2021–2022

Wright State University
International and Domestic (New Students)
Student Health Insurance Plan

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

Anthem Student Advantage
Keeping you at your personal best

121363XXMENXXX Rev. 06/21

Anthem STUDENT ADVANTAGE

WRIGHT STATE UNIVERSITY

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

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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?

- Wright State University student health insurance is a voluntary health insurance program. Enrollment in the program is completed at the time of class registration. Commuter students and Wright State residential students have the option to participate in the plan if enrolled in six credit hours or more. Commuter or residential student may decline coverage and continue with the registration process.
- International students (F1/J1 visa status) do not have the option to decline the Wright State health insurance program during the registration process. Following registration, international students who have financial guarantees through their country are required to obtain a waiver through the University Center for International Education (UCIE) who is authorized to remove the insurance charge.

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	Student
Annual (8/15/2021–8/14/2022)	$2,064
Fall (8/15/2021–1/9/2022)	$837
Spring/Summer (1/10/2022–8/14/2022)	$1,227

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

Important dates for the coverage period

Open enrollment

Open enrollment start opens with registration of classes.

Waiver deadlines

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

- Annual: September 3, 2021
- Fall: September 3, 2021
- Spring/Summer: January 21, 2022

If you have **questions about enrollment and waiver options,** visit https://student.anthem.com/student/schools/wsu or call 1-844-412-0752.

Keep in touch with your benefits information

Student Health Services

Wright State Physicians
Health Center
725 University Blvd
Fairborn, OH 45324
1-937-245-7200
www.wright.edu/student-health-services
Monday–Friday,
8:30 a.m.–5:00 p.m.
(Closed for lunch noon–1:00 p.m.)

RaiderCares

A Counseling and Wellness Services 24-hour crisis phone service. Call RaiderCares at 1-855-224-2887
***Please note this number will change August 1st. Starting August 1, 2021 the new number will be: 937-775-4567*
(TTY: 1-855-327-9151).

Claims, benefits, eligibility and enrollment

1-844-412-0752
Anthem Blue Cross Life and Health Insurance Company
https://student.anthem.com/student/schools/wsu

Your Student Health Services

Wright State University is the primary medical provider for students enrolled in the Student Health Insurance Plan (SHIP). These services and benefits:

For the types of care and services listed below, visit Wright State University Student Health Services in the Wright State Physicians Building on campus.

Convenient, Same-Day Medical Services

A nurse practitioner is always on duty. Walk-in service is available for:

- Treatment of minor/acute illnesses and injuries
- Chronic disease management
- Suture removal
- Birth control
- Prescription refills
- Vaccinations & tuberculosis testing

Mental Health

- RaiderCares
- 24-hour crisis phone service providing:
  - Emotional support
  - Assistance
  - Crisis intervention
  - Suicide prevention

In-Office Testing

- Mono spots
- Urinary tract infections
- Strep screens
- Glucose & hemoglobin A1C
- Urine drug screen
- Blood pressure
- STD

The following are available by appointment only:

- Allergy shots
- Female exams and pap smears
- Physicals

Meeting with a physician is available by appointment only.

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
- 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 Wright State University website

Use www.student.anthem.com/student 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:
Wright State University

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 (EOC), the (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. See the sections below to find out when the Deductible applies. Copayments and Coinsurance are separate from and do not apply to the Deductible.	$500 person / $1,000 family	$1,000 person / $2,000 family
Out-of-Pocket Limit		
(Embedded/Non Embedded) The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum. Amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.	$5,500 person / $11,000 family	$10,000 person / $22,000 family
Preventive Care/Screening/Immunization		
	No charge	40% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Specialist Care Visit	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Prenatal and Post-natal Care	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Other Practitioner Visits		
Retail Health Clinic	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Preferred Online Visit *Includes Mental/Behavioral Health and Substance Abuse*	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 26 visits per benefit period.*	20% coinsurance after deductible is met	40% 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
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy - PCP	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy - Specialist	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray		
Office	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging		
Office	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Freestanding Radiology Center	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	$35 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$125 copay per visit plus 20% coinsurance	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance	Covered as In-Network
Emergency Ambulance *Non-emergency, non-network Ambulance Services are limited to $50,000 per occurrence*	20% coinsurance after deductible is met	30% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Facility Visit Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	40% 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
Outpatient Surgery		
Facility Fees Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and Other Services: Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital Stay (Including Maternity, Mental/Behavioral Health, and Substance Abuse)		
Facility fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Human Organ and Tissue Transplants	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per year combined with home health services.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation Services *Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.*		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac Rehabilitation *Cardiac rehabilitation: Limited to 36 visits per benefit period*		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (in a facility)		
Coverage is limited to 150 days combined per benefit period.	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospice		
	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment		
	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices		
	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Pharmacy

