Your summary of benefits

Anthem STUDENT ADVANTAGE

Anthem BlueCross and BlueShield

University of Kentucky Student Health Plan

Your Network: Blue Access PPO

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

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

Eligibility includes coverage for same and opposite sex domestic partners.

Covered Medical Benefits	Cost if you use a Preferred Provider (UK HealthCare	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.*	$300 per person	$500 per person	$1,000 per person
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost- shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$6,350 individual / $12,700 family		$12,700 individual / $25,400 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Non-Network preventive care services for children prior to their 6th birthday have no deductible.*	No charge	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services **Primary Care Office Visit to treat an injury or illness**	$25 copay per visit	$30 copay per visit	50% coinsurance after deductible is met

Specialist Care Office Visit	$45 copay per visit	$50 copay per visit	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a Preferred Provider (UK HealthCare Providers)	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Prenatal and Post-natal Care	20% coinsurance after medical deductible is met	35% coinsurance after medical deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:			
Retail Health Clinic	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met
On-line Visit *Live Health Online is the preferred telehealth solutions (www.livehealthonline.com)*	Not Applicable	$25 copay per visit	Not covered
Manipulation Therapy *Coverage is limited to 24 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	$15 copay per visit	$15 copay per visit	$15 copay per visit
Other Services in an Office:			
Allergy Testing	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy *Copay applies when chemo/radiation does not follow surgery.*	$15 copay per visit	$15 copay per visit	$15 copay per visit
Hemodialysis	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use a Preferred Provider (UK HealthCare Providers)	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Diagnostic Services			
Lab:			
Office	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:			
Office	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):			
Office	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use a Preferred Provider (UK HealthCare Providers)	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Emergency and Urgent Care			
Urgent Care (Office Setting)	$75 copay per visit	$75 copay per visit	50% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$200 copay per visit 20% coinsurance after deductible is met	$200 copay per visit 20% coinsurance after deductible is met	$200 copay per visit 20% coinsurance after deductible is met
Emergency Room Doctor and Other Services	20% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Ambulance (Air and Ground)	Not covered	35% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Mental Health and Substance Use Disorder			
Doctor Office Visit and Online Visit	$25 copay per visit	$30 copay per visit	50% coinsurance after deductible is met
Facility visit:			
Facility Fees	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use a Preferred Provider (UK HealthCare Providers)	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Surgery			
Facility Fees:			
Hospital	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:			
Hospital	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital Stay (all Inpatient stays including Maternity, Mental and Substance Use Disorder): *Coverage for Maternity includes that for dependent daughters for pregnancy and termination of pregnancy.*			
Facility fees (for example, room & board) *Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Non-Network Providers combined is limited to 60 days per benefit year.*	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met

Recovery & Rehabilitation **Home Care Visits** *Coverage for In-Network Providers and Non-Network Providers combined is limited to 100 visits per benefit period. Visit limit does not apply to Physical, Occupational or Speech Therapy when performed as part of Home Health.*	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a Preferred Provider (UK HealthCare Providers)	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Rehabilitation services (for example, physical/speech/occupational therapy):			
Office *Prior Authorization is required. Visit limit will be based upon medical necessity.. Apply to In-Network Providers and Non- Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	$15 copay per visit	$15 copay per visit	$15 copay per visit
Freestanding Facility *Prior Authorization is required. Visit limit will be based upon medical necessity.. Apply to In-Network Providers and Non- Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	$15 copay per visit	$15 copay per visit	$15 copay per visit
Outpatient Hospital *Prior Authorization is required. Visit limit will be based upon medical necessity.. Apply to In-Network Providers and Non- Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	$15 copay per visit	$15 copay per visit	$15 copay per visit
Inpatient Hospital *Prior Authorization is required. Visit limit will be based upon medical necessity.. Apply to In-Network Providers and Non- Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use a Preferred Provider (UK HealthCare Providers)	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 *Prior Authorization is required. Visit limit will be based upon medical necessity.. Apply to In-Network Providers and Non- Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	$15 copay per visit	$15 copay per visit	$15 copay per visit
Freestanding Facility *Prior Authorization is required. Visit limit will be based upon medical necessity.. Apply to In-Network Providers and Non- Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	$15 copay per visit	$15 copay per visit	$15 copay per visit
Outpatient Hospital *Prior Authorization is required. Visit limit will be based upon medical necessity.. Apply to In-Network Providers and Non- Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	$15 copay per visit	$15 copay per visit	$15 copay per visit
Inpatient Hospital *Prior Authorization is required. Visit limit will be based upon medical necessity.. Apply to In-Network Providers and Non- Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use a Preferred Provider (UK HealthCare Providers)	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Cardiac rehabilitation Office *Prior Authorization is required. Visit limit will be based upon medical necessity..*	$15 copay per visit	$15 copay per visit	$15 copay per visit
Outpatient Hospital *Prior Authorization is required. Visit limit will be based upon medical necessity..*	$15 copay per visit	$15 copay per visit	$15 copay per visit
Skilled Nursing Care (in a facility) *Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Non-Network Providers combined is limited to 60 days per benefit period.*	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment *Coverage for hearing aids services left ear is limited to 1 unit every 36 months Apply to In-Network Providers and Non-Network Providers combined.*	Not applicable	35% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs needed after cancer treatment In-Network Providers and Non-Network Providers combined is limited to 1 items per benefit period.*	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met

