City College of San Francisco
Student Health Insurance Plan

www.anthem.com/studentadvantageca

Anthem Student Advantage
Keeping you at your personal best
Important notice

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

All International and Intensive English Program students enrolled at your school are eligible for and are required to purchase this insurance plan. International students who have been approved for permanent residency are not eligible.

The Company maintains its right to investigate student status and attendance records to verify that the eligibility requirements have been met. If and whenever the Company discovers that the eligibility requirements have not been met, its only obligation is a refund of premium, less any claims paid.
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

International Student Insurance Plan

<table>
<thead>
<tr>
<th>Session</th>
<th>Student</th>
<th>Spouse/ Domestic Partner</th>
<th>Each Child*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall 7/1/2021 to 12/31/2021</td>
<td>$1,218.00</td>
<td>$1,182.00</td>
<td>$1,182.00</td>
</tr>
<tr>
<td>Fall — Late Term 8/1/2021 to 12/31/2021</td>
<td>$1,015.00</td>
<td>$985.00</td>
<td>$985.00</td>
</tr>
<tr>
<td>Spring / Summer 1/1/2022 to 6/30/2022</td>
<td>$1,218.00</td>
<td>$1,182.00</td>
<td>$1,182.00</td>
</tr>
</tbody>
</table>

Intensive English Program

International Student Insurance Plan

<table>
<thead>
<tr>
<th>Session</th>
<th>Student</th>
<th>Spouse/ Domestic Partner</th>
<th>Each Child*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summer 1&amp;2: 6/1/2021 to 7/31/2021</td>
<td>$406.00</td>
<td>$394.00</td>
<td>$394.00</td>
</tr>
<tr>
<td>Summer 1: 6/1/2021 to 6/30/2021</td>
<td>$203.00</td>
<td>$197.00</td>
<td>$197.00</td>
</tr>
<tr>
<td>Summer 2: 7/1/2021 to 7/31/2021</td>
<td>$203.00</td>
<td>$197.00</td>
<td>$197.00</td>
</tr>
<tr>
<td>Fall 1&amp;2: 8/1/2021 to 12/31/2021</td>
<td>$1,015.00</td>
<td>$985.00</td>
<td>$985.00</td>
</tr>
<tr>
<td>Fall 1: 8/1/2021 to 10/31/2021</td>
<td>$609.00</td>
<td>$591.00</td>
<td>$591.00</td>
</tr>
<tr>
<td>Fall 2: 10/1/2021 to 12/31/2021</td>
<td>$609.00</td>
<td>$591.00</td>
<td>$591.00</td>
</tr>
<tr>
<td>Spring 1&amp;2: 1/1/2022 to 05/31/2022</td>
<td>$1,015.00</td>
<td>$985.00</td>
<td>$985.00</td>
</tr>
<tr>
<td>Spring 1: 1/1/2022 to 3/31/2022</td>
<td>$609.00</td>
<td>$591.00</td>
<td>$591.00</td>
</tr>
<tr>
<td>Spring 2: 3/1/2022 to 5/31/2022</td>
<td>$609.00</td>
<td>$591.00</td>
<td>$591.00</td>
</tr>
</tbody>
</table>

*Premium is charged per child, up to three (3) times the premium fee, after which no further premium is charged for additional children.

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

*The rates listed above are pending approval with the state and subject to change.

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Keep in touch with your benefits information

**Student Health Services**
Ocean Campus, HC-100
50 Frida Kahlo Way
San Francisco, CA 94112
[https://www.ccsf.edu/student-services/student-health-services](https://www.ccsf.edu/student-services/student-health-services)
Check the SHS website for available hours.
415-239-3110

**Claims and coverage**
800-888-2108
Anthem Blue Cross Life and Health Insurance Company
P.O. Box 60007
Los Angeles, CA 90060-0007

**Eligibility and enrollment**
Relation Insurance Services
800-537-1777
clientservices@relationinsurance.com
[www.4studenthealth.com/ccsf](http://www.4studenthealth.com/ccsf)
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 app through Anthem Student Advantage, you have instant access to:

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

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

LiveHealth Online

From your mobile device or computer with a webcam, you can use LiveHealth Online to visit with a board-certified doctor, psychiatrist or licensed therapist through live video. 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-doctor/ to find the right doctor or facility close to where you are.

