Medical Students

2021-2022

University of Missouri Columbia - Medical Students

Student Health Insurance Plan

https://student.anthem.com/student/schools/mizzou

Anthem Student Advantage

Keeping you at your personal best

121363XXMENXXX Rev. 06/21

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 student.anthem.com/student/schools/mizzou.

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Welcome to Anthem Student Advantage

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

What you need to know about Anthem Student Advantage

Who is eligible?

› Registered medical students attending classes or participating in an internship or other practical training program are eligible to enroll in the Plan.

Coverage is available for dependents too

If you are covered by Anthem Student Advantage through University of Missouri - Columbia, you may enroll your lawful spouse, domestic partner or dependent children under the age of 26.

Withdraw policy

If you withdraw from classes under a school-approved leave of absence, your coverage will remain for the end of the period for which payment has been received and no premiums will be refunded.

If you withdraw from classes other than under a school-approved leave of absence within 31 days after the policy effective date, you will be considered ineligible for coverage, your coverage will be terminated retroactively and any premiums collected will be refunded. If the withdrawal is more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which payment has been received and no premiums will be refunded.

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

Session	Enrollment Deadline	Student	Student & Spouse	Student & Child(ren)	Student, Spouse & Child(ren)
Fall 8/1/2021 - 12/31/2021	9/6/2021	$1,732	$3,444	$3,444	$5,156
Spring/Summer 1/1/2022 - 7/31/2022	2/7/2022	$2,392	$4,764	$4,764	$7,136
Summer 6/1/2022- 7/31/2022	6/5/2022	$859	$1,698	$1,698	$2,537

Rates and Benefits are pending Missouri Department of Insurance approval.

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

Enrollment

Enrollment

Please visit **https://medicine.missouri.edu/education/medical-insurance** for instructions on how to enroll. You can enroll online using myZou. Please contact (**573) 882-3097** should you have an issue enrolling through myZou.

To enroll dependents, visit **student.anthem.com/student/schools/mizzou** and select **"Enroll"**. For enrollment questions please call, **1-833-332-0798**.

Keep in touch with your benefits information

Student Health Center

Address: 1020 Hitt St, 4th floor
Columbia, MO 65212
Phone: 573-882-7481
Email: umhsshc@health.missouri.edu
Website: studenthealth.missouri.edu/
Please call before going to the Student Health Center to schedule an appointment.

Claims, benefits, eligibility and enrollment

Anthem Blue Cross Blue Shield
Phone: 833-332-0798

Student Counseling Center

Address: 1020 Hitt St, 4th floor
Columbia, MO 65212
Phone: 573-882-6601
Website: counseling.missouri.edu/
If you are interested in therapy, call to schedulean initial evaluation.

The Counseling Center provides a range of services designed to help students navigate life challenges while in college.

Your Student Health Services

University of Missouri – Columbia Student Health Center (SHC) Services

Health Services

The student health insurance plan is designed to work with your campus student health center. The health center's services and location are ideal for students to seek care.

The University of Missouri – Student Health Center is the University's on-campus student health facility. The SHC is committed to providing quality care for all MU students. The SHC offers medical and psychiatric care, and behavioral health consultation services. Administered by the Division of Student Affairs, the SHC is staffed with licensed health professionals, including board certified primary care physicians, psychiatrists, nurse practitioners, psychologists and social workers.

Here are some of the services offered:

- Immunizations
- Health maintenance and physical exams
- Treatment of acute illnesses and injuries
- Treatment and coordination of care for chronic medical issues
- Men's and women's health exams
- Screenings for depression, anxiety and substance use
- Psychiatric assessment and treatment
- 24 hour nurse advice line

Please refer to the SHS website for details regarding services offered: **studenthealth.missouri.edu/primary-care/**

Easy access to care

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

Sydney Health app

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

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

Access the Sydney Health app

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

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 www.anthem.com/find-care/ to find the right doctor or facility close to where you are.