Diabetes Maintenance			
Outpatient Institutional - Diabetes Education/Diabetic Nutritional Counseling	No charge	No charge	50% coinsurance after deductible is met
Outpatient Professional - Diabetes Education/Diabetic Nutritional Counseling	No charge	No charge	50% coinsurance after deductible is met
Office Professional - Diabetes Education/Diabetic Nutritional Counseling	No charge	No charge	50% coinsurance after deductible is met

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Covered Prescription Drug Benefits	Cost if you use a Preferred Provider (UK HealthCare Providers)	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Pharmacy Deductible	Not applicable	Not applicable	Not applicable
Pharmacy Out of Pocket	Not applicable	Not applicable	Not applicable
Prescription Drug Coverage *Traditional Open Drug List*			
Tier 1 - Typically Lower Cost Generic *Covers up to a 30-day supply (retail pharmacy). Covers up to a 90-day supply (home delivery program).*	Retail: 10% Min $10, Max $50 Home Delivery: 30-day RX 20% Min $30, Max $60 90-day RX 20% Min $60, Max $120	Retail: 20% Min $30, Max $60 Home Delivery: 30-day RX 20% Min $30, Max $60 90-day RX 20% Min $60, Max $120	Not covered
Tier 2 – Typically Preferred Brand *Covers up to a 30-day supply (retail pharmacy). Covers up to a 90-day supply (home delivery program).*	Retail: 20% Min $30, Max $60 Home Delivery: 30-day RX 30% Min $50, Max $75 90-day RX 30% Min $100, Max $150	Retail: 30% Min $50, Max $75 Home Delivery: 30-day RX 30% Min $50, Max $75 90-day RX 30% Min $100, Max $150	Not covered
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).*	Retail: 50% Min $60 Home Delivery: 30-day RX 50% Min $75 90-day RX 50% Min $225	Retail: 50% Min $75 Home Delivery: 30-day RX 50% Min $75 90-day RX 50% Min $225	Not covered
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30-day supply (retail pharmacy). Covers up to a 30-day supply (home delivery program).*	Generic Retail: 10% Min $10, Max $50 Generic Home Delivery: 30-day RX 20% Min $75 Specialty Retail & Home Delivery 20%	Retail: 20% Min $30, Max $60 Generic Home Delivery: 30-day RX 20% Min $75 Specialty Retail & Home Delivery 20%	Not covered

*Out of Network: Not covered except for study abroad or other university related and approved travel
$60 per service (prescription) Deductible for Generic drugs, $75 per service (prescription) Deductible for Brand name drugs, then the plan pays 50% of Usual and Customary Charges (50% Coinsurance).
**Women's contraceptives will be covered at 100% only for GENERIC drugs unless a generic is not available.

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Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-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 member's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail.		
Children's Vision Essential Health Benefits (up to age 21) **Child Vision Deductible**	$0 person	Not Applicable
Vision exam *Coverage for UK HealthCare Providers is limited to 1 exam per benefit period.*	100% after a $20 copay	Not covered
Frames *Coverage for UK HealthCare Providers is limited to 1 unit per benefit period. The Covered Individual is eligible to select only one of either Eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses.*		
Eyeglass frames with a retail cost up to $130	100%	Not covered
Eyeglass frames with a retail cost up to $130 - $160	100% after a $15 copay	Not covered
Eyeglass frames with a retail cost up to $160 - $200	100% after a $30 copay	Not covered
Eyeglass frames with a retail cost up to $200 - $250	100% after a $50 copay	Not covered
Eyeglass frames with a retail cost greater than $250	60% coinsurance	Not covered

