2021-2022

Marist College

Student Health Insurance Plan

https://student.empireblue.com/welcome

Anthem Student Advantage

Keeping you at your personal best

Empire BlueCross BlueShield | STUDENT ADVANTAGE

An Anthem Company

121363XXMENXXX Rev. 07/21

Important notice

This is a brief description of your student health plan underwritten by Empire Blue Cross and Blue Shield. 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.empireblue.com/.

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Welcome to Anthem Student Advantage

As your new school year begins, it's important to understand your health care benefits and how they work. Your Anthem Student Advantage plan 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?

You will automatically be enrolled in Anthem Student Advantage if:

- All registered full-time Domestic Undergraduate students enrolled in 9 or more credit hours are required to have health insurance coverage, either through this Student Health Plan or through another individual or family plan. Eligible students will be automatically enrolled in and charged for the Student Health Plan coverage unless a waiver form is submitted by the waiver deadline date.
- All registered International students are required to have health insurance coverage. All international students are automatically enrolled in the Student Health Plan and charged for the coverage. International students do not have the option to waive coverage.

The following student groups are also eligible to enroll:

- All registered Domestic Graduate and Part-time Undergraduate students enrolled in at least 6 but less than 9 credit hours are eligible to enroll in this Student Health Plan on a voluntary basis. Insured Students who are enrolled in the Student Health Plan may also enroll their eligible dependents.

Coverage is available for dependents too

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

- Eligible students may also insure their Dependents.
- Eligible Dependents are the student's spouse or Domestic Partner and dependent children under 26 years of age.
- See the "Who is Covered" section of the Certificate of Coverage for the specific requirements needed to meet Domestic Partner eligibility.

Coverage periods and rates

Coverage will become effective at 12:01 a.m., and will end at 11:59 p.m. on the dates shown below.

Costs and dates of coverage

The rates listed below do not include a prorated annual $15.00 fee for Geo Blue Medical Evacuation and Repatriation Benefits provided by 4 Ever Life International Limited.

Gross Rates	Annual 8-1-2021 to 7-31-2022	Spring 1/1/2021 to 7-31-2022
Student	$2959	$1740.29
Spouse	$2959	$1740.29
Child	$2959	$1740.29
2 or More Children	$5918	$3480.58

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

Important dates for the coverage period

Waiver Deadline Dates/Voluntary and Dependent Enrollment Deadline Dates

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

- Annual - 8/2/2021
- Spring - 2/1/2022
  (for new students to the Spring Semester only)

If you have **questions about enrollment and waiver options,** visit www.mystudentmedical.com/ or call 1-800-734-9326.

Keep in touch with your benefits information

Student Health Center

69 W. Cedar St. Poughkeepsie, NY
1-845-575-3270
Monday - Friday 8:30 am - 5:00 pm

Claims and coverage

1-844-412-0752
Anthem Blue Cross Life and Health Insurance Company
P.O. Box 1407, Church Street Station, New York, NY 10008

Benefits, eligibility and enrollment

The Allen J. Flood Companies, Inc.
500 Mamaroneck Ave., Suite 402
Harrison, NY 10528
1-800-734-9326
http://www.mystudentmedical.com/

Easy access to care

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

Sydney Health app

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

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

Access the Sydney Health app

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

LiveHealth Online

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

24/7 NurseLine

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

Provider finder

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

Anthem Student Advantage Marist College website

Use https://student.empireblue.com/welcome 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

Empire Blue Cross and Blue Shield

Student health insurance plan:
Marist College

Your network:
Empire Blue Access PPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC) will prevail. Plan benefits are pending approval with the state and subject to change.
The deductible and copays will be waived and benefits will be paid at 100% for covered medical expenses incurred when treatment is rendered at the Student Health Center.