Anthem Student Advantage University of Missouri (Columbia) website

Use student.anthem.com/student/schools/mizzou 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.

Your summary of benefits

Anthem Blue Cross and Blue Shield

Student health insurance plan:
University of Missouri - Columbia

Your network:
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		
When the Deductible applies, you must pay it before benefits begin.	$400 per person	$800 per person
Out-of-Pocket Limit		
When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period.	$7,500 student / $15,000 family	Unlimited student / Unlimited family
Preventive care/screening/immunization		
In-network preventive care is not subject to deductible, if your plan has a deductible. Immunizations for children prior to their 6th birthday have No Cost Share for In-Network and Non-Network Charges. This applies to childhood immunizations only, not other preventive care.	No charge	30% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Office Visit to treat an injury or illness	$20 copay per visit; 20% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist Care Office Visit	$40 copay per visit; 20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	No charge	30% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$20 copay per visit; 20% coinsurance after deductible is met	50% coinsurance after deductible is met
Preferred On-line Visit *Medical*	$20 copay per visit; 20% coinsurance after deductible is met	50% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	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
Chiropractor Services *Coverage is limited to 26 visits per benefit period. Treatment beyond 26 visits may require precertification. Does not include manipulation by a professional provider other than a chiropractor.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.
Chemo/Radiation Therapy	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hemodialysis	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
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
X-Ray:		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$200 copay per visit; 20% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Emergency Ambulance (Air and Ground)	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Facility visit: Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees: Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board)	$200 copay per admission; 20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Care Visits *Coverage is unlimited per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for Occupational Rehabilitation services is unlimited visits per benefit period. Coverage for Physical Rehabilitation services is unlimited per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Occupational Rehabilitation services is unlimited visits per benefit period. Coverage for Physical Rehabilitation services is unlimited per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for Occupational Habilitation services is unlimited visits per benefit period. Coverage for Physical Habilitative services is unlimited per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Occupational Habilitation services is unlimited visits per benefit period. Coverage for Physical Habilitative services is unlimited per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