Anthem Student Advantage
City College of San Francisco website

Use www.anthem.com/studentadvantageca 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

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

Student Health Center Benefits: No or Low Charge for Covered Medical Expenses, Co-pay Waived

<table>
<thead>
<tr>
<th>Covered Medical Benefits</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use an Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Deductible</td>
<td></td>
<td>$200 per member</td>
</tr>
<tr>
<td></td>
<td>See notes section to understand how your deductible works.</td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Limit</td>
<td></td>
<td>$8,550 per member</td>
</tr>
<tr>
<td></td>
<td>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.</td>
<td></td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td>In-network preventive care is not subject to deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor Home and Office Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Visit to treat an injury or illness</td>
<td>$40 copay per visit; 20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Specialist Care Visit</td>
<td>$40 copay per visit; 20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Prenatal Preventive Care</td>
<td>No charge</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Post-natal Office Care</td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Other Practitioner Visits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail Health Clinic Visit</td>
<td>$40 copay per visit; 20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td>On-line Visit</td>
<td>$40 copay per visit; 20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
</tbody>
</table>

Anthem Blue Cross
Student health insurance plan: City College of San Francisco
Your network: Prudent Buyer PPO
<table>
<thead>
<tr>
<th>Covered Medical Benefits</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use an Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chiropractic/Manipulation Therapy</strong></td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td><em>Coverage is limited to 20 visits per policy year. Applies to In-Network. Visit limits are combined both across outpatient and other professional visits.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Acupuncture</strong></td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>Other Services in an Office:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Allergy Testing</strong></td>
<td>$40 copay per visit; 20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>Chemo/Radiation Therapy</strong></td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>Hemodialysis</strong></td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>Drugs Administered in the Office</strong></td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td><em>For the drugs itself dispensed in the office through infusion/injection.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lab:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Office</strong></td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>Outpatient Hospital</strong></td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>X-Ray:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Office</strong></td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>Outpatient Hospital</strong></td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Office</strong></td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>Outpatient Hospital</strong></td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>Emergency and Urgent Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care (Office Setting)</strong></td>
<td>$40 copay per visit; 20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>Emergency Room Facility Services</strong></td>
<td>$250 copay per visit; 20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td><em>Copay waived if admitted.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Room Doctor and Other Services</strong></td>
<td>20% coinsurance after deductible is met</td>
<td>20% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>Emergency Ambulance Transportation</strong></td>
<td>20% coinsurance after deductible is met</td>
<td>20% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Covered Medical Benefits</td>
<td>Cost if you use an In-Network Provider</td>
<td>Cost if you use an Out-of-Network Provider</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Outpatient Mental Health and Substance Use Disorder</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor Office Visit and Online Visit</td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Facility visit:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility Fees</td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Doctor Services</td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility Fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Doctor and Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fees (for example, room &amp; board)</td>
<td>$250 copay per visit; 20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Doctor and other services</td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>Recovery &amp; Rehabilitation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td><em>Coverage is limited to 120 visits per year. Limits are combined for home health care and private duty nursing.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services (for example, physical/speech/occupational therapy):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office</td>
<td>$40 copay per visit; 20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Habilitation services (for example, physical/speech/occupational therapy):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office</td>
<td>$40 copay per visit; 20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
</tbody>
</table>
## Covered Medical Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use an Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office</td>
<td>$40 copay per visit; 20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td></td>
<td>Outpatient Hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Skilled Nursing Care (in a facility)</td>
<td>Coverage for skilled nursing services is limited to 120 days per benefit period. Limit is combined In-Network and Out-of-Network.</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>20% coinsurance after deductible is met</td>
<td>40% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Covered Prescription Drug Benefits</td>
<td>Cost if you use an In-Network Provider</td>
<td>Cost if you use an Out-of-Network Provider</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>---------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Pharmacy Deductible</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Pharmacy Out of Pocket</td>
<td>Combined with medical out of pocket maximum</td>
<td>Combined with medical out of pocket maximum</td>
</tr>
<tr>
<td>Prescription Drug Coverage</td>
<td>Traditional Drug List</td>
<td></td>
</tr>
</tbody>
</table>

