2020-2021

University of Toledo
Student Health Insurance Plan

www.anthem.com/studentadvantage

Anthem Student Advantage
Keeping you at your personal best

A003210HMENABS 07/20

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?

- All domestic students taking 6 or more credit hours and all international students taking 1 or more credit hours will automatically be enrolled on the plan unless proof of comparable coverage is provided.
- Degree seeking domestic students taking less than 6 credit hours are eligible to enroll on the plan.
- Students enrolled on the plan are also able to enroll their eligible dependents.

Coverage is available for dependents too

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

- Log onto the myUT portal at myut.utoledo.edu/
- In your toolkit, go to "My Registration Steps"
- Choose the Student Health Insurance – Enroll or Waive link

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	Fall 8/11/2020-12/31/2020	Spring/Summer 1/1/2021-8/10/2021	Summer 5/17/2021-8/10/2021
Student	$911	$1,413	$548
Spouse/ Domestic Partner	$911	$1,413	$548
Each Child	$911	$1,413	$548
Two or More Dependents	$1,822	$2,826	$1,096

[1] Subject to filing approval by the Ohio Department of insurance.

Important dates for the coverage period

Open enrollment deadlines

- Fall: September 30, 2020
- Spring: January 31, 2021
- Summer: July 1, 2021

Waiver deadlines

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

- Fall: 9/30/2020
- Spring: 1/31/2021
- Summer: 7/1/2021*

If you have **questions about enrollment and waiver options,** please contact studenthealthinsurance@utoledo.edu or visit www.utoledo.edu/depts/hr/benefits/student/

*Summer enrollment/waiver only applies to newly enrolled students.

Keep in touch with your benefits information

Student Health Center

Health Sciences Campus
Ruppert Health Center, Room 0013
3125 Transverse Dr.
Toledo, OH 43614
1-419-383-5000
Fax: 1-419-383-2960

University of Toledo Main Campus
1675 West Rocket Dr.
Toledo, OH 43607
1-419-530-3451
Fax: 1-419-530-3499

Family Practice Center
3333 Glendale Ave.
Toledo, OH 43614
1-419-383-5555
Fax: 1-419-383-3113

Student Counseling Center

1735 West Rocket Drive
MS #512
Toledo, OH 43606
1-419-530-2426
www.utoledo.edu/studentaffairs/counseling/

Monday through Friday
8:15 a.m. to 5:00 p.m.

- Screenings
- Individual, couples, and group counseling, and psychotherapy
- Psychoeducational workshops
- Consultation with students, faculty/staff, and parents
- Crisis intervention
- Online screenings

Claims and coverage

1-844-412-0752
Anthem Blue Cross Life and Health Insurance Company
PO BOX 105187,
ATLANTA, GA 30348-5187

Benefits, eligibility and enrollment

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

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

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

Anthem Student Advantage University of Toledo website

Visit https://student.anthem.com/student/schools/utoledo 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 Toledo

Your network:
Blue Access PPO

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

Medical

Covered Medical Benefits	Cost if you use UTMC, UTP	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.*	$0 per covered person	$1,500 per covered person	$3,000 per covered person
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost- shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$7,900 student / $15,800 family	$7,900 student / $15,800 family	$7,900 student / $15,800 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 Out-of-Network Charges. This applies to childhood immunizations only, not other preventive care.*	No charge	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services			
Primary Care Visit to treat an injury or illness.	30% coinsurance after deductible is met	$10 copay per visit then 40% coinsurance after deductible is met	$15 copay per visit then 50% coinsurance after deductible is met
Specialist Care Visit	30% coinsurance after deductible is met	$20 copay per visit then 40% coinsurance after deductible is met	$30 copay per visit then 50% coinsurance after deductible is met
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:			
Retail Health Clinic	30% coinsurance after deductible is met	$20 copay per visit then 40% coinsurance after deductible is met	$30 copay per visit then 50% coinsurance after deductible is met
On-line Visit *Includes Mental/Behavioral Health and Substance Abuse Live Health Online is the preferred telehealth solution. (www.livehealthonline.com)*	30% coinsurance after deductible is met	$10 copay per visit then 40% coinsurance after deductible is met	$15 copay per visit then 50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use UTMC, UTP	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Chiropractic Services *Coverage is unlimited per benefit period. Applies to In- Network and Out-of-Network. Does not include manipulation by a professional provider other than a chiropractor.*	30% coinsurance after deductible is met	40% coinsurance after deductible is met for first	50% coinsurance after deductible is met
Acupuncture	Not covered	Not covered	Not covered
Other Services in an Office:			
Allergy Testing	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Hemodialysis	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs *For the drug itself dispensed in the office through infusion/injection.*	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services			
Lab:			
Office *Office Cost Share applies only when Freestanding/ Reference Labs are not used.*	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:			
Office	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):			
Office	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care			
Urgent Care	30% coinsurance after deductible is met	$30 copay per visit then 40% coinsurance after deductible is met	$45 copay per visit then 50% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted*	$250 copay per visit	$250 copay per visit	Covered as In- Network

