

**San Diego State University**  
**Graduate Student Health Insurance Plan (GSHIP)**  
**2022 – 2023**

**Who is Eligible for the Plan?**

**Students:** All SDSU students enrolled in graduate or post-baccalaureate programs at SDSU and SDSU Imperial Valley, excluding those covered by the existing SDSU International Student requirement, are automatically enrolled in this insurance plan, unless a waiver on the basis of other current health insurance coverage is submitted. Students must actively attend classes on campus for the first 31 consecutive days after the effective date, except for university authorized breaks. Remote courses such as home study, correspondence and online courses do not fulfill this requirement. A once-per-lifetime medical withdrawal exception may be granted to students on school approved medical leave during the first 31 days of coverage.

The SDSU GSHIP plan includes the following coverages through Anthem Student Advantage:

- Health Insurance Coverage
- Dental Insurance Coverage
- Vision Insurance Coverage

**EPO Network:**

The SDSU GSHIP-sponsored Student Health Insurance plan provided through Anthem is an EPO plan. An EPO Plan (Exclusive Provider Organizations) is a lot like an HMO, in that they don't cover care outside the plan's provider network. SDSU GSHIP does not cover benefits for services provided by non-preferred providers or facilities (Emergency Room and Ambulance excluded). If you wish to locate an Anthem provider, you can do so by utilizing Anthem's Provider Search tool located at: <https://www.anthem.com/ca/find-care/>

**Plan Dates**

Terms	Fall
Insurance Start Date (12:01am)	1/16/2023
Insurance End Date (11:59pm)	8/14/2023
Waiver Opens	11/1/2022
Waiver Deadline	1/31/2023

**Included Coverage:**

**Anthem Student Health, Dental, and Vision:**

Mobile ID Cards will NOT be available until the term start date, or 3 weeks after enrolling in the plan, whichever is later. Access your ID card with Sydney Health app through Anthem Student Advantage. From your mobile device or tablet go to the App Store or Google Play and search for the Sydney Health app to download it today. Questions about the app, please visit [www.anthem.com/ca](http://www.anthem.com/ca) or call Anthem Student Advantage at: 1-800-888-2108. If you are unable to download the app, please register here: <https://www.anthem.com/register/>

## 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, and remind you about scheduling important screenings and exams, and more.

## 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.<sup>2</sup> To use, go to your Sydney Health app or [livehealthonline.com](http://livehealthonline.com). You can also download the free LiveHealth Online app to sign up.

## Sydney Health app

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

- › Your member ID card.
- › The Find Care 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).

## Important Contacts:

### **Anthem Dental and Vision PPO Network:**

To locate an EPO (in-network) Medical, Dental and Vision providers, answer benefit questions or check the status of a Claim, visit the Anthem website or call the number below.

(800) 888-2108

[www.anthem.com/ca](http://www.anthem.com/ca)

### **24/7 NurseLine**

Anthem Student Advantage

1-844-545-1429

### **Eligibility, Enrollment & Waivers:**

Find answers to most of your eligibility questions by visiting our website

[www.jcbins.com](http://www.jcbins.com)

(510) 542-5306



2022-2023



## San Diego State University - Graduate Plan Student Health Insurance Plan

[www.anthem.com/studentadvantageca](http://www.anthem.com/studentadvantageca)

# Anthem Student Advantage

Keeping you at your personal best



**Important notice**

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

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**Welcome  
to Anthem  
Student  
Advantage**



As your new school year begins, it's important to understand your health care benefits and how they work. Your Anthem Student Advantage plan will help guide you through that process with information about who is eligible, what is covered, how much it costs, and the best ways to access care.

## What you need to know about Anthem Student Advantage



### Who is eligible for the Plan?

All SDSU students enrolled in graduate or post-baccalaureate programs at SDSU and SDSU Imperial Valley, excluding those covered by the existing SDSU International Student requirement, are automatically enrolled in this insurance plan, unless a waiver on the basis of other current health insurance coverage is submitted.

Students must actively attend classes on campus for the first 31 consecutive days after the effective date, except for university-authorized breaks.