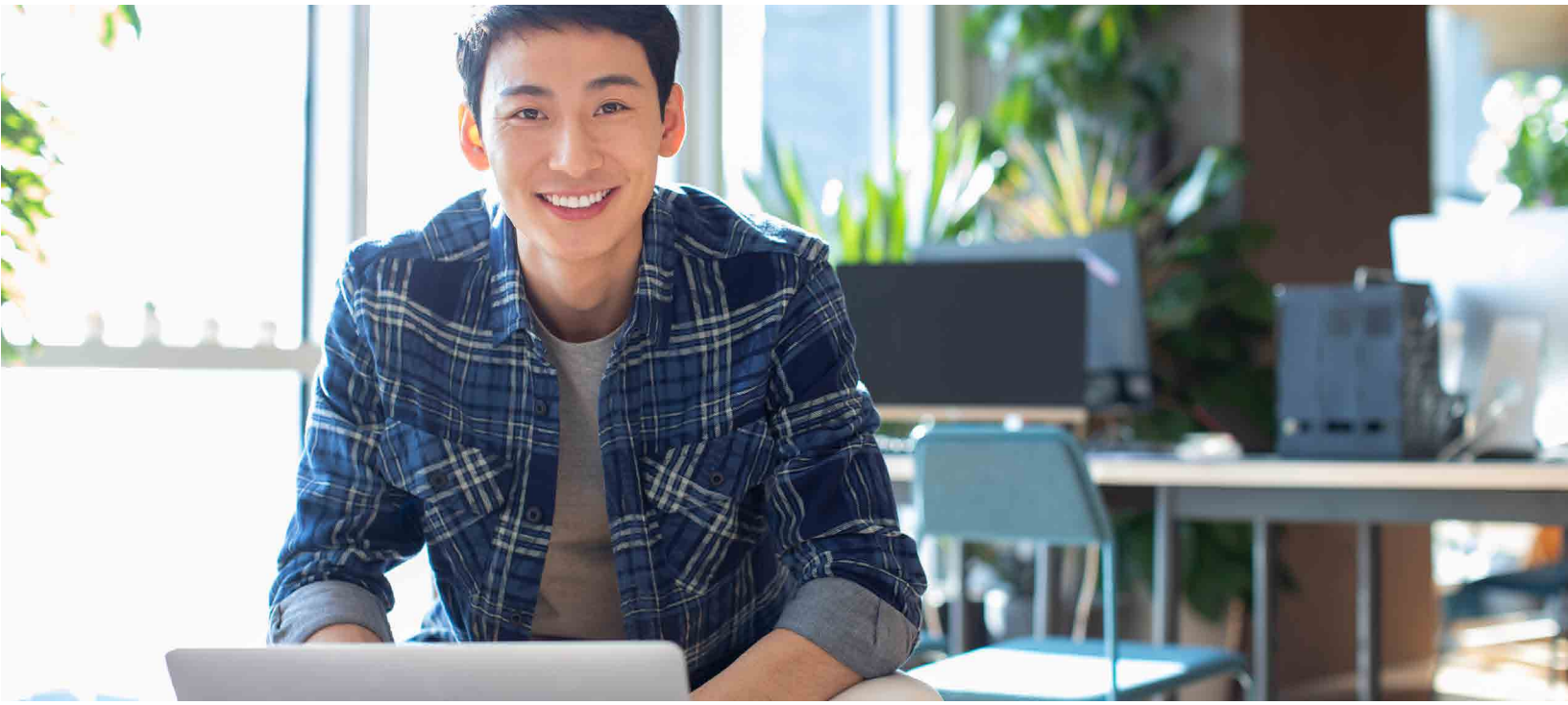
Medical

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible		
See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.	$100 person	$200 person
Out-of-Pocket Limit		
When you meet your out-of-pocket limit, you will no longer have to pay cost- shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.	$7,900 person / $13,200 family	None / None
Preventive care/screening/immunization		
In-network preventive care is not subject to deductible, if your plan has a deductible.	No charge	20% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness *Hospital clinics are not covered.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Specialist Care Visit	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Prenatal Care *In-Network preventive prenatal services are covered at 100%.*	No charge	20% coinsurance after deductible is met
Post-natal Care	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental Health and Substance Use Disorder Live Health Online is the preferred telehealth solution. (www.livehealthonline.com).*	10% coinsurance after deductible is met	20% 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 Participating Provider On-line Visit *Includes Mental Health and Substance Use Disorder*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Chiropractor Services	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Acupuncture	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Radiation/Chemotherapy/Non Preventive Infusion & Injection	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Hemodialysis	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office *Office Cost Share applies only when Freestanding/Reference Labs are not used.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding Laboratory Facility *Empire's participating Freestanding Labs are Laboratory Corporation of America or Quest Diagnostics. Please check Provider Finder for additional participating Freestanding Labs in your area.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
X-Ray:		
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care Center Office Visit	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$100 copay per visit 10% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	10% coinsurance after deductible is met	Covered as In-Network
Emergency Ambulance Transportation	10% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Facility visit: Facility Fees *Family counseling related to Substance Abuse is limited to 20 visits per year. Limit is combined In-Network and Out-of-Network. Limit is combined across professional visits and outpatient facilities. Coinsurance limited to the copay amount reflected for Primary Care Office visit.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Doctor Services *Family counseling related to Substance Abuse is limited to 20 visits per year. Limit is combined In-Network and Out-of-Network. Limit is combined across professional visits and outpatient facilities.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Surgery		
Facility fees: Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding Surgical Center	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Doctor and Other Services Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding Surgical Center	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period. Limit is combined In-Network and Out-of-Network.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Doctor and other services	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 40 visits per benefit period. Limit is combined In-Network and Out-of-Network. Limit does not apply to separate Physical or Occupational or Speech Therapy limits, when performed as part of Home Health.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period. Limit is combined for In-Network and Out-of-Network. Limit is combined across professional visits and outpatient facilities.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital *Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period. Limit is combined for In-Network and Out-of-Network. Limit is combined across professional visits and outpatient facilities.*	10% coinsurance after deductible is met	20% 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
Habilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period. Limit is combined for In-Network and Out-of-Network. Limit is combined across professional visits and outpatient facilities.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital *Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period. Limit is combined for In-Network and Out-of-Network. Limit is combined across professional visits and outpatient facilities.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Cardiac rehabilitation		
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Limited to 200 days per benefit period.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Hospice *Limited to 210 day per benefit period. Five (5) visits for family bereavement counseling.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Durable Medical Equipment	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Prosthetic Devices *One (1) prosthetic device, per limb, per lifetime.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Shoe Inserts	10% coinsurance after deductible is met	20% 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 out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *Traditional Open Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*		
Tier 1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*	$15 copay per prescription, 0% coinsurance (retail) $45 copay per prescription, 0% coinsurance (home delivery)	20% coinsurance after deductible is met (retail) 20% coinsurance after deductible is met (home delivery)
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*	$30 copay per prescription, 0% coinsurance (retail) $90 copay per prescription, 0% coinsurance (home delivery)	20% coinsurance after deductible is met 20% coinsurance after deductible is met (home delivery)
Tier 3 - Typically Non-Preferred Brand / Specialty Drugs *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*	$30 copay per prescription, 0% coinsurance (retail) $90 copay per prescription, 0% coinsurance (home delivery)	20% coinsurance after deductible is met 20% coinsurance after deductible is met (home delivery)

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

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for student's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's vision services count towards your out of pocket limit.		
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	$0	$0
Vision exam *Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.*	No charge	$0 copay plus all charges in excess of the maximum allowed amount
Frames *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copay plus all charges in excess of the maximum allowed amount
Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.* *Single vision lenses* *Bifocal lenses* *Trifocal lenses* *Standard Progressive*	No charge	$0 copay plus all charges in excess of the maximum allowed amount
Elective contact lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copay plus all charges in excess of the maximum allowed amount
Non-Elective contact lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copay plus all charges in excess of the maximum allowed amount