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket	Combined with medical	Combined with medical
Prescription Drug Coverage *Traditional Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs. Home delivery is not covered out-of-network.*		
Tier 1 - Typically Generic *30-day supply (retail pharmacy); 90-day supply (home delivery)*	$15 copay per prescription, deductible does not apply (retail) and $37.50 copay per prescription, deductible does not apply (home delivery)	$15 copay per prescription generic drug plus 40% coinsurance (retail only)
Tier 2 – Typically Preferred/Brand *30-day supply (retail pharmacy); 90-day supply (home delivery)*	$30 copay per prescription, deductible does not apply (retail) and $75 copay per prescription, deductible does not apply (home delivery)	$30 copay per prescription brand name drug plus 40% coinsurance (retail only)
Tier 3 - Typically Non-Preferred/Specialty Drugs *30-day supply (retail pharmacy); 90-day supply (home delivery)*	$45 copay per prescription, deductible does not apply (retail) and $112.50 copay per prescription, deductible does not apply (home delivery)	$45 copay per prescription generic drug plus 40% coinsurance (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 *Limited to covered persons under the age of 19.*		
Children's 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 $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 *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 fillings and simple extractions*	20% coinsurance	20% coinsurance
Major services	50% coinsurance	50% coinsurance
Endodontic, Periodontics, Oral Surgery	50% coinsurance	50% coinsurance
Medically Necessary Orthodontia Services	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 geobluestudents.com to learn more.

GeoBlue benefits for the 2021–22 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.

Notes

- Dependent age: To end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using out-of-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments, and coinsurance apply toward the out-of-pocket maximum (excluding out-of-network Human Organ and Tissue Transplant (HOTT) Services).
- All network covered services cost share for both preferred and in-network apply to the in-network OOP.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing an out-of-network provider, the member is responsible for any balance due after the plan payment.
- If your plan includes out-of-network benefits, in-network and out-of-network deductibles, copayments, coinsurance, and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- Your copays, coinsurance, and deductible count toward your out-of-pocket amount.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect 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 (EOC), the (EOC), will prevail.

Exclusions

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. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

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

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.
    o) Cone beam images.
    p) Anatomical crown exposure.
    q) Temporary anchorage devices.
    r) Sinus augmentation.
    s) Temporomandibular Joint Disorder (TMJ), unless covered by the medical benefits of this Certificate.
    t) Oral hygiene instructions.
    u) Repair or replacement of lost or broken appliances.
    v) 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).
    w) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth
    x) Separate services billed when they are an inherent component of another covered service.
    y) Dental services for which you would have no legal obligation to pay in the absence of this or like coverage.
    z) Additional treatment necessary to correct or relieve the results of treatment previously benefited under the Certificate.
    aa) Biological tests for determination of periodontal disease or pathologic agents, unless covered by the medical benefits of this Certificate.
    bb) Collection of oral cytology samples via scraping of the oral mucosa, unless covered by the medical benefits of this Certificate.
    cc) Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannon satisfactorily restore the case.
    dd) Pulp vitality tests.
    ee) 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).
    ff) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
    gg) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
    hh) 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 notapply 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 Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
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:
    a) Eyeglass lenses, frames, or contact lenses for Members age 19 and older, unless listed as covered in this booklet.
    b) Visual therapy, such as orthoptics or vision training, and any associated supplemental testing, unless covered under the medical benefits in this Booklet.
    c) For two pairs of glasses in lieu of bifocals.
    d) For plano lenses (lenses that have no refractive power).
    e) For medical or surgical treatment of the eyes, including inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Booklet.
    f) Lost or broken lenses or frames, unless the member has reached the member's normal interval for service when seeking replacements.
    g) Cosmetic lens options, such as special lens coatings or non-prescription lenses, unless specifically stated as covered in this Booklet.
    h) Safety glasses and accompanying frames.
    i) Vision services not listed as covered in this Booklet.
    j) 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.
    k) For Members through age 18, no benefits are available for frames or contact lenses not on the Anthem formulary.
    l) 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 **1-844-412-0752**.