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Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Lenses *Coverage for UK HealthCare Providers is limited to 1 unit per benefit period. The Covered Individual is eligible to select only one of either Eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses.*		
Single Vision	100% after a $40 copay	Not covered
Bifocal	100% after a $40 copay	Not covered
Trifocal	100% after a $40 copay	Not covered
Lenticular	100% after a $40 copay	Not covered
Contact lenses *Coverage for UK HealthCare Providers is limited to 1 unit per benefit period. Limited to a 12-month supply. The Covered Individual is eligible to select only one of either Eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses.*	15% off price after $130 allowance	Not covered
Covered Contact Lens Selection *Coverage for UK HealthCare Providers is limited to 1 unit per benefit period. Limited to a 12-month supply. The Covered Individual is eligible to select only one of either Eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses.*	100% after a $40 copay	Not covered
Necessary Contact Lenses *Coverage for UK HealthCare Providers is limited to 1 unit per benefit period. The Limited to a 12-month supply. Covered Individual is eligible to select only one of either Eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses.*	100% after a $40 copay	Not covered
Adult Vision (age 21 and older) **Adult Vision Coverage** *Limited to certain vision screenings required by Federal law and covered under the "Preventive Care" benefit.*	100% after a $20 copay	Not covered

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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.* ***Benefits are available only for Necessary Dental Services.*** *The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease, does not mean that the procedure or treatment is a Covered Dental Service under this Plan.* ***Pre-Treatment Estimate*** *– If the charge for a Dental Service is expected to exceed $300 or if a dental exam reveals the need for fixed bridgework, the Covered Individual may notify the Claims Administrator of such treatment before treatment begins and receive a pre-treatment estimate. To receive a pre-treatment estimate, the Covered Individual or Dental provider should send a notice to the Claims Administrator, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide the Claims Administrator with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.* ***If a treatment plan is not submitted, the Covered Individual will be responsible for payment of any dental treatment not approved by the Claims Administrator.*** *Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.*		
Children's Dental Essential Health Benefits (up to age 21) **Diagnostic and preventive** *Includes cleanings, exams, x-rays, sealants, fluoride; space maintainers*	50% coinsurance	Not covered
Basic services *Includes fillings and simple extractions*	50% coinsurance	Not covered
Adjunctive Services *General services (including Emergency Treatment of dental pain) – Covered as a separate Benefit only if no other service was done during the visit other than x-rays. General anesthesia is covered when necessary.* *Occlusal guards for Covered Individuals age 13 and older – limited to one guard every 12 months.*	50% coinsurance	Not covered

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Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Major services/Prosthodontic *Inlays, onlays, crowns (partial to full crowns), fixed and removable prosthetics, denture repair, repairs or adjustments to bridges, crowns, full dentures and partial dentures*	50% coinsurance	Not covered
Endodontic, Periodontics, Oral Surgery *Periodontal surgery, scaling and root planing, periodontal maintenance, endodontics and oral surgery*	50% coinsurance	Not covered
Medically Necessary Orthodontia	50% coinsurance	Not covered
Implants *Placement, supported prosthetics, maintenance procedures, repair implant supported prosthesis, abutment supported crown or retainer crown, repair implant abutment by support, radiographic/surgical implant index by report* *Each service limited to once per 60 months.*	50% coinsurance	Not covered
Deductible	$500 per person	Not applicable
Adult Dental (age 21 and over)	Not covered	Not covered

Exclusions and Limitations

Nothing in this Exclusions and Limitations section shall be interpreted as excluding Essential Health Benefits.

No benefits will be paid for a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to any of the following:

1. Acupuncture.
2. Cosmetic procedures, except reconstructive procedures, to:
    a. Correct an Injury or treat an Illness for which benefits are otherwise payable under this Plan. The primary result of the procedure is not a changed or improved physical appearance.
    b. Treat or correct Congenital Conditions of a Newborn or adopted Infant.
    c. Correct hemangiomas and port wine stains of the head and neck areas for Covered Individuals 18 years of age or younger.
    d. Correct limb deformities such as club hand, club foot, syndactyly, polydactyly, or macrodactylia.
    e. Improve hearing by directing sound in the ear canal by performing Otoplasty, when ear or ears are absent o deformed from Injury, surgery, disease or Congenital Condition.
    f. Correct diagnosis of tongue-tied by performing tongue release.
    g. Treat or correct Congenital Conditions causing skull deformity such as Crouzon's disease.
    h. Correct cleft lip and cleft palate.
3. Custodial Care.
    a. Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
    b. Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
4. Dental treatment, except:
    a. For accidental Injury to Sound, Natural Teeth.
    b. As described under Dental Treatment in the Plan.
    c. Benefits specifically provided under Pediatric Dental Services Benefits.
5. Elective Surgery or Elective Treatment.
6. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline; or chartered aircraft only while participating in a school sponsored intercollegiate sport.
7. Foot care for the following:
    a. Flat foot conditions.
    b. Supportive devices for the foot.
    c. Subluxations of the foot.
    d. Fallen arches.
    e. Weak feet.
    f. Chronic foot strain.
    g. Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