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

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's dental services count towards your out of pocket limit.		
Children's Dental Essential Health Benefits (up to age 19)		
Diagnostic and preventive *Includes cleanings, exams, x-rays, sealants, fluoride.*	No charge	No charge
Basic services *Includes filling and simple extractions*	20% coinsurance	20% coinsurance
Major services/Prosthodontic	50% coinsurance	50% coinsurance
Endodontic, Periodontics, Oral Surgery	50% coinsurance	50% coinsurance
Medically Necessary Orthodontia services	50% coinsurance	50% coinsurance
Deductible	Not applicable	Not applicable
Adult Dental	Not covered	Not covered

Benefits that go with you

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

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

GeoBlue benefits for the 2021-2022 school year

Use of benefits must be coordinated and approved by GeoBlue.

International telemedicine services[2]	
Global TeleMD™	Confidential access to international doctors by telephone or video call.
Coverage outside the U.S., excluding student's home country.	
Medical Expenses	Maximum benefit up to $250,000 per coverage year, no deductibles or copays. Consult coverage certificate for benefit limitations and exclusions.[3]
Coverage worldwide except within 100 miles of primary residence for U.S. students. Coverage worldwide, excluding home country for international students.	
Emergency medical evacuation	Unlimited
Repatriation of remains	Unlimited
Emergency family travel arrangements	Maximum benefit up to $5,000 per coverage year
Political emergency and natural disaster evacuation (Available only when traveling outside the United States)[4]	Covered 100% up to $100,000 per person. Subject to a combined $5,000,000 limit per any one covered event for all people covered under the plan.
Accidental death and dismemberment	Maximum benefit up to $10,000 per coverage year

GeoBlue

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

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

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

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

Designed with you in mind

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

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 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.

Exclusions and Limitations

No coverage is available under this Certificate for the following:

1. **Aviation.**
   We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.
2. **Convalescent and Custodial Care.**
   We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.
3. **Conversion Therapy.**
   We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for any individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.
4. **Cosmetic Services.**
   We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.
5. **Coverage Outside of the United States, Canada or Mexico.**
   We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.
6. **Dental Services.**
   We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services and Pediatric Dental Care sections of this Certificate.
7. **Experimental or Investigational Treatment.**
   We do not Cover any health care service, procedure, treatment, device or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of 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 Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.
8. **Felony Participation.**
   We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).
9. **Foot Care.**
   We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.
10. **Government Facility.**
    We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.
11. **Medically Necessary.**
    In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drugis otherwise Covered under the terms of this Certificate.
12. **Medicare or Other Governmental Program.**
    We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).
13. **Military Service.**
    We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.
14. **No-Fault Automobile Insurance.**
    We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.
15. **Services Not Listed.**
    We do not Cover services that are not listed in this Certificate as being Covered.
16. **Services Provided by a Family Member.**
    We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

17. **Services Separately Billed by Hospital Employees.**
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

18. **Services With No Charge.**
We do not Cover services for which no charge is normally made.

19. **Vision Services.**
We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Pediatric Vision Care section of this Certificate.

20. **War.**
We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

21. **Workers' Compensation.**
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

Access help in your language

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

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

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل بقسم خدمات الأعضاء الموجود على بطاقة هويتك للمساعدة في التحدث إلى مترجم فوري. (TTY/TDD: 711)

Armenian

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

Chinese

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

Farsi

شما این حق را دارید که این اطلاعات و کمکهای مربوط به آن را به زبان خود دریافت کنید. برای کمک دریافت به زبان خود با شماره عضو که روی کارت شناسایی شما درج شده است تماس بگیرید. (TTY/TDD: 711)

