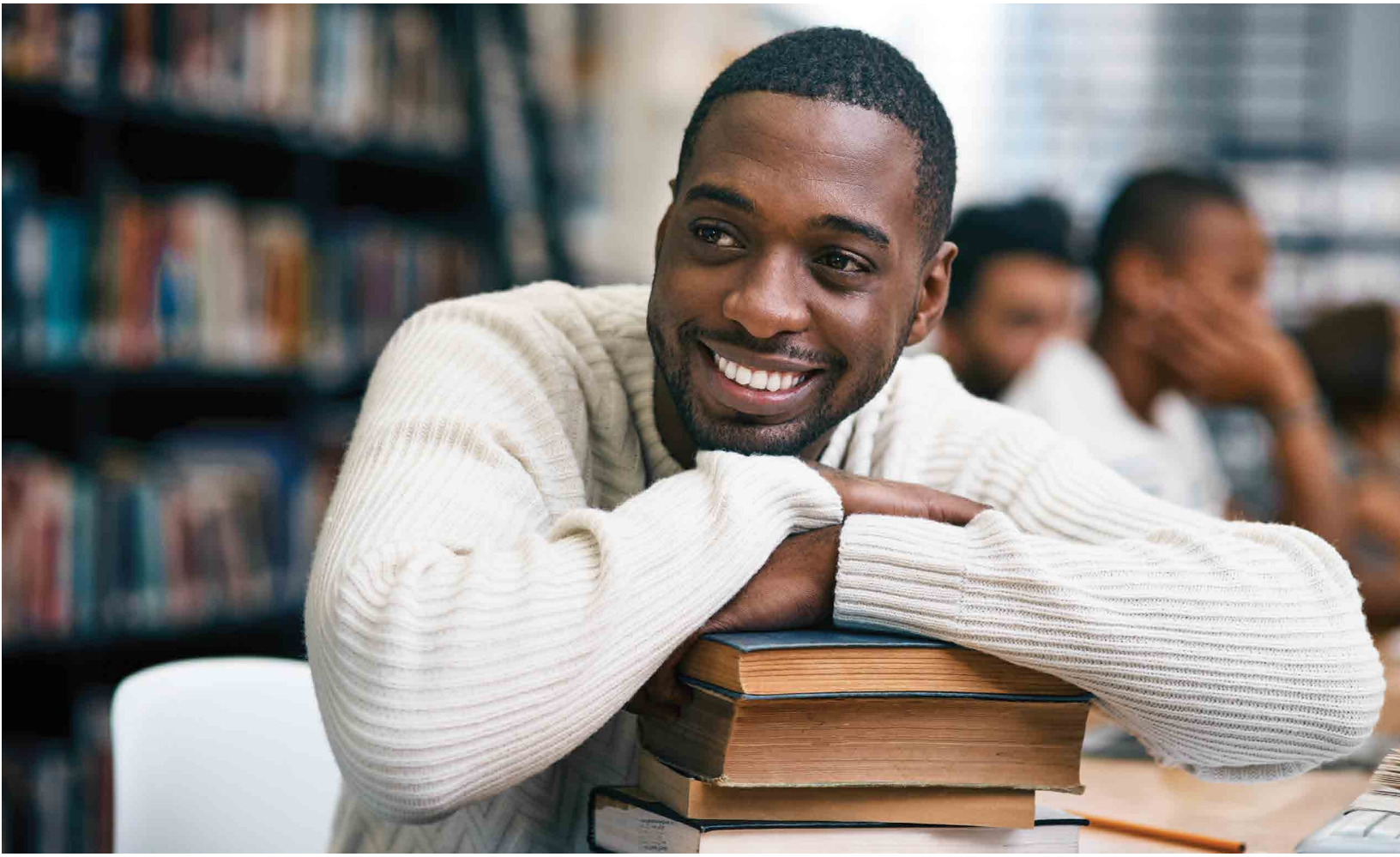
Medical

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible		
See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.	$500	$1,000
Out-of-Pocket Limit		
When you meet your out-of-pocket limit, you will no longer have to pay cost- shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.	$6,000	$6,000
Preventive care/screening/immunization		
Deductible does not apply to In-Network	0% coinsurance	0% coinsurance
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness *Deductible does not apply*	$20 copay per visit 0% coinsurance	20% coinsurance
Specialist Care Office Visit *Deductible does not apply*	$20 copay per visit 0% coinsurance	20% coinsurance
Prenatal and Post-natal Care	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Other Practitioner Visits:		
Retail Health Clinic *Deductible does not apply*	$20 copay per visit 0% coinsurance	$40 copay per visit 0% coinsurance
On-line Visit *Includes Mental/Behavioral Health and Substance Abuse. Live Health Online is the preferred telehealth solution. Deductible does not apply.*	$20 copay per visit 0% coinsurance	$40 copay per visit 0% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Chiropractic	20% coinsurance	40% coinsuranc
Acupuncture	20% coinsurance	40% coinsuranc
Other Services in an Office:		
Allergy Testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Chemo/Radiation Therapy	20% coinsurance	40% coinsurance
Hemodialysis	20% coinsurance	40% coinsurance
Diagnostic Services Lab:		
Office	20% coinsurance	40% coinsurance
Freestanding Lab/Reference Lab	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
X-Ray:		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Emergency and Urgent Care		
Urgent Care (Office Setting) *Deductible does not apply*	$50 copay per visit, 20% coinsurance	$75 copay per visit, 40% coinsurance
Emergency Room Facility Services *Deductible does not apply* *Emergency Room copay is waived if directly admitted to the hospital.*	$200 copay per visit, 20% coinsurance	Covered as In-Network
Emergency Room Doctor and Other Services *Deductible does not apply* *Emergency Room copay is waived if directly admitted to the hospital.*	$200 copay per visit, 20% coinsurance	Covered as In-Network
Ambulance (Air and Ground) *Non-emergency, Non-Network ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	20% coinsurance	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$20 copay per visit, 0 coinsurance	$40 copay per visit, 0% coinsurance
Facility visit:		
Facility Fees	20% coinsurance	40% coinsurance