**Tier 1 - Typically Generic**
Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days.

50% coinsurance not to exceed $250 per 30 day supply

50% coinsurance not to exceed $250 per 30 day supply

**Tier 2 - Typically Preferred Brand**
Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).

50% coinsurance not to exceed $250 per 30 day supply

50% coinsurance not to exceed $250 per 30 day supply

**Tier 3 - Typically Non-Preferred Brand**
Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).

50% coinsurance not to exceed $250 per 30 day supply

50% coinsurance not to exceed $250 per 30 day supply
# Pediatric Vision

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

<table>
<thead>
<tr>
<th>Covered Vision Benefits</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use an Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pediatric Vision Deductible</strong></td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
| **Routine Eye Exam**  
*A comprehensive eye examination once per benefit period.* | $0 copay | $0 Copay up to Maximum Allowed Amount |
| **Eyeglass Frames**  
*One pair of eyeglass frames per benefit period.* | $0 copay, formulary | $0 Copay up to Maximum Allowed Amount |
| **Eyeglass Lenses (instead of contact lenses)**  
*One pair of standard glass or plastic prescription lenses per benefit period.* | | |
| • Single vision lenses | $0 copay | $0 Copay up to Maximum Allowed Amount |
| • Bifocal lenses | $0 copay | $0 Copay up to Maximum Allowed Amount |
| • Trifocal lenses | $0 copay | $0 Copay up to Maximum Allowed Amount |
| • Lenticular lenses | $0 copay | $0 Copay up to Maximum Allowed Amount |
| • Progressive lenses (standard, premium, select, ultra) | $0 copay | $0 Copay up to Maximum Allowed Amount |
| **Eyeglass Lens Enhancements (instead of contact lenses)**  
*When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.* | | |
| • Transitions lenses (for a child under age 19) | $0 copay | $0 Copay up to Maximum Allowed Amount |
| • Standard polycarbonate (for a child under age 19) | $0 copay | $0 Copay up to Maximum Allowed Amount |
| • Factory Scratch Coating | $0 copay | $0 Copay up to Maximum Allowed Amount |
| **Contact Lenses (one year supply of contacts instead of eyeglass lenses)**  
*Contact lens allowance will only be applies toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.* | | |
| • Elective conventional (non-disposable) OR | $0 copay, formulary | $0 Copay up to Maximum Allowed Amount |
| • Elective disposable OR | $0 copay, formulary | $0 Copay up to Maximum Allowed Amount |
| • Non-elective (medically necessary) | $0 copay | $0 Copay up to Maximum Allowed Amount |
| **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 |
Pediatric Dental *Limited to covered persons under the age of 19.*

This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage / Disclosure form / Certificate. If there is a difference between this summary and either Evidence of Coverage / Disclosure form / Certificate, the Evidence of Coverage / Disclosure form / Certificate will prevail. Only children’s dental services count towards your out of pocket limit.