French

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

Haitian

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

Italian

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

Japanese

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

Korean

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

Navajo

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

Polish

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

Punjabi

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

Russian

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

Spanish

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

Tagalog

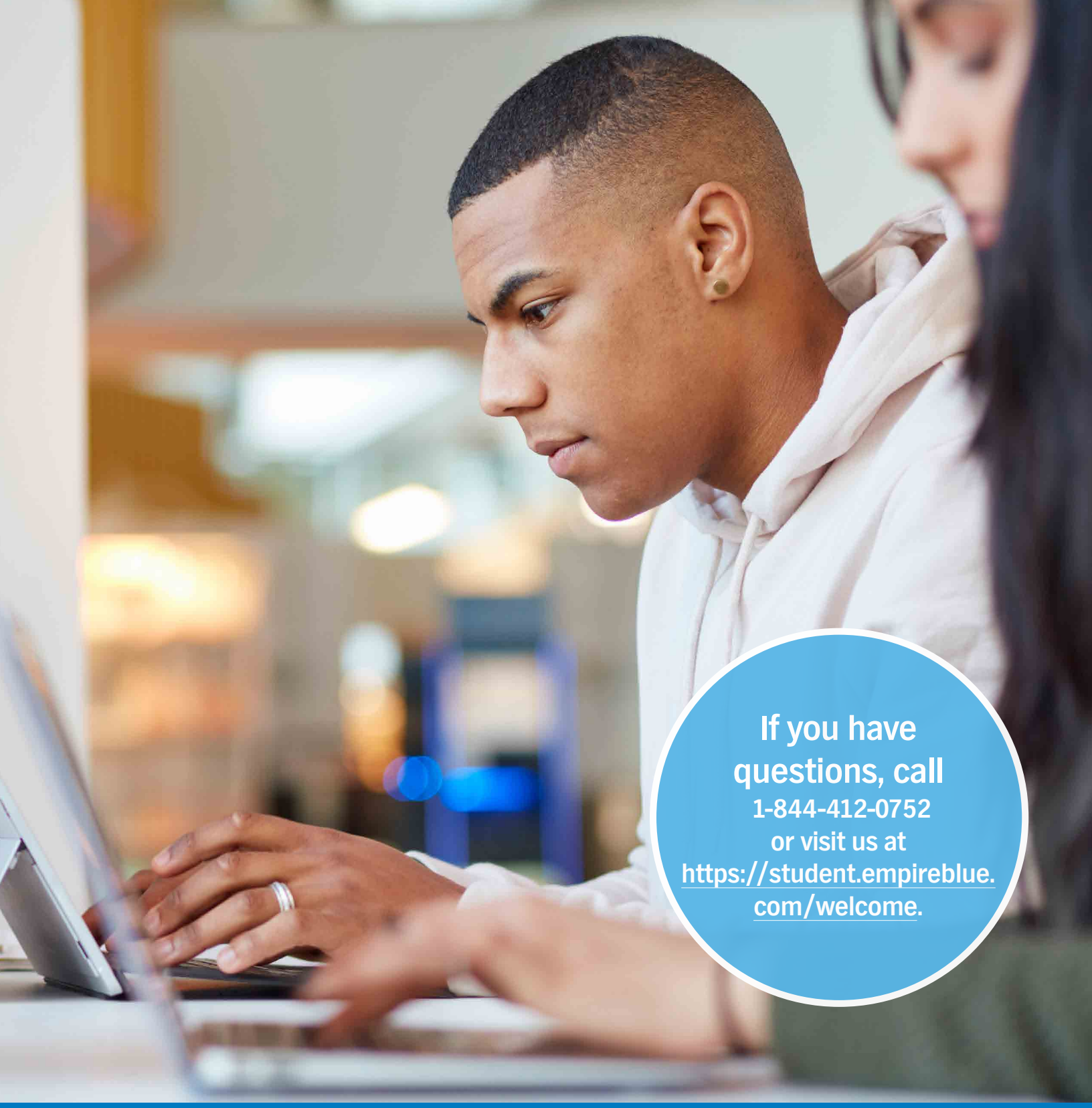
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Vietnamese

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

It is important we treat you fairly

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



If you have questions, call
1-844-412-0752
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