Doctor Services	20% coinsurance	40% coinsurance
Outpatient Surgery Facility Fees:		
Hospital	20% coinsurance	40% coinsurance
Freestanding Surgical Center	20% coinsurance	40% coinsurance
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board)	$50 copay per visit, 20% coinsurance	$100 copay per visit, 40% coinsurance
Doctor and other services	20% coinsurance	40% coinsurance
Preadmission Testing	20% coinsurance	40% coinsurance
Recovery & Rehabilitation		
Home Health Care	20% coinsurance	40% coinsurance
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Habilitation services (for example, physical/speech/occupational therapy):		
Office	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Cardiac rehabilitation		
Office	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Skilled Nursing Care (in a facility)		
	$50 copay per visit, 0% coinsurance	$100 copay per visit, 40% coinsurance
Hospice		
	20% coinsurance	40% coinsurance
Durable Medical Equipment		
Coverage for hearing aids services is limited to 1 item per ear every 48 months. Covered for children 18 years of age or under. Limit is combined In-Network and Non-Network across all settings. Coverage is limited to $3,000 per hearing aid.	20% coinsurance	40% coinsurance
Prosthetic Devices		
	20% coinsurance	40% coinsurance



Pharmacy

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *Traditional Open Formulary List* *This product has a 90-day Retail Pharmacy Network available.* *A 90-day supply is available at most retail pharmacies.*		
Tier 1 - Typically Lower Cost Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$15 copay per prescription	$15 copay per prescription 20% coinsurance
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$45 copay per prescription	$45 copay per prescription 20% coinsurance
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$75 copay per prescription	$75 copay per prescription 20% coinsurance

Dental

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's dental services count towards your out of pocket limit.		
Children's Dental Essential Health Benefits		
Diagnostic and preventive *Coverage for In-Network providers and Out-of-Network Providers combined is limited to 2 visits per benefit period.*	No charge	Same as In-Network
Basic services	20% coinsurance	20% coinsurance
Major services/Prosthodontic	50% coinsurance	50% coinsurance
Cosmetic Orthodontia	Not Covered	Not Covered
Medically Necessary Orthodontia	50% coinsurance	50% coinsurance
Deductible	No deductible	No deductible
Adult Dental	Not covered	Not covered