### Children’s Dental Essential Health Benefits (up to age 19)

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use an Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic and Preventive</strong></td>
<td>[No charge]</td>
<td>[No charge]</td>
</tr>
<tr>
<td><em>Includes cleanings, exams, x-rays, sealants, fluoride</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Basic services</strong></td>
<td>[20% coinsurance]</td>
<td>[20% coinsurance]</td>
</tr>
<tr>
<td><em>Includes fillings and simple extractions</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Major services/Prosthodontic</strong></td>
<td>[50% coinsurance]</td>
<td>[50% coinsurance]</td>
</tr>
<tr>
<td><strong>Endodontic, Periodontics, Oral Surgery</strong></td>
<td>[50% coinsurance]</td>
<td>[50% coinsurance]</td>
</tr>
<tr>
<td><strong>Medically Necessary Orthodontia</strong></td>
<td>[50% coinsurance]</td>
<td>[50% coinsurance]</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>[Not applicable]</td>
<td>[Not applicable]</td>
</tr>
<tr>
<td><strong>Adult Dental</strong></td>
<td>[Not covered]</td>
<td>[Not covered]</td>
</tr>
</tbody>
</table>
Benefits that go with you

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

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

► To register online, please click on the link above and select “Log in or Register,” then select “Register as a Member.” Please enter your Anthem ID Number or Access Code: GTB9999ACM35.

► Please contact GeoBlue with any questions at the following numbers: Inside the U.S.: 1-844-268-2686, Outside the U.S.: +1-610-263-2847

<table>
<thead>
<tr>
<th>GeoBlue benefits for the 2021-2022 school year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of benefits must be coordinated and approved by GeoBlue.</td>
</tr>
</tbody>
</table>

### International telemedicine services²

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global TeleMD™</td>
<td>Confidential access to international doctors by telephone or video call.</td>
</tr>
</tbody>
</table>

### Coverage outside the U.S., excluding student’s home country.

<table>
<thead>
<tr>
<th>Expense</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Expenses</td>
<td>Maximum benefit up to $250,000 per coverage year, no deductibles or copays. Consult coverage certificate for benefit limitations and exclusions.³</td>
</tr>
</tbody>
</table>

### Coverage worldwide except within 100 miles of primary residence for U.S. students.

<table>
<thead>
<tr>
<th>Coverage worldwide, excluding home country for international students.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency medical evacuation</td>
</tr>
<tr>
<td>Repatriation of remains</td>
</tr>
<tr>
<td>Emergency family travel arrangements</td>
</tr>
<tr>
<td>Political emergency and natural disaster evacuation</td>
</tr>
<tr>
<td>Accidental death and dismemberment</td>
</tr>
</tbody>
</table>

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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) services 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 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.
» Dependent age: to end of the month in which the child attains age 26.

» Members are encouraged to always obtain prior approval when using non-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 Non-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 Non-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. 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.

1. **Administrative Charges.**
   a) Charges to complete claim forms,
   b) Charges to get medical records or reports,
   c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include fees for educational brochures or calling you to give you test results.

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

3. **Alternative / Complementary Medicine.** Services or supplies for alternative or complementary medicine. This includes the following. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.
   a) Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body.
   b) Aquatic therapy and other water therapy except for other water therapy services that are part of a physical therapy treatment plan and covered under the “Therapy Services” section of this Booklet,
   c) Holistic medicine,
   d) Homeopathic medicine,
   e) Hypnosis,
   f) Aroma therapy,
   g) Massage and massage therapy, except for other massage therapy services that are part of a physical therapy treatment plan and covered under the “Therapy Services” section of this Booklet,
   h) Reiki therapy,
   i) Herbal, vitamin or dietary products or therapies,
   j) Naturopathy,
   k) Thermography,
   l) Orthomolecular therapy,
   m) Contact reflex analysis,
   n) Bioenergial synchronization technique (BEST),
   o) Iridology-study of the iris,
   p) Auditory integration therapy (AIT),
   q) Colonic irrigation,
   r) Magnetic innervation therapy,
   s) Electromagnetic therapy,
   t) Neurofeedback / Biofeedback.