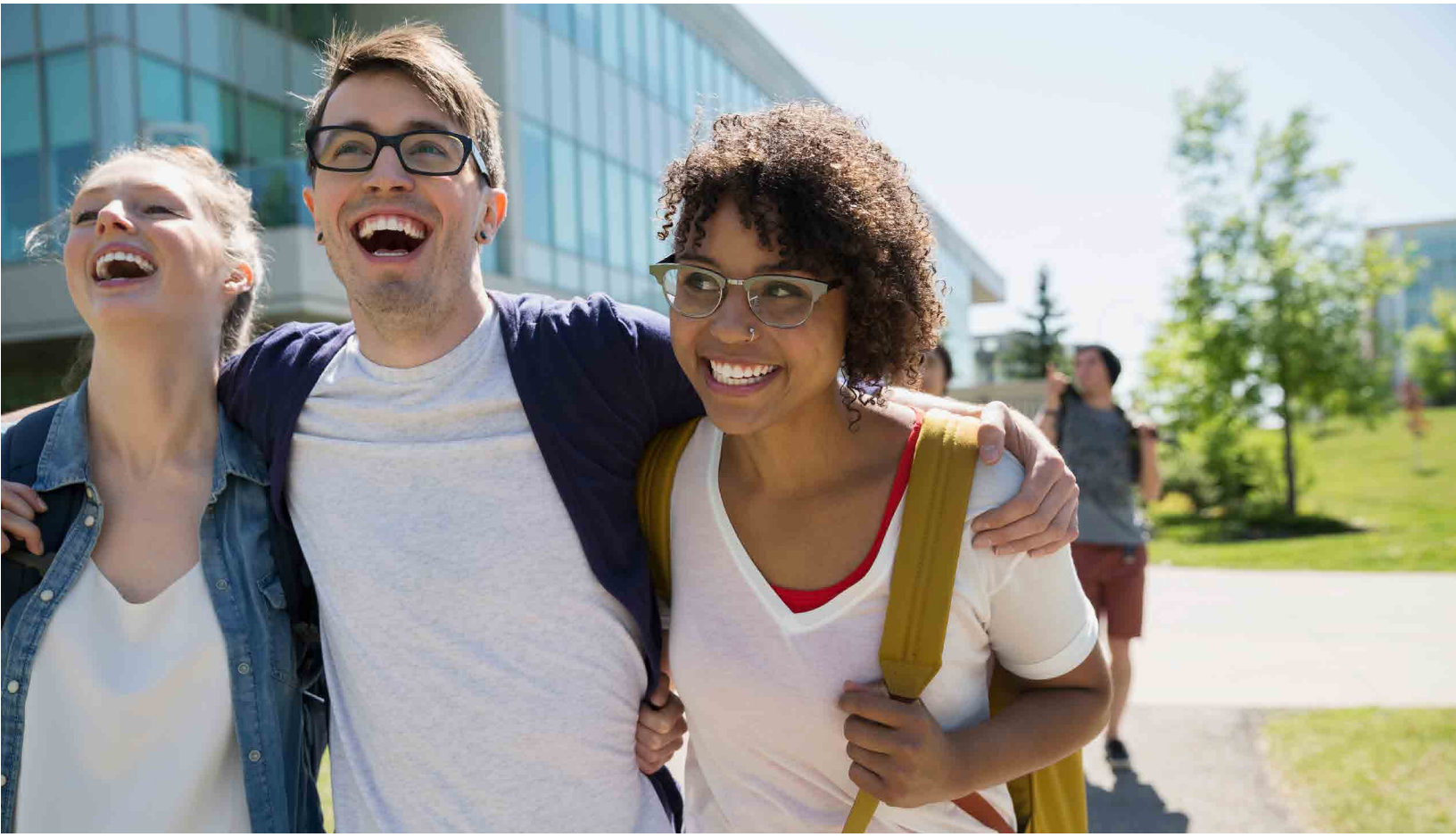
Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Cardiac rehabilitation		
Office Visit *Coverage is unlimited visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital *Coverage is unlimited visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Physical Medicine, Rehab & Skilled Nursing Facility unlimited per benefit period.*	$200 copay per admission; 20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for Wigs after cancer treatment is limited to one (1) per benefit period In-Network Providers and Out-of-Network Providers combined. Coverage for hearing aids services in each ear is limited to 1 unit every 36 months. Limit is combined In-Network and Out-of-Network.*	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	Not applicable	Not applicable
Prescription Drug Coverage *Traditional Drug List* *This product has a 30-day Retail Pharmacy Network available. A 30 day supply is available at most retail pharmacies.*		
Tier 1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.*	$15 copay per prescription (retail only). $30 copay per prescription (home delivery only).	$15 copay per prescription (retail only).
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.*	$40 copay per prescription (retail only). $80 copay per prescription (home delivery only).	$40 copay per prescription (retail only).
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.*	$65 copay per prescription (retail only). $130 copay per prescription (home delivery only).	$65 copay per prescription (retail only).
Tier 4 – Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program), No coverage for non-formulary drugs.*	$100 copay per prescription (retail only). $100 copay per prescription (home delivery only).	$100 copay per prescription (retail only).