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

ىلع دوجوملا ءاضعلأا تامدخ مقرب لصتا .اًناجم كتغلب ةدعاسملاو تامولعملا هذه ىلع لوصحلا كل قحي
(TTY/TDD: 711).ةدعاسملل كب ةصاخلا فيرعتلا ةقاطب

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

تروصب ار اهکمک و تاعلاطا نیا هک دیراد ار قح نیا امش
هب کمک تفایرد یارب .دینک تفایرد ناتدوخ نابز هب ناگیار
جرد ناتی یاسانش تراک یور رب هک ءاضعا تامدخ زکرم هرامش
دیریگب سامت ،تسا .(TTY/TDD: 711) هدش

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

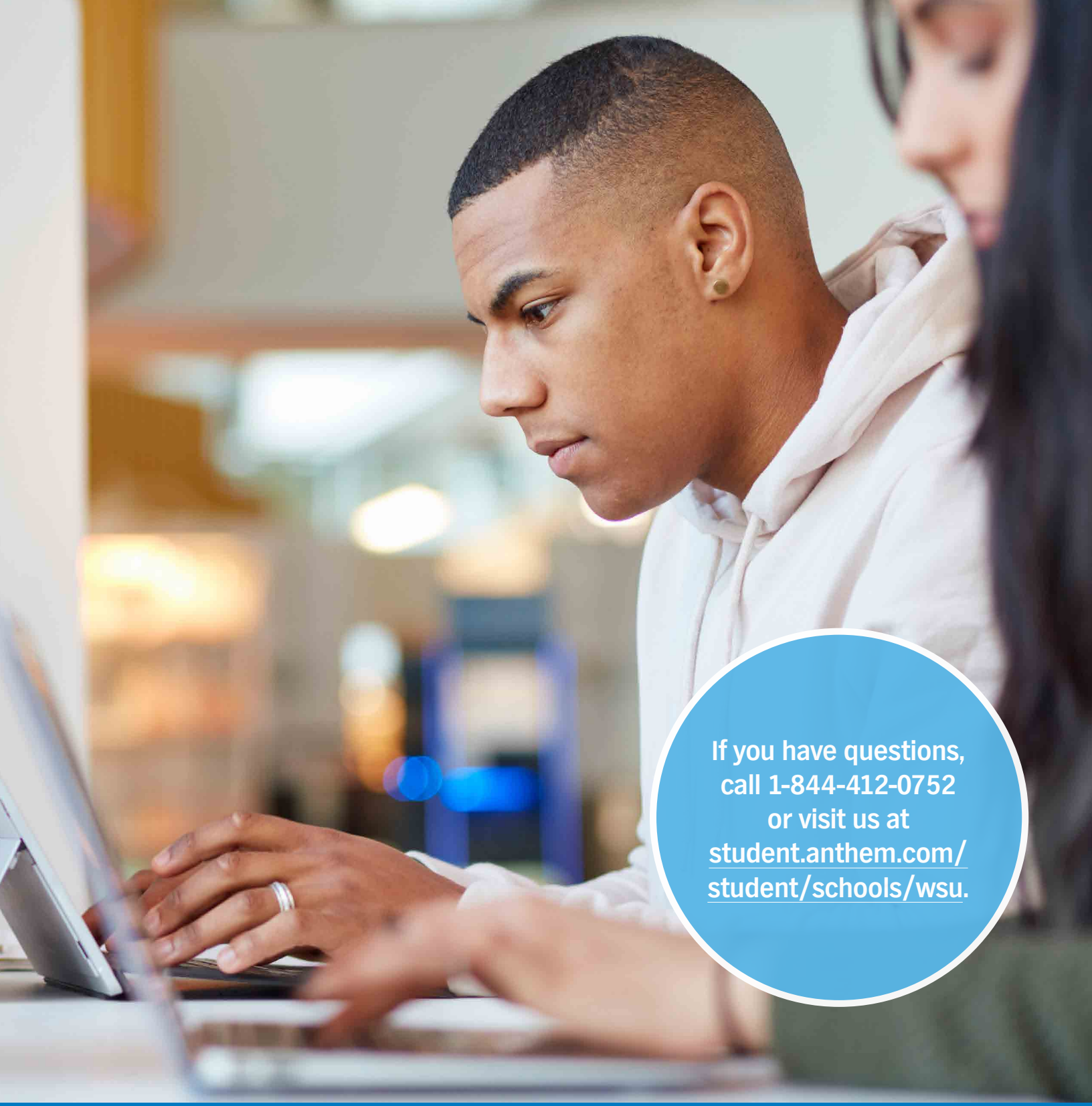
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