Covered Medical Benefits	Cost if you use UTMC, UTP	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Emergency Room Doctor and Other Services	30% coinsurance deductible does not apply	30% coinsurance deductible does not apply	Covered as In- Network
Ambulance (Air and Ground)	30% coinsurance after deductible is met	30% coinsurance after deductible is met	Covered as In- Network
Outpatient Mental/Behavioral Health and Substance Abuse			
Doctor Office Visit	30% coinsurance after deductible is met	$10 copay per visit then 40% coinsurance after deductible is met	$15 copay per visit then 50% coinsurance after deductible is met
Facility visit:			
Facility Fees	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery Facility Fees:			
Hospital	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:			
Hospital	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	30% coinsurance after deductible is met	40% 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) *Physical Medicine, Rehab & Skilled Nursing Facility limited to 150 days combined per benefit period.*	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Recovery & Rehabilitation			
Home Care Visits *Coverage is limited to 100 visits per benefit period. Private Duty Nursing included with Home Health Care is limited to 90 visits per benefit period. Limit is combined In-Network and Out-of-Network. Benefit limit does not apply to Home Infusion Therapy. Limit does not apply to separate Physical or Occupational or Speech Therapy limits, when performed as part of Home Health.*	30% coinsurance after deductible is met	40% 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 per benefit period. Coverage for Physical Rehabilitation services is unlimited per benefit period. Limit is combined In- Network and Out-of-Network across all outpatient settings. Limit is combined across professional visits and outpatient facilities.*	30% coinsurance after deductible is met for first	40% coinsurance after deductible is met for first	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use UTMC, UTP	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital *Coverage for Occupational Rehabilitation services is unlimited per benefit period. Coverage for Physical Rehabilitation services is unlimited per benefit period. Limit is combined In- Network and Out-of-Network across all outpatient settings. Limit is combined across professional visits and outpatient facilities.*	30% coinsurance after deductible is met for first	40% coinsurance after deductible is met for first	50% coinsurance after deductible is met
Habilitation services (for example, physical/speech/ occupational therapy):			
Office *Coverage for Occupational Habilitation services is unlimited per benefit period. Coverage for Physical Habilitative services is unlimited per benefit period. Limit is combined In-Network and Out-of-Network across all outpatient settings. Limit is combined across professional visits and outpatient facilities..*	30% coinsurance after deductible is met for first	40% coinsurance after deductible is met for first	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Occupational Habilitation services is unlimited per benefit period. Coverage for Physical Habilitative services is unlimited per benefit period. Limit is combined In-Network and Out-of-Network across all outpatient settings. Limit is combined across professional visits and outpatient facilities.*	30% coinsurance after deductible is met for first	40% coinsurance after deductible is met for first	50% coinsurance after deductible is met
Cardiac rehabilitation			
Office *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Out-of-Network across all outpatient settings.*	30% coinsurance after deductible is met for first	40% coinsurance after deductible is met for first	50% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Out-of-Network across all outpatient settings.*	30% coinsurance after deductible is met for first	40% coinsurance after deductible is met for first	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Physical Medicine, Rehab & Skilled Nursing Facility limited to 90 days combined per benefit period. Limit is combined In-Network and Out-of- Network.*	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	30% coinsurance after deductible is met	40% 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. Newborn hearing aids no limit. Limit is combined In-Network and Out-of-Network.*	30% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met