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

5. **Before Effective Date or After Termination Date.** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

6. **Certain Providers.** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

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

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

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

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

11. **Compound Drugs.** Compound Drugs unless all of the ingredients are FDA-approved in the form in which they are used in the Compound Drug and 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.

12. **Cosmetic Services.** Treatments, services, Prescription Drugs, equipment, or supplies given for Cosmetic Services. Cosmetic Services are meant to preserve, change, or improve how you look.

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

14. **Crime.** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if the services are Medically Necessary, your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.

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

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

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

18. **Dental Services.**
   a) Dental care for Members age 19 and older, except for what is provided for in the “What’s Covered” section under Dental Services (All Members/All Ages).
   b) Dental services not listed as covered in this Booklet.
   c) Dental services which a Member would be entitled to receive for a nominal charge or without charge if this coverage were not in force under any Worker’s Compensation Law, Federal Medicare program, or
Federal Veteran’s Administration program. However, if a Member receives a bill or direct charge for dental services under any governmental program, then this Exclusion shall not apply. Benefits under this Plan will not be reduced or denied because dental services are rendered to a Student (or Dependent) who is eligible for or receiving medical assistance.

d) Procedures which are not generally accepted standards of dental practice within the organized dental community in California.

e) Dental services or health care services not specifically listed in the “What’s Covered” section of this EOC (including any Hospital charges or Prescription Drug charges and dental services or supplies that do not have an American Dental Association Procedure Code, unless covered by the medical benefits of this Plan).

f) Dental services completed prior to the date the Member became eligible for coverage or received after the coverage under this Plan has ended.

g) Analgesia, analgesia agents, medicines and Drugs for surgical or non-surgical care.

h) Local anesthetic when billed separately from a Covered Service, as this is a part of the final service, such as for restoration services (fillings, crowns).

i) Dental services performed other than by a licensed dentist, licensed Physician, his or her employees.

j) Dental care services you received which you are not legally obligated to pay or dental care services you received that would be no charge to you in the absence of insurance.

k) Covered Services received from a person who lives in the Member’s home or who is related to the Member by blood, marriage or adoption.

l) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including; increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

m) Dental services provided by dentists solely for the purpose of improving the appearance of the tooth when the tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist. This includes tooth whitening agents, bonding and veneers or restorations (such as fillings) placed for preventive purposes.

n) Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (filling, crown) has not been placed.

o) Athletic mouth guards, enamel microabrasion and odontoplasty.

p) Bacteriologic tests.

q) Cytology sample collection.

r) Separate services billed when they are an inherent component of another Covered Service.

s) Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.

t) Additional, elective or enhanced prosthodontic procedures including connector bars, stress breakers and precision attachments.

u) Provisional splinting, temporary procedures or interim stabilization.

v) Adjunctive diagnostic tests.

w) one beam images.

x) Anatomical crown exposure.

y) Temporary anchorage devices.

z) 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).

aa) Incomplete endodontic treatment and bleaching of discolored teeth.

bb) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.

cc) Services or supplies that are not Medically Necessary.

19. Dental Treatment. Excluded treatment includes preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:
   a) Removing, restoring, or replacing teeth;
   b) Medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet);
   c) Services to help dental clinical outcomes.

   Dental treatment for injuries that are a result of biting or chewing is also excluded, unless the chewing or biting results from a medical or mental condition.

   This Exclusion does not apply to services that we must cover by law.

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

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

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

23. Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications. Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by Anthem.

24. Drugs That Do Not Need a Prescription. Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter Drugs that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a Physician.

25. Educational Services. Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes 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. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

26. Experimental or Investigational Services. Services or supplies that we find are Experimental / Investigational, except as specifically stated under Clinical Trials in the section “What’s Covered.” This Exclusion applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

   The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational. If a Member has a life-threatening or seriously debilitating condition and Anthem determines that requested treatment is not a Covered Service because it is Experimental or Investigational, the Member may request an Independent Medical Review. See the “Grievance and External Review Procedures” section for further details.
30. **Family Members.** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

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

32. **Foot Orthotics.** Foot orthotics, orthopedic shoes or footwear or support items except as covered under Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical Surgical Supplies or used for a systemic illness affecting the lower limbs, such as severe diabetes.

