2021-2022

University of Kentucky
Student Health Plan

www.anthem.com/studentadvantage

Anthem Student Advantage
Keeping you at your personal best

A00386KYMENABS 06/21

Anthem | STUDENT ADVANTAGE

Important notice

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

- International Students – Health insurance is mandatory at UK for international students. F-1, J-1, and J-2 students are enrolled in the Student Health Plan automatically. The premium (cost) for this health plan is automatically added to the international student's bill when he or she registers for any class (including zero or two-credit hour courses).
- Funded Graduate Assistants – A qualifying funded graduate student is automatically enrolled in the coverage provided by this health plan. To qualify, a student must be enrolled in the Graduate School, degree-seeking, and receiving support from UK in the form of a Full-time Assistantship (TA, RA, GA), qualifying fellowship, or a combination of these positions. Full-time Assistantship standing means an assignment of 20 hours per week or a fellowship stipend of $9,000 or more paid through the UK payroll system.

The following student groups are also eligible to enroll:

- Voluntary Enrollment Group – Undergraduate and non-funded graduate students may purchase coverage provided by this health plan. An undergraduate student must be enrolled in at least six (6) credit hours at the University of Kentucky or Bluegrass Community and Technical College (BCTC) campuses located at Cooper, Newtown, and Leestown. A non-funded graduate student must be enrolled in any course with the university. Students in the Voluntary Enrollment Group are required to pay the full Premium for the Coverage Period chosen.
- Student Athletes - Student Athletes are eligible for coverage under this Student Health Plan. If a Student Athlete is covered under another health plan designed to cover Injury or Illness associated with his or her participation in an athletics program [such as coverage sponsored by the National Collegiate Athletic Association (NCAA)], this Student Health Plan will be secondary to any coverage of benefits provided by the Student Athlete's athletics program coverage.

Coverage is available for dependents too

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

- An eligible student may also cover an eligible spouse and eligible children.

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

ESL

Session	Fall 1 8/15/2021 through 10/16/2021	Fall 2 10/17/2021 through 12/31/2021	Spring 1 1/1/2022 through 3/15/2022	Spring 2 3/16/2022 through 6/15/2022	Summer 6/16/2022 through 8/14/2022
Student	$455	$550	$535	$666	$434
Spouse	$455	$550	$535	$666	$434
Child	$455	$550	$535	$666	$434
Children	$910	$1,100	$1,070	$1,332	$868

Continued

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

Funded Graduate International

Session	Fall 8/15/2021 through 12/31/2021	Summer/Spring 1/1/2022 through 8/14/2022
Student	$1,003	$1,638
Spouse	$1,003	$1,638
Child	$1,003	$1,638
Children	$2,006	$3,276

Visiting Scholars

Session	1st Special - VS 8/15/2021 through 10/14/2021	2nd Special - VS 10/15/2021 through 12/14/2021	3rd Special - VS 12/15/2021 through 2/14/2022
Student	$440	$440	$440
Spouse	$440	$440	$440
Child	$440	$440	$440
Children	$880	$880	$880

Session	4th Special - VS 2/15/2022 through 4/14/2022	5th Special - VS 4/15/2022 through 6/14/2022	6th Special - VS 6/15/2022 through 8/14/2022
Student	$440	$440	$440
Spouse	$440	$440	$440
Child	$440	$440	$440
Children	$880	$880	$880

Voluntary

Session	Fall 8/15/2021 through 12/31/2021	Summer/Spring 1/1/2022 through 8/14/2022
Student	$1,053	$1,720
Spouse	$1,053	$1,720
Child	$1,053	$1,720
Children	$2,106	$3,440

Important dates for the coverage period

Open enrollment

- **Early Arrival Fall 1***
  6/21/2021–8/13/2021
- **Early Arrival Fall 2****
  7/14/2021–9/14/2021
- **Fall**
  7/14/2021–9/14/2021
- **Spring/Summer**
  12/1/2021–2/18/2022

Waiver deadlines (for International Students only)

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

- **Fall**
  7/14/2021–9/15/2021
- **Spring/Summer**
  12/01/2021–2/22/2022

*Only New to SHIP 1st Year Medical students eligible for Early Start Fall 1, attestation with audit
**Only for those who are required to come early from academic department

If you have **questions about enrollment and waiver options,** visit uky.myahpcare.com.