Pharmacy

Covered Medical Benefits	Cost if you use UTMC, UTP	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Pharmacy Deductible	Not applicable	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *Traditional Open Drug List*			
Tier 1 - Typically Generic *Covers up to a 90 day supply (retail pharmacy). No coverage for non-formulary drugs.*	$5 copay per prescription	$10 copay per prescription and 40% coinsurance, deductible does not apply (retail)	$15 copay per prescription and 50% coinsurance, deductible does not apply (retail)
Tier 2 – Typically Preferred Brand *Covers up to a 90 day supply (retail pharmacy). No coverage for non-formulary drugs.*	$15 copay per prescription	$20 copay per prescription and 40% coinsurance, deductible does not apply (retail)	$30 copay per prescription and 50% coinsurance, deductible does not apply (retail)
Tier 3 - Typically Non-Preferred Brand *Covers up to a 90 day supply (retail pharmacy). No coverage for non-formulary drugs.*	$30 copay per prescription	$30 copay per prescription and 40% coinsurance, deductible does not apply (retail)	$60 copay per prescription and 50% coinsurance, deductible does not apply (retail)
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.*	$75 copay per prescription	Not covered	Not covered

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 *Includes cleanings, exams, x-rays, sealants, fluoride*	No charge	No charge
Basic services *Includes fillings and simple extractions*	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Major services/Prosthodontic	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Endodontic, Periodontics, Oral Surgery	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Medically Necessary Orthodontia	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Deductible	Not applicable	Not applicable
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 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.*		
Single Vision lenses	$0 copay	$0 copay (up to $25)
Bifocal lenses	$0 copay	$0 copay (up to $45)
Trifocal lenses	$0 copay	$0 copay (up to $55)
Lenticular lenses	$0 copay	$0 copay (up to $70)
Progressive lenses (standard, premium, select, ultra)	$0 copay	$0 copay (up to $40)
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 $120
Eyeglass Lens Enhancements *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.* *Transitions Lenses* *Standard polycarbonate* *Factory Scratch Coating*	No charge	No allowance when obtained out of network
Adult Vision (age 19 and older)		
Adult Vision Coverage	$0	$0
Vision exam *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

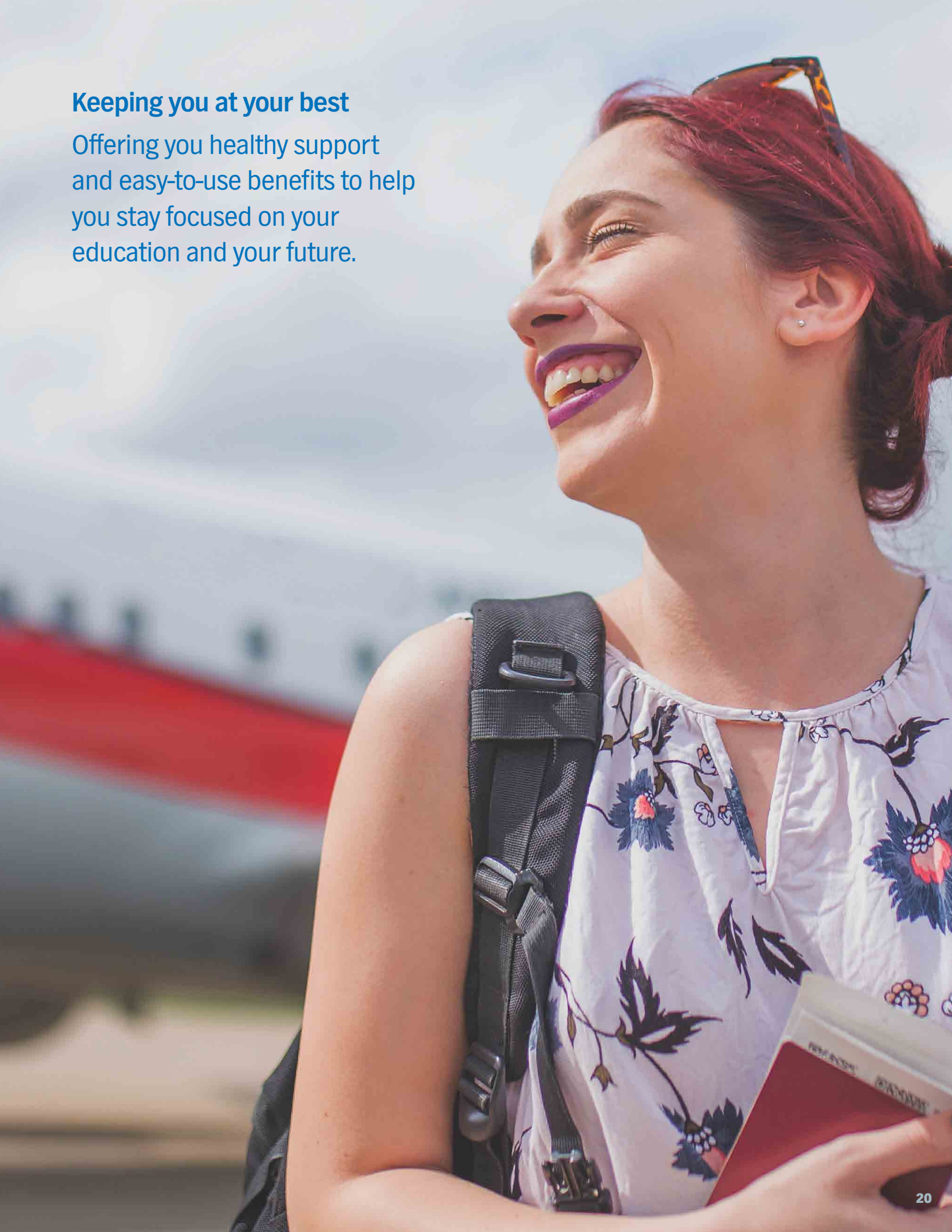
Your GeoBlue benefits	
Emergency medical evacuation	Unlimited
Repatriation of remains	Unlimited
Emergency family travel arrangements	Maximum benefit up to $5,000 per coverage year
Political emergency and natural disaster evacuation *(Available only when traveling outside the U.S.)*	Covered 100% up to $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.