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

Your summary of benefits

Anthem® Blue Cross Blue Shield

Wright State University

Your Network: PPO

Student Health Center Benefits:
No Charge for Covered Medical Expenses
Deductible and Copays Waived

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Out-of-Network Provider
Overall Deductible	$500 person / $1,000 family	$1,000 person / $2,000 family
Out-of-Pocket Limit	$5,500 person / $11,000 family	$10,000 person / $22,000 family
(Embedded/Non Embedded) The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum. Amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	40% coinsurance after deductible is met
Doctor Home and Office Services **Primary Care Visit**	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Specialist Care Visit	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Prenatal and Post-natal Care	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met

Your summary of benefits

Anthem | STUDENT ADVANTAGE

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Out-of-Network Provider
Other Practitioner Visits:		
Retail Health Clinic	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 26 visits per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy - PCP	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy - Specialist	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs- *Dispensed in the office*	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Your summary of benefits

Anthem | STUDENT ADVANTAGE

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Out-of-Network Provider
Diagnostic Services		
Lab:		
Office	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray:		
Office	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging		
Office	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Freestanding Radiology Center	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	$35 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$125 copay per visit plus 20% coinsurance	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance	Covered as In-Network
Ambulance *Non-emergency non-network Ambulance Services are limited to $50,000 per occurrence*	20% coinsurance after deductible is met	Covered as In-Network

Your summary of benefits

Anthem | STUDENT ADVANTAGE

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Out-of-Network Provider
Outpatient Mental / Behavioral Health and Substance		
Doctor Office Visit	$25 copay per visit plus 20% coinsurance	40% coinsurance after deductible is met
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital Stay (Including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Human Organ and Tissue Transplants	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Your summary of benefits

Anthem | STUDENT ADVANTAGE

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Out-of-Network Provider
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per year combined with home health services.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation services *Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.*		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation *Cardiac rehabilitation: Limited to 36 visits per benefit period*		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage is limited to 150 days combined per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Your summary of benefits

Anthem | STUDENT ADVANTAGE

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical	Combined with medical
Prescription Drug Coverage *Traditional Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs. Home delivery is not covered out-of-network.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy); 90 day supply (home delivery)*	$15 copay per prescription, deductible does not apply (retail) and $37.50 copay per prescription, deductible does not apply (home delivery)	$15 copay per prescription generic drug plus 40% coinsurance (retail only) $30 copay per prescription brand name drug plus 40% coinsurance (retail only)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy); 90 day supply (home delivery)*	$30 copay per prescription, deductible does not apply (retail) and $75 copay per prescription, deductible does not apply (home delivery)	$15 copay per prescription generic drug plus 40% coinsurance (retail only) $30 copay per prescription brand name drug plus 40% coinsurance (retail only)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy); 90 day supply (home delivery)*	$45 copay per prescription, deductible does not apply (retail) and $112.50 copay per prescription, deductible does not apply (home delivery)	$15 copay per prescription generic drug plus 40% coinsurance (retail only) $30 copay per prescription brand name drug plus 40% coinsurance (retail only)

Your summary of benefits

Anthem | STUDENT ADVANTAGE

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)		
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
Adult Vision (age 19 and older) **Adult Vision Coverage** *Limited to certain vision screenings required by Federal law and covered under the "Preventive Care" benefit.*	See "Preventive Care" benefit	See "Preventive Care" benefit