Vision

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for student's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail.		
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	$0	$0
Vision exam *Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Frames *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $45
Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$25 reimbursement for Single, $45 reimbursement for bifocal and $55 reimbursement for trifocal vision lens
Single vision lenses		
Bifocal lenses		
Trifocal lenses		
Lenticular lenses		
Progressive lenses (standard, premium, select, ultra)		
Transitions Lenses		
Standard polycarbonate		
Factory Scratch Coating		
Elective contact lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $60
Non-Elective Contact Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $210
Adult Vision (age 19 and older)		
Adult Vision Coverage		
Limited to certain vision screenings required by Federal law and covered under the "Preventive Care" benefit.	See "Preventive Care" benefit	See "Preventive Care" benefit

Benefits that go with you

You are covered for emergency health situations when travelling abroad. With our 24/7 help center and international network of doctor advisors, you have the right support and services when you need them through GeoBlue®.

In a medical emergency:

1. Go immediately to the nearest doctor or hospital.

2. Call us at **1-833-511-4763**. The GeoBlue Global Health & Safety Team will contact the doctor treating you and closely monitor your situation to decide whether a medical evacuation is needed. When you call, have this information ready:

   - Your name
   - Details of the emergency
   - The name and contact information of the doctor and/or the hospital treating you
   - The ID number on the front of your member ID card
   - The name of your health coverage program: **Anthem Student Advantage**
   - Your specific location, using GPS if it is available

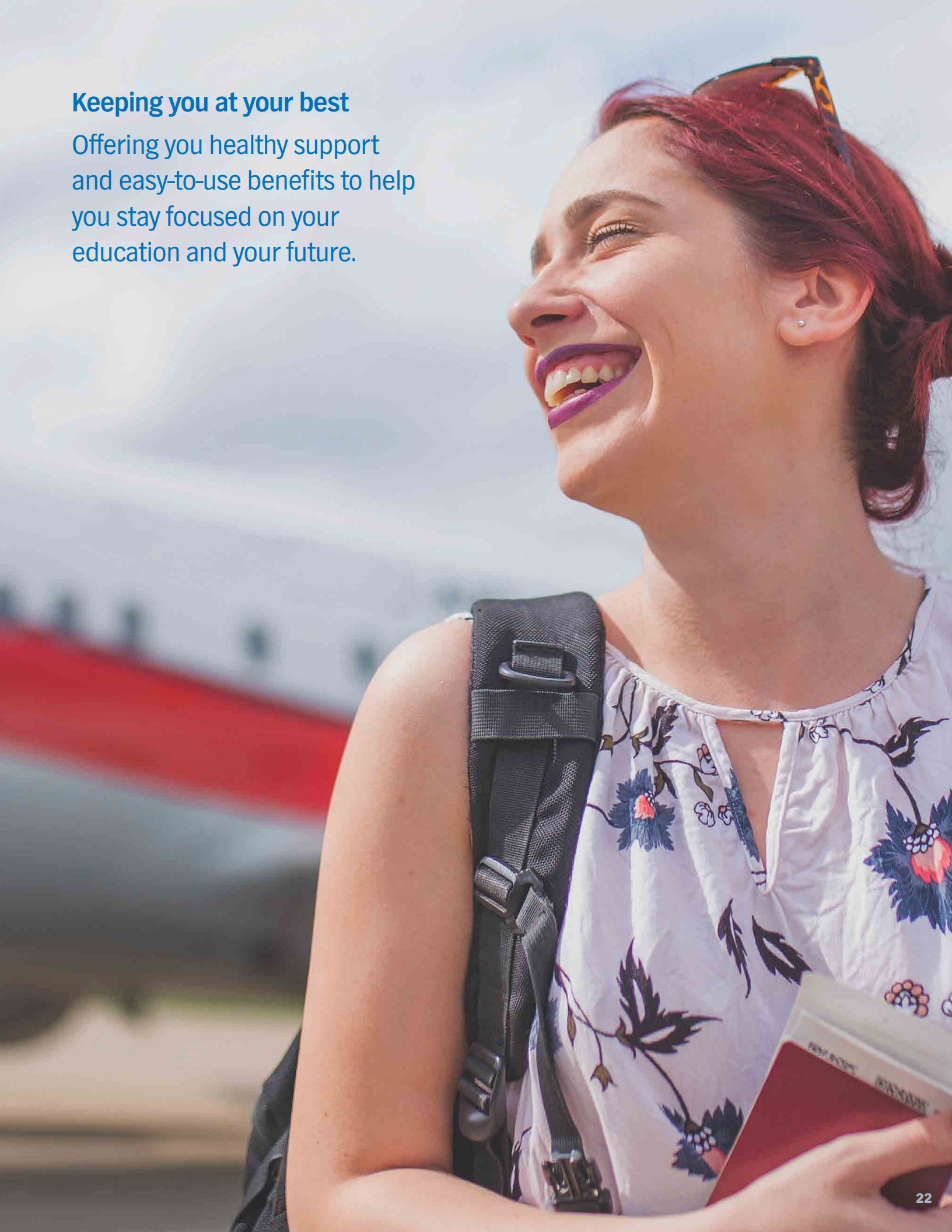
Your GeoBlue benefits	
Emergency medical evacuation	Unlimited
Repatriation of remains	Unlimited
Emergency family travel arrangements	Maximum benefit up to $5,000 per coverage year
Political emergency and natural disaster evacuation *(Available only when traveling outside the U.S.)*	Covered 100% up to $100,000 per person. Subject to a combined $5,000,000 limit per any one covered event for all people covered under the plan.
Accidental death and dismemberment	Maximum benefit up to $10,000 per coverage year