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
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. Only children's vision services count towards your out of pocket limit.		
Children's Vision Essential Health Benefits (up to age 19) *Limited to covered persons under the age of 19.*		
Child Vision Deductible	$0	$0
Vision exam *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Frames *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $45
Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	$25 Reimbursement for Single, $45 Reimbursement for Bifocal, $55 Reimbursement for Trifocal Vision Lens and $70 for Lenticular lens
Elective contact lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $60
Non-Elective contact lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $210



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
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 (up to age 19) *Limited to covered persons under the age of 19.*		
Diagnostic and preventive *Includes cleanings, exams, x-rays, sealants, fluoride.*	No charge	No charge
Basic services *Includes filling and simple extractions*	20% coinsurance	20% coinsurance
Major services/Prosthodontic	50% coinsurance	50% coinsurance
Endodontic, Periodontics, Oral Surgery	50% coinsurance	50% coinsurance
Medically Necessary Orthodontia	50% coinsurance	50% coinsurance
Deductible	Not applicable	Not applicable

Benefits that go with you

You can count on medical coverage anywhere worldwide with GeoBlue.[1] Easily access international doctors by phone or video and use our 24/7 help center for emergency health questions. Anthem Student Advantage and GeoBlue provides the right support and services when you need them the most.

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

GeoBlue benefits for the 2021-2022 school year

Use of benefits must be coordinated and approved by GeoBlue.

International telemedicine services[2]	
Global TeleMD™	Confidential access to international doctors by telephone or video call.
Coverage outside the U.S., excluding student's home country.	
Medical Expenses	Maximum benefit up to $250,000 per coverage year, no deductibles or copays. Consult coverage certificate for benefit limitations and exclusions.[3]
Coverage worldwide except within 100 miles of primary residence for U.S. students. Coverage worldwide, excluding home country for international students.	
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 United States)[4]	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

GeoBlue

1 GeoBlue is the trade name of Worldwide Insurance Services, LLC (Worldwide Services Insurance Agency, LLC in California and New York), an independent licensee of the Blue Cross and Blue Shield Association. GeoBlue is the administrator of coverage provided under insurance policies issued by 4 Ever Life International Limited, Bermuda, an independent licensee of the Blue Cross Blue Shield Association. Coverage is not available in all states. Some restrictions apply.

2 Telemedicine services are provided by Teladoc Health, directly to members. GeoBlue assumes no liability and accepts no responsibility for information provided by Teladoc Health and the performance of the services by Teladoc Health. Support and information provided through this service does not confirm that any related treatment or additional support is covered under a member's health plan.

3 These medical expenses are limited and are subject to limitations and exclusions. See full certificate of insurance for a full description of services and coverage of what is and isn't covered.

4 The Political, Military and Natural Disaster Evacuation Services (PEND) are provided through Crisis24, an independent third party, non-affiliated service provider. Crisis24 does not supply Blue Cross or Blue Shield products or other benefits, and is therefore solely responsible for PEND and other collateral services it provides. GeoBlue makes no warranty, express or implied, and accepts no responsibility resulting from the provision or use of Crisis24 PEND or other Crisis24 services.

Designed with you in mind

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

Exclusions

Notes:

- Please reference the master policy for details.
- Exclusions and limitations apply.

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary.

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

1. **Abortion** Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery.

   This Exclusion does not apply to therapeutic abortions, which are abortions performed to save the life of the mother.

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, or release of nuclear energy.

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. **Aids for Non-verbal Communication** Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.

5. **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
   a. Acupuncture,
   b. Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body,
   c. Holistic medicine,
   d. Homeopathic medicine,
   e. Hypnosis,
   f. Aroma therapy,
   g. Massage and massage therapy,
   h. Reiki therapy,
   i. Herbal, vitamin or dietary products or therapies,
   j. Naturopathy,
   k. Thermography,
   l. Orthomolecular therapy,
   m. Contact reflex analysis,
   n. Bioenergial synchronization technique (BEST),
   o. Iridology-study of the iris,
   p. Auditory integration therapy (AIT),
   q. Colonic irrigation,
   r. Magnetic innervation therapy,
   s. Electromagnetic therapy

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 "What's Covered" section.

7. **Autopsies** Autopsies and post-mortem testing.

8. **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.

9. **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.

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

11. **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.

12. **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.

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

    If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

14. **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.