Keep in touch with your benefits information

University Health Service

830 S. Limestone
Lexington, KY 40536
Phone: 859-323-2778 (APPT)
Fax: 859-257-8708
ukhealthcare.uky.edu/university-health-service
Monday - Friday: 8 a.m. - 4:30 p.m.
Saturday: 9 a.m. - 11 am

Claims and Benefits

1-844-412-0752
Anthem Blue Cross and Blue Shield
P.O. Box 105187
Atlanta, GA 30348-5187

Eligibility and enrollment

Academic HealthPlans
uky.myahpcare.com

Student Counseling Center

830 S. Limestone
Lexington, KY 40536
1-859-323-5511
ukhealthcare.uky.edu/university-health-service/student-health/services/behavioral-health
Monday - Friday: 8 a.m. - 4:30 p.m.
Saturday: 9 - 11:00 a.m.
Services available for:

- Depression
- Anxiety
- Drug and alcohol abuse
- Eating disorders
- Attention difficulties
- Stress
- Grief

Your Student Health Center services

University of Kentucky is the primary medical provider for students enrolled in the Student Health Plan (SHP). These services and benefits:

- Are not covered benefits under your SHP.
- Are not subject to the coinsurance, co-pay or deductible amounts under your SHP.

For the types of care and services listed below, visit the University Health Service.

The Health Fee covers unlimited office visits for:

- Primary care visits for injury or illness
- GYN/GU (gynecology)
- Behavioral health
- Health education and wellness services, including:
  - Health and wellness coaching
  - Nutrition counseling
  - Tobacco treatment counseling
  - Sexual health education sessions
  - Well-patient, travel and employment physical exams.
  - Allergy injections (With orders from an allergy doctor).
  - Phone Information Nurse
  - Observation room care
  - On-call physician for after-hours advice
  - Limited medications
  - Some STI lab testing
  - CLIA waived in-office tests (except rapid flu and rapid HIV)

Services NOT covered by the Health Fee are billed as fee-for-service visits; these services include but are not limited to:

- Laboratory services (blood work)
- X-rays
- Immunizations (offered at a discount rate)
- Additional diagnostic testing (such as MRI or CT Scans)
- In-clinic procedures (such as wart removal or sutures)
- Emergency room visits
- Most prescriptions
- Referrals to specialty clinics (such as physical therapy or orthopedic surgery)
- Dentistry. See information on on-campus clinic options
- Ophthalmology (vision screens and/or prescription lenses)
- Surgery
- Hospitalization

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 **1-877-924-7758** to speak to a registered nurse who can help you with health issues like fever, allergy relief, cold and flu symptoms and where to go for care. Nurses can also help you enroll in health management programs if you have specific health conditions, remind you about scheduling important screenings and exams, and more.

Provider finder

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

1 Sydney Health is a service mark of CareMarket, Inc.
2 Appointments subject to availability of a therapist. Psychologists or therapists using LiveHealth Online cannot prescribe medications. Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 1-800-784-2433 (National Suicide Prevention Lifeline) or 911 and ask for help. If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.
LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

Your summary of benefits

Anthem Blue Cross and Blue Shield

Student Health Plan:
University of Kentucky

Your network:
Blue Access PPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC) will prevail. Plan benefits are pending approval with the state and subject to change.
Student Health Center Benefits: No Charge for Covered Medical Expenses, Deductible Waived