Exclusions

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

We do not provide benefits for procedures, equipment, services, supplies or charges:

1. Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.
2. Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples of non-Covered Providers include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.
4. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
5. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
6. For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
7. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
8. For court ordered testing or care unless Medically Necessary.
9. For which you have no legal obligation to pay in the absence of this or like coverage.
10. For the following:
    a) Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member except as otherwise described in this Booklet.
    b) Surcharges for furnishing and/or receiving medical records and reports.
    c) Charges for doing research with Providers not directly responsible for your care.
    d) Charges that are not documented in Provider records.
    e) Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
    f) For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
11. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group. This exclusion does not apply to Covered Services that have not been exhausted and are not paid for by another source.
12. Prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
13. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
14. For missed or canceled appointments.
15. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.
16. 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, when you are eligible, We will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large Out-of-Pocket costs.
17. Charges in excess of Our Maximum Allowable Amounts.
18. Incurred prior to your Effective Date.
19. Incurred after the termination date of this coverage except as specified elsewhere in this Booklet.
20. For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Booklet. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.
21. For maintenance therapy, which is rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to "Habilitative Services" as described in the "What's Covered" section.
22. For Custodial Care, convalescent care or rest cures.

23. For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
    a) cleaning and soaking the feet.
    b) applying skin creams in order to maintain skin tone.
    c) other services that are performed when there is not a localized illness, injury or symptom involving the foot.
24. For foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.
25. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
26. For dental treatment, under the medical portion of this Plan, regardless of origin or cause, except as specified elsewhere in this Booklet. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to:
    a) extraction, restoration and replacement of teeth.
    b medical or surgical treatments of dental conditions.
    c) services to improve dental clinical outcomes.
    This exclusion does not apply to covered dental services for Members through age 18.
27. For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
28. For the following dental services:
    a) Dental care for members age 19 and older, unless covered by the medical benefits of this Certificate.
    b) For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a member receives the benefits in whole or in part. This exclusion also applies whether or not the member claims the benefits or compensation. It also applies whether or not the member recovers from any third party.
    c) Dental services or health care services not specifically covered under the Certificate (including any hospital charges, prescription drug charges and dental services or supplies that do not have an American Dental Association Procedure Code).
    d) For dental services received prior to the effective date of this Certificate or received after the coverage under this Certificate has ended.
    e) Anesthesia services, (such as intravenous or non-intravenous conscious sedation, analgesia, nitrous oxide, and general anesthesia) are not covered when given separate from a covered oral surgery service, except as required by law.
    f) Analgesia, analgesia agents, oral sedation and anxiolysis nitrous oxide.
    g) Services of anesthesiologist, unless required by law.
    h) Dental services given by someone other than a licensed provider (dentist or physician) or their employees.
    i) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
    j) Dental services provided by dentists 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.
    k) Case presentations, office visits.
    l) Enamel microabrasion and odontoplasty.
    m) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
    n) Provisional splinting.