    This Exclusion does not apply to Emergency Services or problems resulting from Complications of Pregnancy.

15. **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.

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

    This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy (including reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance). It also does not apply to care and treatment necessary to correct birth defects and birth abnormalities.

17. **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.

18. **Crime** Treatment of an injury or illness that results from a felony you committed, or tried to commit, or treatment required because of your engagement in an illegal occupation. 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.

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

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

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

22. **Dental Devices for Snoring** Oral appliances for snoring.

23. **Dental Services**
    a. Dental Services for Members age 19 or older.
    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 Booklet).
    c. Services of anesthesiologists, unless required by law or listed as covered in the "Dental Services (All Members / All Ages)" section of this Booklet.
    d. Anesthesia Services (such as intravenous or non-intravenous conscious sedation or general anesthesia), are not covered when given separate from complex surgical services, except as required by law or when listed as covered in the "Dental Services (All Members / All Ages)" section of this Booklet.
    e. Analgesia, analgesia agents, oral sedation and anxiolysis nitrous oxide, unless listed as covered in the "Dental Services (All Members / All Ages)" section of this Booklet.
    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 the tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
    h. Case presentations and office visits.
    i. Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
    j. Enamel microabrasion and odontoplasty.
    k. Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.
    l. Biological tests for determination of periodontal disease or pathological agents, unless covered by the medical benefits of this Booklet.
    m. Collection of oral cytology samples via scraping of the oral mucosa, unless covered by the medical benefits of this Booklet.
    n. Separate services billed when they are an inherent component of another covered service.
    o. Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
    p. Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bars, stress breakers and precision attachments.
    q. Provisional splinting, temporary procedures or interim stabilization.
    r. Pulp vitality tests.
    s. Adjunctive diagnostic tests.
    t. Incomplete root canals.
    u. Cone beam images.
    v. Temporary anchorage devices.
    w. Sinus augmentation.
    x. Oral hygiene instructions.
    y. Repair or replacement of lost or broken appliances.
    z. Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials and the procedures used to prepare and place materials in the canals (tooth roots).
    aa. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
    bb. The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
    cc. Services to treat temporomandibular joint disorder (TMJ), unless covered by the medical benefits of this Booklet.
    dd. Athletic mouth guards.

24. **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.

25. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.

26. **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.

27. **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.

28. **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.

29. **Educational Services Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

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

31. **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.

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** 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.
37. **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.
38. **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
39. **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 you get from Workers Compensation, and services from free clinics.

    If your Group is not required to have Workers Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
40. **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
41. **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.
42. **Home Care**
    a. Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
    b. Food, housing, homemaker services and home delivered meals.
43. **Hospital Services Billed Separately** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.
44. **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).
45. **Infertility Treatment** Testing or treatment related to infertility.
46. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
47. **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to "Habilitative Services" as described in the "What's Covered" section.
48. **Medical Equipment, Devices, and Supplies**
    a. Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
    b. Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
    c. Non-Medically Necessary enhancements to standard equipment and devices.
    d. Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.
    e. Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section.]
49. **Medicare** For which benefits are payable under Medicare Parts A and/or B, except as required by law, as described in the section titled "Medicare" in "General Provisions".
50. **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
51. **Non-Approved Drugs** Drugs not approved by the FDA.
52. **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.
53. **53. 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.
54. **Nutritional Formulas or Dietary Supplements** Nutritional formulas 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.
55. **Off label use** Off label use, unless we must cover it by law or if we approve it.
56. **Personal Care, Convenience and Mobile/Wearable Devices**
    a. Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
    b. First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
    c. Home workout or therapy equipment, including treadmills and home gyms,
    d. Pools, whirlpools, spas, or hydrotherapy equipment.
    e. Hypo-allergenic pillows, mattresses, or waterbeds,

f. Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
g. Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

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

58. **Prosthetics** Prosthetics for sports or cosmetic purposes. This does not apply to breast prostheses (whether internal or external) after a mastectomy, as required by state and federal law.