Use of benefits must be coordinated and approved by GeoBlue.

GeoBlue®

Keeping you at your best

Offering you healthy support and easy-to-use benefits to help you stay focused on your education and your future.



Notes

- This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits. This summary of benefits, as updated, is subject to the approval of the Colorado Department of Insurance.
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and Colorado laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual out-of-pocket maximums include deductible, copays, coinsurance and prescription drug.
- In-network and out-of-network deductible and out-of-pocket maximum are exclusive of each other.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (for example, X-ray, lab, surgery), after any applicable deductible.
- Preventive care services include physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For medical emergency care rendered by a non-participating provider or non-contracting hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- If your plan includes out-of-network benefit and you use a out-of-network provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- Non-emergency, out-of-network air ambulance services are limited to Anthem maximum payment of $50,000 per trip.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
- Human organ and tissues transplants require precertification and are covered as any other service in your summary of benefits.
- The family deductible and out-of-pocket maximum are embedded indicating the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; additionally, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- All medical and pharmacy deductibles, copayments and coinsurance apply to the out of pocket maximum.
- Additional visits may be authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- If your plan includes out-of-network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.

- Respite care limited to five consecutive days per admission.
- Freestanding lab and radiology center is defined as services received in a non-hospital based facility.
- Coordination of benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense.
- Supply limits for certain drugs may be different; go to Anthem's website or call Customer Service.
- Certain drugs require preauthorization approval to obtain coverage.
- This plan includes custom benefits that may supersede some of the information included in the limitations and exclusions list provided here. Please see your EOC for full details on your covered benefits.

Exclusions

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

1. **Acts of War, Disasters, or Nuclear Accidents**
   In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.
   Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.
2. **Administrative Charges**
   a) Charges to complete claim forms,
   b) Charges to get medical records or reports,
   c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
3. **Alternative / Complementary Medicine**
   Services or supplies for alternative or complementary medicine, regardless of the Provider rendering such services or supplies.This includes, but is not limited to:
   a) Holistic medicine,
   b) Homeopathic medicine,
   c) Hypnosis,
   d) Aroma therapy,
   e) Reiki therapy,
   f) Herbal, vitamin or dietary products or therapies,
   g) Naturopathy,
   h) Thermography,
   i) Orthomolecular therapy,
   j) Contact reflex analysis,
   k) Bioenergial synchronization technique (BEST),
   l) Iridology-study of the iris,
   m) Auditory integration therapy (AIT),
   n) Colonic irrigation,
   o) Magnetic innervation therapy,
   p) Electromagnetic therapy,
   q) Neurofeedback / Biofeedback.
4. **Applied Behavioral Treatment**
   (including, but not limited to, Applied Behavior Analysis and intensive behavior interventions) for all indications except as described under Autism Services.
5. **Before Effective Date or After Termination Date**
   Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
6. **Certain Providers**
   Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet, or which are not recognized by us as an eligible Provider under this Plan.
7. **Charges Over the Maximum Allowed Amount**
   Charges over the Maximum Allowed Amount for Covered Services, except as written in this Plan.
8. **Charges Not Supported by Medical Records**
   Charges for services not described in your medical records.
9. **Clinically-Equivalent Alternatives**
   Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.
10. **Collegiate Sports**
    Charges for services related to injuries or illness sustained while participating in, practicing for or, travelling to or from, an intercollegiate sport or competition. Additionally, Covered Services do not include expenses covered or eligible for coverage under any separate NCAA-sponsored or sanctioned insurance policy for student athletes.
11. **Complications of Non-Covered Services**
    Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.
12. **Cosmetic Services**
    Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).
13. **Court Ordered Testing**
    Court ordered testing or care unless the testing or care is Medically Necessary and otherwise a Covered Service under this Booklet.
14. **Crime**
    Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
15. **Custodial Care**
    Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
16. **Delivery Charges**
    Charges for delivery of Prescription Drugs.