33. **Growth Hormone Treatment.** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

34. **Health Club Memberships and Fitness Services.** Health club memberships, workout equipment, charges from a physical fitness or health club, including: a) replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.

35. **Inpatient Diagnostic Tests.** Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

36. **间距**

37. **In-vitro Fertilization.** Services or supplies for in-vitro fertilization (IVF) for purposes of pre-implant genetic diagnosis (PGD) of embryos, regardless of whether they are provided in connection with infertility treatment.

38. **Lifestyle Programs.** Programs to alter one’s lifestyle which may include diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us. This Exclusion does not apply to Medically Necessary preventive care services as specified in the “Preventive Care” provision in the section “What’s Covered”.

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

40. **Maintenance Therapy.** Rehabilitation treatment or care that is provided when no further gains or improvements in your current level of function 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.

41. **Medical Equipment, Devices and Supplies.** Any services or supplies that are not Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.

42. **Medicare.** For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled “Medicare” in “General Provisions.” If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when you should enroll and when you are allowed to delay enrollment without penalties.

43. **Medical Equipment.** Any equipment, device, or drug that is not medically necessary for your condition.

44. **Medically Necessary.** Services or supplies that are provided by a local, state, or federal government agency, or by a public school system or school district, except when payment under this Plan is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free. You are not required to seek any such services prior to receiving Medically Necessary health care services that are covered by this Plan.

45. **Miscellaneous Charges.** Charges for missed or cancelled appointments.

46. **Non-Medically Necessary Services.** Any services or supplies that are not Medically Necessary as defined. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

47. **Non-Approved Drugs.** Drugs not approved by the FDA.

48. **Nutritional or Dietary Supplements.** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.
52. Off Label Use. Off label use, unless we must cover it by law or if we approve it.

53. Oral Surgery. Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.

54. Personal Care, Convenience and Mobile/Wearable Devices.
   a) Items for personal comfort, convenience, protection, cleanliness or beautification such as air conditioners, humidifiers, air or water purifiers, sports helmets, raised toilet seats, and shower chairs.
   b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads, disposable sheaths and supplies).
   c) Home workout or therapy equipment, including treadmills and home gyms.
   d) Pools, whirlpools, spas, or hydrotherapy equipment.
   e) Hypo-allergenic pillows, mattresses, or waterbeds.
   f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair lifts, emergency alert equipment, handrails).
   g) Consumer wearable / personal mobile devices such as a smart phone, smart watch, or other personal tracking devices, including any software or applications.

55. Private Contracts. Services or supplies provided pursuant to a private contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

56. Private Duty Nursing. Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the “Home Care Services” benefit.

57. Prosthetics. Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics.

58. Residential Accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies, or charges for the following:
   a) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
   b) Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
   c) Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
   This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

59. Routine Physicals and Immunizations. Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, (sports programs,) or for other purposes, which are not required by law under the “Preventive Care” benefit. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

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

61. Services You Receive for Which You Have No Legal Obligation to Pay. Services you actually receive for which you have no legal obligation to pay or for which no charge would be made if you did not have health plan or insurance coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines: a) it must be internationally known as being devoted mainly to medical research, and b) at least ten percent of its yearly budget must be spent on research not directly related to patient care, and c) at least one third of its gross income must come from donations or grants other than gifts or payments for patient care, and d) it must accept patients who are unable to pay, and e) two-thirds of its patients must have conditions directly related to the Hospital research.

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

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

64. Sterilization. Services to reverse an elective sterilization.

65. Surrogate Mother Services. Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including the bearing of a child by another woman for an infertile couple).