59. **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.

60. **Routine Physicals and Immunizations** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Error! Reference source not found." benefit.

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

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

63. **Sport, Contest, or Competition** Injury sustained while:
    a) Participating in any intercollegiate or professional sport, contest or competition.
    b) Traveling to or from such sport, contest or competition as a participant.
    c) Participating in any practice or conditioning program for such sport, contest or competition.

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

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

66. **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).

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

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

69. **Vision Services**
    a. Vision services for Members age 19 or older, unless listed as covered in this Booklet.
    b. For safety glasses and accompanying frames.
    c. For two pairs of glasses in lieu of bifocals.
    d. Plano lenses (lenses that have no refractive power)
    e. Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
    f. Vision services not listed as covered in this Booklet.
    g. Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically stated as covered in this booklet.
    h. For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
    i. For Members through age 18, no benefits are available for frames or contact lenses not on the Anthem formulary.
    j. Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed provider.
    k. Blended lenses.

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

71. **Weight Loss Programs** 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.

72. **Weight Loss Surgery** Bariatric surgery performed for the purposes of weight loss, including revision of a prior bariatric surgery to a new procedure. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. With the exception of Emergency Services, complications of such procedures, directly related to bariatric surgery, that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Certificate. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure.

73. **Wilderness or other outdoor camps and/or programs.**

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 **1-833-332-0798**.

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

Arabic

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

Armenian

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

Chinese

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

Farsi

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

French

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

Haitian

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

Italian

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

Japanese

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

Korean

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

Navajo

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

Polish

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

Punjabi

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

Russian

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

Spanish

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

Tagalog

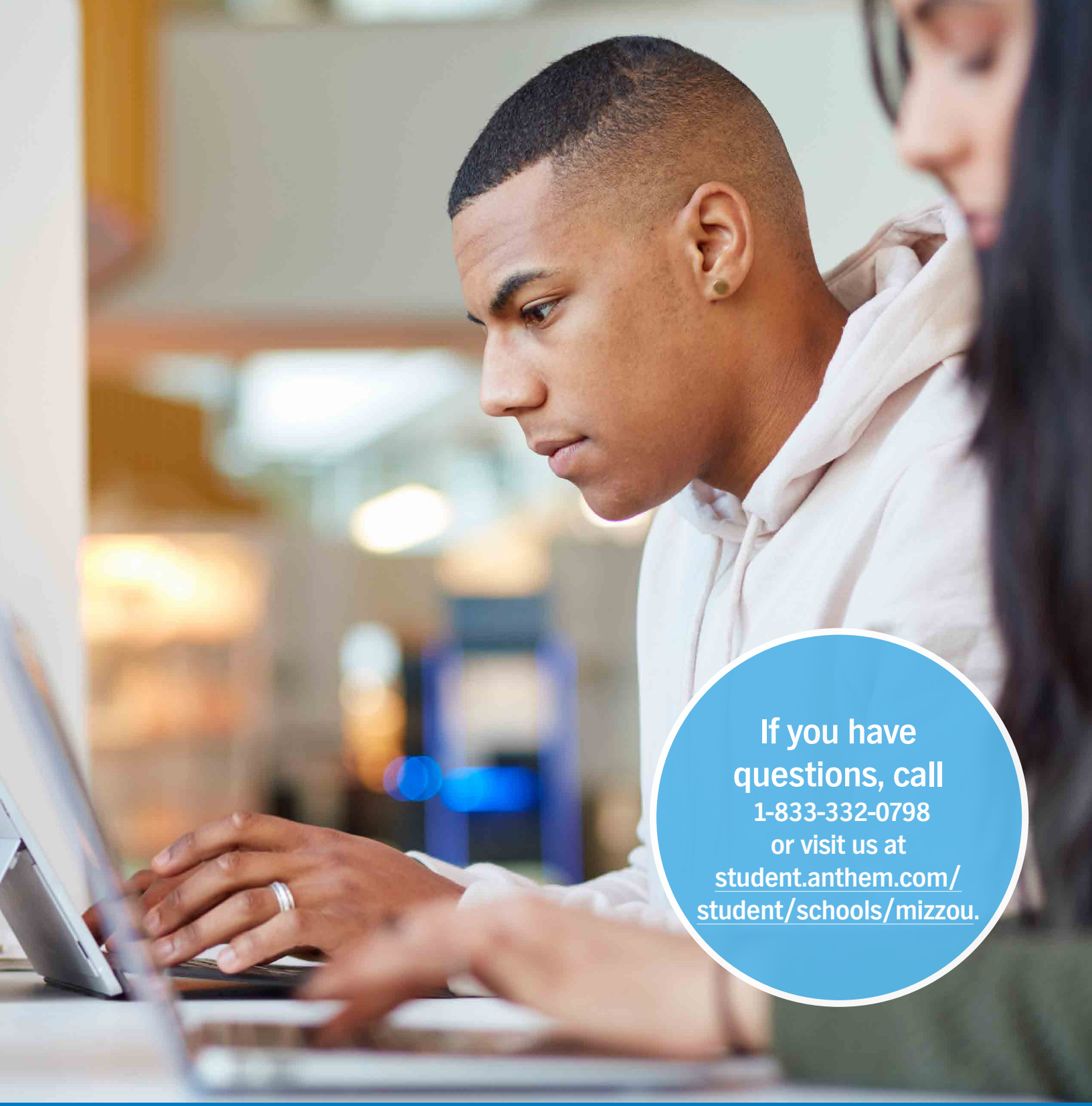
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Vietnamese