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

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

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

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

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

20. **Educational Services**

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

21. **Experimental or Investigational Services**

    Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

    The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational.

22. **Eyeglasses and Contact Lenses**

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

23. **Eye Exercises**

    Orthoptics and vision therapy.

24. **Eye Surgery**

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

25. **Family Members**

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

26. **Foot Care**

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

27. **Foot Orthotics**

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

28. **Foot Surgery**

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

29. **Free Care**

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

30. **Hearing Aids**

    Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

31. **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.

32. **Infertility Treatment**

Infertility procedures not specified in this Booklet.

33. **Intractable Pain and/or Chronic Pain**

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

34. **Lost or Stolen Drugs**

Refills of lost or stolen Drugs.

35. **Maintenance Therapy**

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

36. **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.

37. **Medicare**

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

38. **Missed or Cancelled Appointments**

Charges for missed or cancelled appointments.

39. **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.

40. **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.

41. **Off label use**

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

42. **Oral Surgery**

Extraction of teeth, surgery for impacted teeth, jaw augmentation or reduction (orthognathic Surgery), and other oral surgeries to treat the teeth, jaw or bones and gums directly supporting the teeth, except as listed in this Booklet.

43. **Personal Care and Convenience**

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

44. **Private Duty Nursing**

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

45. **Prosthetics**

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

46. **Residential Accommodations**

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

47. **Services Received From Student Health Center**

Services covered or provided by the CSU Health Network if covered by the on campus benefits.

48. **Sexual Dysfunction**

Services or supplies for male or female sexual problems.

49. **Stand-By Charges**

Stand-by charges of a Doctor or other Provider.

50. **Sterilization**

Services to reverse an elective sterilization.

51. **Surrogate Mother Services**

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

52. **Temporomandibular Joint Treatment**

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

53. **Travel Costs**

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

54. **Vein Treatment**

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

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

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

57. **Weight Loss Programs**
    Programs, whether or not under medical supervision, unless listed as covered in this Booklet.
    This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

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

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

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

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

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

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

4. **Contrary to Approved Medical and Professional Standards**
   Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

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

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

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

8. **Drugs Over Quantity or Age Limits**
   Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.

9. **Drugs Over the Quantity Prescribed or Refills After One Year**
   Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.

10. **Drugs Prescribed by Providers Lacking Qualifications/Certifications**
    Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, including certifications, as determined by Anthem.

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

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

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

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

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

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

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

18. **Non-approved Drugs**
    Drugs not approved by the FDA.
19. **Off label use**
    Off label use, unless we must cover the use by law or if we, or the PBM, approve it.
20. **Onychomycosis Drugs**
    Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
21. **Over-the-Counter Items**
    Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
    This Exclusion does not apply to over-the-counter products that we must cover as a "Preventive Care" benefit under Federal law with a Prescription.
22. **Sexual Dysfunction Drugs**
    Drugs to treat sexual or erectile problems.
23. **Syringes**
    Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
24. **Weight Loss Drugs**
    Any Drug mainly used for weight loss.

Access help in your language

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

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

Arabic

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

Armenian

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

Chinese

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

Farsi

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

French

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

Haitian

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

Italian

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

Japanese

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

Korean

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

Navajo

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

Polish

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

Punjabi

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

Russian

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

Spanish

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

Tagalog

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

Vietnamese

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

It is important we treat you fairly

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

If you have questions, call 1-844-412-0752 or visit us at www.anthem.com/studentadvantage.

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