Your summary of benefits

Anthem STUDENT ADVANTAGE

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	20% coinsurance
Major services	50% coinsurance	50% coinsurance
Endodontic, Periodontics, Oral Surgery	50% coinsurance	50% coinsurance
Medically Necessary Orthodontia services	50% coinsurance	50% coinsurance
Deductible	Not applicable	Not applicable
Adult Dental	Not covered	Not covered

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using Out-of-Network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT) Services).
- Network Deductibles Preferred and In-Network commingle towards each other.
- All network covered services cost share for both Preferred and In-Network apply to the In-Network OOP.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Out-of-network provider, the member is responsible for any balance due after the plan payment.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- Your copays, coinsurance and deductible count toward your out of pocket amount.

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.

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. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

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

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:
    - 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.
    - Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with Providers not directly responsible for your care.
    - Charges that are not documented in Provider records.
    - 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.
    - 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:
    - cleaning and soaking the feet.
    - applying skin creams in order to maintain skin tone.
    - 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:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - 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:
    - Dental care for members age 19 and older, unless covered by the medical benefits of this Certificate.
    - 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.
    - 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).
    - For dental services received prior to the effective date of this Certificate or received after the coverage under this Certificate has ended.
    - 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.
    - Analgesia, analgesia agents, oral sedation and anxiolysis nitrous oxide.
    - Services of anesthesiologist, unless required by law.
    - Dental services given by someone other than a licensed provider (dentist or physician) or their employees.
    - 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.
    - 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.
    - Case presentations, office visits.
    - Enamel microabrasion and odontoplasty.
    - Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
    - Provisional splinting.
    - Cone beam images.
    - Anatomical crown exposure.
    - Temporary anchorage devices.
    - Sinus augmentation.
    - Temporomandibular Joint Disorder (TMJ), unless covered by the medical benefits of this Certificate.
    - Oral hygiene instructions.
    - Repair or replacement of lost or broken appliances.
    - 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).
    - Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
    - Separate services billed when they are an inherent component of another covered service.
    - Dental services for which you would have no legal obligation to pay in the absence of this or like coverage.

- Additional treatment necessary to correct or relieve the results of treatment previously benefited under the Certificate.
- Biological tests for determination of periodontal disease or pathologic agents, unless covered by the medical benefits of this Certificate.
- Collection of oral cytology samples via scraping of the oral mucosa, unless covered by the medical benefits of this Certificate.
- Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannon satisfactorily restore the case.
- Pulp vitality tests.
- 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).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- 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:
    - transplant preparation.
    - initiation of immunosuppresives.
    - 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:
    - Air conditioners, humidifiers, air purifiers;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor’s meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;
    - Safety helmets for Members with neuromuscular diseases; or
    - Sports helmets.
    - 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 Drugs**,** and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
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:
    - 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.
    - 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.
    - 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.
    - Visual therapy, such as orthoptics or vision training, and any associated supplemental testing, unless covered under the medical benefits in this Booklet.
    - For two pairs of glasses in lieu of bifocals.
    - For plano lenses (lenses that have no refractive power).
    - For medical or surgical treatment of the eyes, including inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Booklet.
    - Lost or broken lenses or frames, unless the member has reached the member’s normal interval for service when seeking replacements.
    - Cosmetic lens options, such as special lens coatings or non-prescription lenses, unless specifically stated as covered in this Booklet.
    - Safety glasses and accompanying frames.
    - Vision services not listed as covered in this Booklet.
    - 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.
    - For Members through age 18, no benefits are available for frames or contact lenses not on the Anthem formulary.
    - Certain benefits may be covered under the “Preventive Care” benefit. Please see that section for further details.

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (844) 241-7085

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 (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (844) 241-7085 .

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՝ (844) 241-7085:

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(844) 241-7085。

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 (844) 241-7085 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 (844) 241-7085.

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 (844) 241-7085.

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 (844) 241-7085.

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、(844) 241-7085 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(844) 241-7085로 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (844) 241-7085.

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: (844) 241-7085.

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, (844) 241-7085 ਤੇ ਕਾਲ ਕਰੋ।

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. (844) 241-7085.

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 (844) 241-7085.

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 (844) 241-7085.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (844) 241-7085.

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't 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 isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services 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. Or you can 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.