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

It is important we treat you fairly

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



Anthem | STUDENT ADVANTAGE

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://eoc.anthem.com/eocdps/SH08012021L02868. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (855) 330-1101 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$400**/person for In-Network Providers. **$800**/person for Out-of-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care for In-Network Providers. Tier 1, Tier 2, Tier 3, Tier 4 for Prescription Drugs for In-Network Providers. Pediatric vision for In-Network Providers. Pediatric dental for In-Network and Out-of-Network Providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$7,500**/person or **$15,000**/family for In-Network Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, PPO. See https://www.anthem.com/health-insurance/provider-directory/searchcriteria?planstat	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan

	e=MO&plantype=NETWORK&planname=Blue+Access or call (855) 330-1101 for a list of network providers.	pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit then 20% coinsurance	50% coinsurance	--------none--------
	Specialist visit	$40/visit then 20% coinsurance	50% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	30% coinsurance	Prescribed FDA approved contraceptives are not subject to cost-shares. Immunizations for children prior to their 6th birthday have no cost share for In-Network and Non-Network charges. Non-Network preventive care services for children prior to their 6th birthday have no deductible. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	Costs may vary by site of service. Includes coverage for Breast Tomosynthesis.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Costs may vary by site of service.
If you need drugs to treat your illness or condition	Tier 1 - Typically Generic	$15/prescription deductible does not apply (retail) and $30/prescription	$15/prescription deductible does not apply (retail)	*See Prescription Drug section