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

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

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

   a) Vision care for Members age 19 and older, unless covered by the medical benefits of this Plan.
   b) Safety glasses and accompanying frames.
   c) Two pairs of glasses in lieu of bifocals.
   d) Plano lenses (lenses that have no refractive power)
   e) Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
   f) Vision services or supplies not specifically listed as covered in this Booklet.
   g) Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed in this Booklet.
   h) Blended lenses.
   i) Oversize lenses.
   j) Sunglasses.
   k) 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.
   l) For Members through age 18, no benefit is available for frames or contact lenses purchased outside of our formulary.
1. Administration Charges. Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.

2. Charges Not Supported by Medical Records. Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.

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

4. Compound Drugs. Compound Drugs unless all of the ingredients are FDA-approved in the form in which they are used in the Compound Drug and 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.

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


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

8. Drugs Not on the Prescription Drug List (a formulary). Drugs not on the Prescription Drug List except if authorized through prior authorization. If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to the “Prescription Drug List” in the section “Prescription Drug Benefit at a Retail Pharmacy” for details on requesting an exception. You can get a copy of the list by calling us or visiting our website at www.anthem.com/ca.

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

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


12. Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications. Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by Anthem.

13. Drugs that Do Not Need a Prescription. Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter Drugs that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a Physician.

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

15. Gene Therapy. Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the “Prescription Drug Benefit at a Retail Pharmacy” benefit, benefits may be available under the “Gene Therapy Services” benefit. Please see that section for details.

16. Growth Hormone Treatment. Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

17. Hyperhidrosis Treatment. Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).

18. Infertility Drugs. Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT).

19. Items Covered as Durable Medical Equipment (DME). Therapeutic DME, devices and supplies except as described in this Booklet or that we must cover by law, including peak flow meters, spacers, and blood glucose monitors, and other diabetes supplies. See the “Diabetes Equipment, Education, and Supplies” section for more information. Items not covered under the “Prescription Drug Benefit at a Retail Pharmacy” benefit may be covered under the “Durable Medical Equipment and Medical Devices” benefit. Please see that section for details.

20. Items Covered Under the “Allergy Services” Benefit. Allergy desensitization products or allergy serum. While not covered under the “Prescription Drug Benefit at a Retail Pharmacy” benefit, these items may be covered under the “Allergy Services” benefit. Please see that section for details.
21. **Lost or Stolen Drugs.** Refills of lost or stolen Drugs.

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

23. **Non-Approved Drugs.** Drugs not approved by the FDA. If Anthem determines that the requested drug is not covered because it is investigational or prescribed for Experimental indications, the Member may request an Independent Medical Review. See the “Grievance and External Review Procedures” section for further details.

24. **Non-Medically Necessary Services.** Any services or supplies that are not Medically Necessary as defined. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

25. **Nutritional or Dietary Supplements.** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

26. **Off Label Use.** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.

27. **Onychomycosis Drugs.** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immune-compromised or diabetic.

28. **Over-the-Counter Items.** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product may not be covered, even if written as a Prescription. This includes Prescription Legend Drugs when any version or strength becomes available over the counter. This Exclusion does not apply to over-the-counter products that we must cover as a “Preventive Care” benefit under state law or federal law with a Prescription.

29. **Sanctioned or Excluded Providers.** Any 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.

30. **Sexual Dysfunction Drugs.** Drugs to treat sexual or erectile problems unless Medically Necessary or as stated in this Plan. Documentation of a confirmed diagnosis of erectile dysfunction must be submitted to us for review.

31. **Syringes.** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.

32. **Weight Loss Drugs.** Any Drug mainly used for weight loss, except for the Medically Necessary treatment of morbid obesity.
It is important we treat you fairly

That is why we follow federal civil rights laws in our health programs and activities. We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language is not English, we offer free language assistance services through interpreters and other written languages. If you are interested in these services, call the Customer Service number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
If you have questions, call 1-800-888-2108 or visit us at www.anthem.com/studentadvantageca.