    For the following dental services:
    a) Cone beam images.
    b) Anatomical crown exposure.
    c) Temporary anchorage devices.
    d) Sinus augmentation.
    e) Temporomandibular Joint Disorder (TMJ), unless covered by the medical benefits of this Certificate.
    f) Oral hygiene instructions.
    g) Repair or replacement of lost or broken appliances.
    h) Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials, nor the procedures used to prepare and place materials in the canals (tooth roots).
    i) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
    j) Separate services billed when they are an inherent component of another covered service.
    k) Dental services for which you would have no legal obligation to pay in the absence of this or like coverage.
    l) Additional treatment necessary to correct or relieve the results of treatment previously benefited under the Certificate.
    m) Biological tests for determination of periodontal disease or pathologic agents, unless covered by the medical benefits of this Certificate.
    n) Collection of oral cytology samples via scraping of the oral mucosa, unless covered by the medical benefits of this Certificate.
    o) Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannon satisfactorily restore the case.
    p) Pulp vitality tests.
    q) Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
    r) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
    s) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
    t) Oral appliances for snoring.
29. For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or as specified elsewhere in this Booklet. The only exceptions to this are for any of the following:
    a) transplant preparation.
    b) initiation of immunosuppresives.
    c) treatment related to an accidental injury, cancer or cleft palate.
30. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly except as specified elsewhere in this Booklet.

31. Weight loss programs whether or not they are pursued under medical or Physician supervision, unless specifically 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. This Exclusion does not apply to weight management programs required under federal law as part of the "Preventive Care" benefit.
32. For bariatric surgery, regardless of the purpose it is proposed or performed. 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. Complications 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 Anthem plan, 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 Booklet. 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. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.
33. For marital counseling.
34. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service for Member's through age 18. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.
35. For vision orthoptic training.
36. For hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.
37. For 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., except as otherwise specified herein.
38. For services to reverse voluntarily induced sterility.
39. For diagnostic testing or treatment related to infertility except as otherwise stated as covered in the Schedule of Benefits.
40. For personal hygiene, environmental control, or convenience items including but not limited to:
    a) Air conditioners, humidifiers, air purifiers;
    b) Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    c) Charges for non-medical self-care except as otherwise stated;
    d) Purchase or rental of supplies for common household use, such as water purifiers;
    e) Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    f) Infant helmets to treat positional plagiocephaly;
    g) Safety helmets for Members with neuromuscular diseases; or
    h) Sports helmets.
    i) Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.
41. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
42. For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by Us, or as otherwise described in this Booklet.
43. For care received in an emergency room which is not Emergency Care, except as specified in this Certificate. For non-Emergency Care please use the closest Network Urgent Care Center and/or your Primary Care Physician for services. As required by Ohio law, please note that coverage for Emergency Care will be provided as described in "Emergency Care Services" in the Covered Services section. Examples of non-Emergency Care may include, but are not limited to: suture removal, routine pregnancy test, sore throat, ear ache/infection, rashes, sprains/strains, constipation, diarrhea, abrasions, sleep disorder, conjunctivitis/pink eye, back pain that is not sudden and severe in onset, and dental caries/cavity.
44. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
45. For self-help training and other forms of non-medical self-care, except as otherwise provided in this Booklet.
46. For examinations relating to research screenings.
47. For stand-by charges of a Physician.
48. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes. This exclusion does not apply to Covered Services that have not been exhausted and are not paid for by another source.
49. For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.
50. For Manipulation Therapy services rendered in the home as part of Home Care Services.
51. Services and supplies related to male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription.
52. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT),

colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

53. For any services or supplies provided to a person not covered under the Plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
54. For surgical treatment of gynecomastia.
55. For medical and surgical treatment of hyperhidrosis (excessive sweating).
56. For any service for which you are responsible under the terms of this Booklet to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of- Network Provider.
57. 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.
58. Complications of/or services directly related to services, supplies, or treatment related to or for problems that is a non-Covered Service under this Booklet because it was determined by Us to be Experimental/ Investigational or non-Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/ Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.
59. For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply. This exclusion does not apply to Preventive Services and over-the-counter products that We must cover under federal law with a Prescription.
60. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
61. Treatment of telangiectatic dermal veins (spider veins) by any method.
62. Reconstructive services except as specifically stated in the "What's Covered" section of this Booklet, or as required by law.
63. Nutritional and/or dietary supplements, except as provided in this Booklet or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist. This exclusion does not apply to Covered Services received for Home Infusion Therapy under the "Home Care Services" benefit.
64. For 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.
65. For Applied Behavioral Treatment (including, but not limited to, Applied Behavior Analysis and Intensive Behavior Interventions) for all indications except as described under Habilitative Services in the "What's Covered" section unless otherwise required by law.
66. For expenses incurred for the treatment of accidents or injuries resulting from the participation in interscholastic, intercollegiate, or professional sport, contest or competition; traveling to or from such sport, contest or competition as a participant; or while participating in any practice or conditioning program for such sport, contest, or competition to the extent such accidents or injuries are covered by an NCAA, NAIA, or student athletic department accident or injury policy. In combination with insurance/benefits provided by these sources, students will not incur any more out-of-pocket costs than they, or any other student, would if covered solely by this Plan.
67. For Student Health Plan Services provided normally without charge by the health service of the University or School. This includes services covered or provided by the student health fee.
68. For certain Prescription Drugs 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.

69. For delivery charges for delivery of Prescription Drugs.
70. For drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.
71. For drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
72. For 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.
73. For Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by us.
74. For drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
75. For drugs not on the Anthem Prescription Drug List (a formulary). You can get a copy of the list by calling us or visiting our website at [www.anthem.com].
76. For refills of lost or stolen Drugs.
77. For residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center.
78. For physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes, which are not required by law under the "Preventive Care" benefit.
79. For 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.

80. For 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.
81. Drugs not approved by the FDA.
82. For 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.
83. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.
84. For autopsies and post-mortem testing.
85. For 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.
86. For charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.
87. 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.
88. 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.
89. For wilderness or other outdoor camps and/or programs.
90. Services from a Facility or Residential Treatment Center / Facility that do not fall within the definitions of "Facility" or "Residential Treatment Center / Facility" listed in the "Definitions" section.
91. For the following vision services: * Eyeglass lenses, frames, or contact lenses for Members age 19 and older, unless listed as covered in this booklet.
    a) Visual therapy, such as orthoptics or vision training, and any associated supplemental testing, unless covered under the medical benefits in this Booklet.
    b) For two pairs of glasses in lieu of bifocals.
    c) For plano lenses (lenses that have no refractive power).
    d) For medical or surgical treatment of the eyes, including inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Booklet.
    e) Lost or broken lenses or frames, unless the member has reached the member's normal interval for service when seeking replacements.
    f) Cosmetic lens options, such as special lens coatings or non-prescription lenses, unless specifically stated as covered in this Booklet.
    g) Safety glasses and accompanying frames.
    h) Vision services not listed as covered in this Booklet.
    i) 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.
    j) For Members through age 18, no benefits are available for frames or contact lenses not on the Anthem formulary.
    k) Certain benefits may be covered under the "Preventive Care" benefit. Please see that section for further details.

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 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)

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

Polish

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

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ 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

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)

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.

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/fi. 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) 333-5735 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**/covered person for UTMC, UTP. **$1,500**/covered person for In-Network Providers. **$3,000**/covered 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. Prescription Drugs for In-Network and Out-of-Network Providers. Preventive care for In-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?	**$7,900**/student or **$15,800**/family. All 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, Blue Access Choice. See https://student.anthem.com/student/schools/utoledo or call (855) 333-5735 for a list of network providers.	You pay the least if you use a provider in UTMC,UTP. You pay more if you use a provider in In-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 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
		UTMC, UTP Provider (You will pay the least)	In-Network Provider (You will pay more)	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	30% coinsurance	$10/visit then 40% coinsurance	$15/visit then 50% coinsurance	--------none--------
	Specialist visit	30% coinsurance	$20/visit then 40% coinsurance	$30/visit then 50% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	No charge	50% coinsurance	Immunizations for children prior to their 6th birthday have No charge for In-Network and Out-of-Network Providers. 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)	30% coinsurance	40% coinsurance	50% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	30% coinsurance	40% coinsurance	50% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/ National	Tier 1 - Typically Generic	$5/prescription (retail)	$10/prescription then 40% coinsurance deductible does not apply (retail)	$15/prescription then 50% coinsurance deductible does not apply (retail)	*See Prescription Drug section
	Tier 2 - Typically Preferred / Brand	$15/prescription (retail)	$20/prescription then 40% coinsurance deductible does not apply (retail)	$30/prescription then 50% coinsurance deductible does not apply (retail)	
	Tier 3 - Typically Non-Preferred / Specialty Drugs	$30/prescription (retail)	$30/prescription then 40% coinsurance deductible does not apply (retail)	$60/prescription then 50% coinsurance deductible does not apply (retail)	