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/SH08012021L02868

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/ Traditional Drug List		deductible does not apply (home delivery)		
	Tier 2 - Typically Preferred / Brand	$40/prescription deductible does not apply (retail) and $80/prescription deductible does not apply (home delivery)	$40/prescription deductible does not apply (retail)	
	Tier 3 - Typically Non-Preferred / Specialty Drugs	$65/prescription deductible does not apply (retail) and $130/prescription deductible does not apply (home delivery)	$65/prescription deductible does not apply (retail)	
	Tier 4 - Typically Specialty (brand and generic)	$100/prescription deductible does not apply (retail) and $100/prescription deductible does not apply (home delivery)	$100/prescription deductible does not apply (retail)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Costs may vary by site of service.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	$200/visit then 20% coinsurance	Covered as In-Network	Copay waived if admitted. 20% coinsurance for Emergency Room Physician Fee
	Emergency medical transportation	20% coinsurance	Covered as In-Network	--------none--------
	Urgent care	20% coinsurance	50% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	$200/admission then 20% coinsurance	50% coinsurance	--------none--------
	Physician/surgeon fees	20% coinsurance	50% coinsurance	--------none--------
If you need mental health, behavioral health,	Outpatient services	Office Visit $20/visit then 20% coinsurance Other Outpatient	Office Visit 50% coinsurance Other Outpatient 50% coinsurance	Office Visit --------none-------- Other Outpatient --------none--------

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/SH08012021L02868

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
or substance abuse services		20% coinsurance		
	Inpatient services	$200/admission then 20% coinsurance	50% coinsurance	--------none--------
If you are pregnant	Office visits	No charge	30% coinsurance	In-Network preventive prenatal services are covered at 100%. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$200/admission then 20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	--------none--------
	Rehabilitation services	20% coinsurance	50% coinsurance	*See Therapy Services section
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	$200/admission then 20% coinsurance	50% coinsurance	150 days limit/benefit period.
	Durable medical equipment	20% coinsurance	50% coinsurance	--------none--------
	Hospice services	20% coinsurance	50% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	No charge	Reimbursed Up to $30.	*See Vision Services section
	Children's glasses	No charge	Reimbursed Up to $45.	
	Children's dental check-up	No charge	No charge	*See Dental Services section

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long- term care
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care 26 visits/benefit period.
- Hearing aids one hearing aid/ear every 36 months.
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/SH08012021L02868

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Missouri Department of Insurance, Consumer Complaints, P.O. Box 690, Jefferson City, MO 65102-0690, (800) 726-7390. Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

Missouri Department of Insurance, Consumer Complaints, P.O. Box 690, Jefferson City, MO 65102-0690, (800) 726-7390

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/SH08012021L02868

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$400
Specialist *copayment*	$40
Hospital (facility) *copayment*	$200
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,870**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$400
Specialist *copayment*	$40
Hospital (facility) *copayment*	$200
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$1,200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$400
Specialist *copayment*	$40
Hospital (facility) *copayment*	$200
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$10
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$910**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 330-1101

Amharic (አማርኛ)፦ ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 330-1101 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 330-1101.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 330-1101:

Bassa (Bàsɔ̀ɔ̀ Wùdù): Mˋ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nià kɛ dyí ní, ɔ mɔ̀ nì dyí-bèdɛ̀ìn-dɛ̀ bé m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (855) 330-1101.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 330-1101 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (855) 330-1101 သို့ ခေါ်ဆိုပါ။

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (855) 330-1101。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (855) 330-1101.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 330-1101.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 330-1101 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 330-1101.

Language Access Services:

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 330-1101.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 330-1101.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (855) 330-1101.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 330-1101.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (855) 330-1101 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855) 330-1101.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (855) 330-1101.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (855) 330-1101.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (855) 330-1101.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 330-1101

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 330-1101 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (855) 330-1101 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (855) 330-1101.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 330-1101 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (855) 330-1101.

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídíłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h íłínígóó. Ataʼ halneʼígíí łaʼ bichʼį́ʼ hadeesdzih nínízingo kojį́ʼ hodíílnih (855) 330-1101.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (855) 330-1101

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (855) 330-1101 bilbilla.

Pennsylvania Dutch (Deitsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (855) 330-1101 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (855) 330-1101.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (855) 330-1101.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 330-1101 ਤੇ ਕਾਲ ਕਰੋ।

Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (855) 330-1101.

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 330-1101.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ‘aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (855) 330-1101.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (855) 330-1101.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 330-1101.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (855) 330-1101.

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