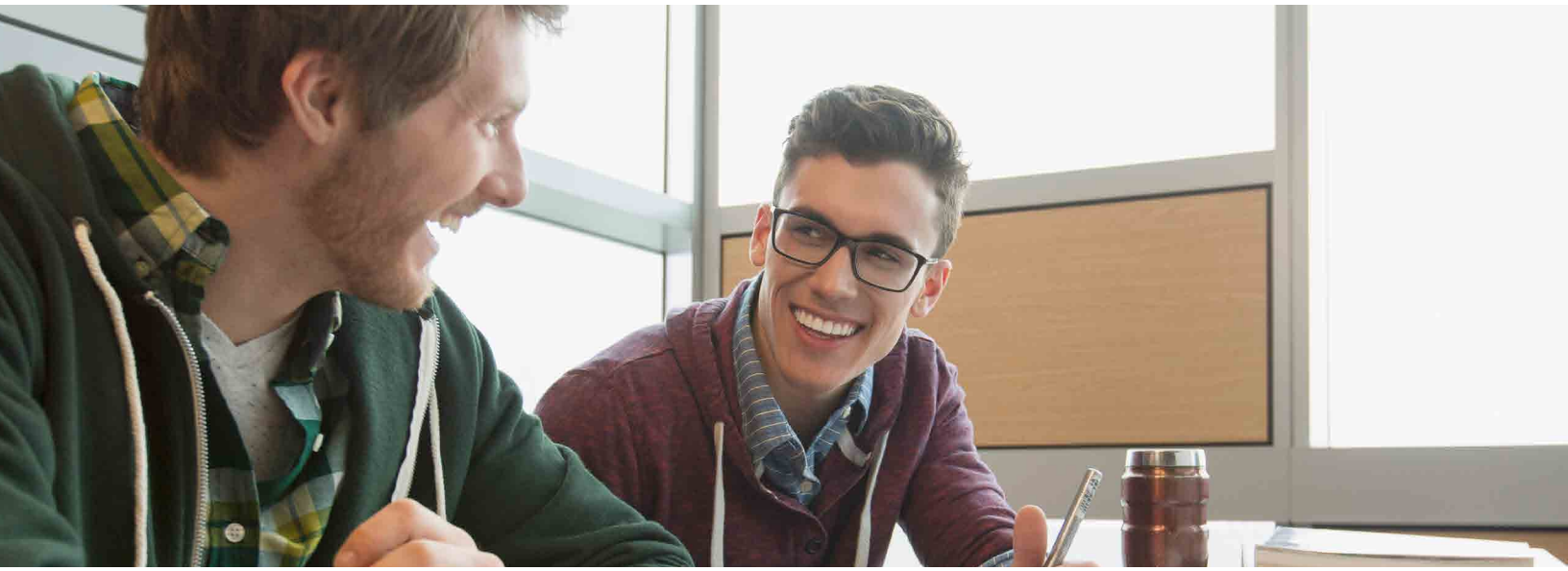
Medical

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
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
Specialist Care Office Visit	$45 copay per visit	$50 copay per visit	50% coinsurance
Prenatal and Post-natal Care	No charge	No charge	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 solution. (www.livehealthonline.com)*	Not covered	$25 copay per visit	Not covered
Manipulation Therapy *Coverage is limited to 12 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

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
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 drug 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
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
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. Non-emergency use of the emergency room is not covered.*	$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 Ambulance (Air and Ground)	Not covered	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
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
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 / Behavioral Health, and Substance Abuse) *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
Rehabilitation services (for example, physical/speech/occupational therapy):			
Office *Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. 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 *Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. 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

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 *Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. 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 *Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. 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
Cardiac rehabilitation			
Office *Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.*	$15 copay per visit	$15 copay per visit	$15 copay per visit
Outpatient Hospital *Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.*	$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	Not covered	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.*	Not covered	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 item per benefit period.*	20% coinsurance after deductible is met	35% coinsurance after deductible is met	50% coinsurance after deductible is met



Pharmacy

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 20% Min $100, Max $150	Retail: 30% Min $50, Max $75 Home Delivery: 30-day RX 30% Min $50, Max $75 90-day RX 20% 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.*

Pediatric Vision *Limited to covered persons under the age of 21.*

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 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) *Limited to covered persons under the age of 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
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 *Bifocal* *Trifocal* *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)	**Cost if you use a UK HealthCare Provider only**	
Adult Vision Coverage		
All members are eligible for one routine vision exam (including refraction) per year.	100% after a $20 copay	

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

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 or 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,
   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, regardless of intended use, except as specifically provided in the Plan.
   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. Vision correction surgery. Treatment for visual defects and problems. 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-baby 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

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

ىلع دوجوملا ءاضعلأا تامدخ مقرب لصتا .اًناجم كتغلب ةدعاسملاو تامولعملا هذه ىلع لوصحلا كل قحي
ةقاطب فيرعتلا ةصاخلا كب ةدعاسملل.(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

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

French

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

Haitian

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

Italian

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

Japanese

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

Korean

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

Navajo

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

Polish

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

Punjabi

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

Russian

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

Spanish

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

Tagalog

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

Vietnamese

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

It is important we treat you fairly

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

If you have questions, visit uky.myahpcare.com or www.anthem.com/studentadvantage.

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