    This exclusion does not apply to preventive foot care for Covered Individuals with diabetes.
8. Health spa or similar facilities. Strengthening programs.
9. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process. This exclusion does not apply to:
    a. Hearing defects or hearing loss as a result of an Illness or Injury.

   b. Benefits specifically provided in the Plan.
10. Hypnosis.
11. Immunizations, except as specifically provided in the Plan. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the Plan.
12. Injury or Illness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
13. Injury sustained while:
    a. Participating in any intercollegiate or professional sport, contest or competition.
    b. Traveling to or from such sport, contest or competition as a participant.
    c. Participating in any practice or conditioning program for such sport, contest or competition.
14. Investigational services.
15. Marital or family counseling.
16. Commission of or attempt to commit a felony.
17. Prescription Drugs, services or supplies as follows:
    a. Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances.
    b. Immunization agents, except as specifically provided in the Plan. Biological sera. Blood or blood products administered on an outpatient basis.
    c. Drugs labeled, "Caution – limited by federal law to investigational use" or experimental drugs.
    d. Products used for cosmetic purposes.
    e. Drugs used to treat or cure baldness. Anabolic steroids used for body building.
    f. Anorectics – drugs used for the purpose of weight control.
    g. Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
    h. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
18. Reproductive/Infertility services including the following:
    a. Procreative counseling.
    b. Genetic counseling and genetic testing.
    c. Cryopreservation of reproductive materials. Storage of reproductive materials.
    d. Fertility tests.
    e. Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
    f. Premarital examinations.
    g. Impotence, organic or otherwise.
    h. Reversal of sterilization procedures.
19. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the Plan.
20. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. This exclusion does not apply: 1) when due to a covered Injury or Illness, 2) to benefits specifically provided under Pediatric Vision Services, and 3) to one pair of eyeglasses or contact lenses following intraocular lens implantation to treat cataracts or aphakia, or 4) to benefits specifically provided under the Plan.
21. Routine Newborn Infant Care and well-aby nursery and related Physician charge, except as specifically provided in the Plan.
22. Preventive care services, except as specifically provided in the Plan, including:
    a. Routine physical examinations and routine testing.
    b. Preventive testing or treatment.

c. Screening exams or testing in the absence of Injury or Illness.

23. Services provided normally without charge by the Health Service of the Covered Individual.
24. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis.
25. Sleep disorders.
26. Supplies, except as specifically provided in the Plan.
27. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Plan.
28. Treatment in a Government hospital, unless there is a legal obligation for the Covered Individual to pay for such treatment.
29. Charges for Illness or Injury from any war or any act of war, declared or undeclared; or while in the armed forces of any country.
30. Charges for weight management, weight reduction, nutrition programs, treatment for obesity, or surgery for removal of excess skin or fat.

Pediatric Vision Exclusions and Limitations

The following Pediatric Vision Exclusions and Limitations are in addition to those listed in the Exclusions and Limitations of the Plan:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which benefits are available as stated in the Plan.
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken, except as specifically provided in the Eyeglass Replacement provision.
4. Optional Lens Extras not listed in Benefits for Vision Care Services.
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

Pediatric Dental Exclusions and Limitations

The following Pediatric Dental Exclusions and Limitations are in addition to those listed in the Exclusions and Limitations of the Plan:

1. Any Dental Service or Procedure not listed as a Covered Dental Service under the Plan.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen

is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jawbone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office at least a 24-hour notice.
15. Expenses for Dental Procedures begun prior to the Covered Individual's Effective Date of coverage.
16. Dental Services otherwise covered under the Plan, but rendered after the date individual coverage under the Plan terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Plan terminates.
17. Services rendered by a provider with the same legal residence as the Covered Individual or who is a member of the Covered Individual's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
21. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
22. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
23. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
25. Maxillofacial prosthetic services, except for the following when provided by a board-certified prosthodontist:
    a. A nasal prosthesis
    b. An auricular prosthesis
    c. A facial prosthesis
    d. A mandibular resection prosthesis
    e. A pediatric speech aid
    f. An adult speech aid
    g. A palatal augmentation prosthesis
    h. A palatal lift prosthesis
    i. An oral surgical splint
    j. An unspecified maxillofacial prosthetic.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (855) 837-8541

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(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 837-8541 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 837-8541:

Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(855) 837-8541。

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French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 837-8541.

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Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (855) 837-8541.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 837-8541 ਤੇ ਕਾਲ ਕਰੋ।

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