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UTMC, UTP Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Tier 4 - Typically Specialty (brand and generic)	$75/prescription (retail)	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	40% coinsurance	50% coinsurance	--------none--------
	Physician/surgeon fees	30% coinsurance	40% coinsurance	50% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	$250/visit	$250/visit	Covered as In-Network	Copay waived if admitted.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Covered as In-Network	--------none--------
	Urgent care	30% coinsurance	$30/visit then 40% coinsurance	$45/visit then 50% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	50% coinsurance	--------none--------
	Physician/surgeon fees	30% coinsurance	40% coinsurance	50% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 30% coinsurance Other Outpatient 30% coinsurance	Office Visit $10/visit then 40% coinsurance Other Outpatient 40% coinsurance	Office Visit $15/visit then 50% coinsurance Other Outpatient 50% coinsurance	Office Visit --------none-------- Other Outpatient --------none--------
	Inpatient services	30% coinsurance	40% coinsurance	50% coinsurance	--------none--------
If you are pregnant	Office visits	30% coinsurance	40% coinsurance	50% 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	30% coinsurance	40% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	40% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	50% coinsurance	100 visits/benefit period for In-Network Providers and Out-of-Network Providers combined with private duty nursing.
	Rehabilitation services	30% coinsurance	40% coinsurance	50% coinsurance	*See Therapy Services section
	Habilitation services	30% coinsurance	40% coinsurance	50% coinsurance	
	Skilled nursing care	30% coinsurance	40% coinsurance	50% coinsurance	90 days limit/benefit period for In-Network Providers and Out-of-Network Providers combined.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UTMC, UTP Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	30% coinsurance	40% coinsurance	50% coinsurance	*See Durable Medical Equipment Section
	Hospice services	30% coinsurance	40% coinsurance	50% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	Not covered	No charge	Reimbursed Up to $30	*See Vision Services section
	Children's glasses	Not covered	No charge	Reimbursed Up to $45	
	Children's dental check-up	Not covered	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)
- Dental Check-up
- Eye exams for a child
- Glasses for a child
- Infertility treatment
- Long- term care
- 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
- Hearing aids 1 unit every 36 months.
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Private-duty nursing 100 visits/benefit period combined with home health care.
- Routine eye care (adult)

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

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: Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300, Columbus, Ohio 43215, (800) 686-1526, (614) 644-2673. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov 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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov

Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300, Columbus, Ohio 43215, (800) 686-1526, (614) 644-2673

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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/fi.

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	$0
Specialist *coinsurance*	30%
Hospital (facility) *coinsurance*	30%
Other *coinsurance*	30%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$3,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,880**

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

The plan's overall deductible	$0
Specialist *coinsurance*	30%
Hospital (facility) *coinsurance*	30%
Other *coinsurance*	30%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,360**

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

The plan's overall deductible	$0
Specialist *coinsurance*	30%
Hospital (facility) *coinsurance*	30%
Other *coinsurance*	30%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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) 333-5735

Amharic (አማርኛ)፦ ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 333-5735 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) 333-5735.

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) 333-5735:

Bassa (Bàsɔ̀ɔ̀ Wùdù): M̀ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà 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) 333-5735.

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) 333-5735 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (855) 333-5735 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) 333-5735。

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) 333-5735.

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) 333-5735.

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) 333-5735 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) 333-5735.

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) 333-5735.

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) 333-5735.

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) 333-5735.

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) 333-5735.

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) 333-5735 ।

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) 333-5735.

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) 333-5735.

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) 333-5735.

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) 333-5735.

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) 333-5735

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) 333-5735 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (855) 333-5735 ។

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) 333-5735.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 333-5735 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (855) 333-5735.

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídiłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h ílínígóó. Ataʼ halneʼígíí łaʼ bichʼį́ʼ hadeesdzih nínízingo kojį́ʼ hodíilnih (855) 333-5735.

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) 333-5735

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) 333-5735 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) 333-5735 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) 333-5735.

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) 333-5735.

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