Remote courses such as home study, correspondence and online courses do not fulfill this requirement.

A once-per-lifetime medical withdrawal exception may be granted to students on school approved medical leave during the first 31 days of coverage.

All refund requests must be sent to the University who will confirm non-student status with JCB, and submit

the refund request on behalf of the student. Only refunds submitted by the University before the refund deadline will be considered. Credit card refunds must be requested and processed within 120 days of the date of purchase and before the refund deadline. No refunds will be considered after the refund deadline. All refunds will be processed back to the original form of payment only, no exceptions. All refunds will be assessed a \$35 processing fee. Please allow 30 business days for us to receive and process the refund request, then an additional 3-5 business days to receive your refund from your financial institution. Pro-rated/partial refunds are not allowed. NOTE: You can check to see if your refund has been processed by logging in to your JCB account.

Coverage for dependents (spouse/children) is not available under this plan.



# Coverage periods

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



## Dates of coverage (San Diego State Graduate Plan)

### Session

#### Fall

8/15/2022 - 1/15/2023

#### Spring/Summer

1/16/2023 - 8/14/2023

\*Coverage for dependents (spouse/children) is not available under this plan.  
\*The above rates include premiums for the plan and commissions and administrative fees.  
\*Rates are pending approval with the state and subject to change.





# Keep in touch with your benefits information



## Eligibility and Enrollment questions

<https://jcbins.com/>

1-619-415-0233



## Student Health Center

San Diego State University

Student Health Services

Calpulli Center, 5700 Hardy Avenue, San Diego, CA 92115

1-619-594-4325

<https://sa.sdsu.edu/student-health-services>



## Claims and coverage

1-800-888-2108

Anthem Blue Cross Life and Health Insurance Company

P.O. Box 60007

Los Angeles, CA 90060-0007

# 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<sup>1</sup> app through Anthem Student Advantage, you have instant access to:

- › Your member ID card.
- › The Find Care 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<sup>SM</sup> or Google Play<sup>TM</sup> and search for the Sydney Health app to download it today.



## Anthem Student Advantage SDSU website

Use [www.anthem.com/studentadvantageca](http://www.anthem.com/studentadvantageca) to see your health plan information, including providers, benefits, claims, covered drugs and more.



## ID Cards

To download your ID card, please access the Sydney app. You can also log onto [anthem.com/ca](http://anthem.com/ca) to register and view your ID card.



## 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, and remind you about scheduling important screenings and exams, and more.



## Provider finder

Use [www.anthem.com/find-doctor/](http://www.anthem.com/find-doctor/) to find the right doctor or facility close to where you are.



## 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.<sup>2</sup> To use, go to your Sydney Health app or [www.livehealthonline.com](http://www.livehealthonline.com). You can also download the free LiveHealth Online app to sign up.

<sup>1</sup> Sydney Health is a service mark of CareMarket, Inc.

<sup>2</sup> 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

Student health insurance plan:  
San Diego State University  
(Graduate Plan)

Your network:  
Prudent Buyer 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.

## Medical

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>		
See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.	\$500 student	Not applicable
<b>Out-of-Pocket Limit</b>		
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.	\$8,700 student	Not applicable
<b>Preventive care/screening/immunization</b>		
In-network preventive care is not subject to deductible, if your plan has a deductible.	No charge	Not covered
<b>Doctor Home and Office Services</b>		
Primary Care Visit to treat an injury or illness	\$20 copay per visit deductible does not apply	Not covered
Specialist care visit	\$20 copay per visit deductible does not apply	Not covered
Prenatal Care and Post-natal Care	No charge	Not covered
<b>Other practitioner visits:</b>		
Retail Health Clinic Visit	\$20 copay per visit deductible does not apply	Not covered
On-line Visit <i>Live Health Online is the preferred telehealth solutions (<a href="http://www.livehealthonline.com">www.livehealthonline.com</a>)</i>	\$20 copay per visit deductible does not apply	Not covered
Chiropractic/Manipulation Therapy <i>Coverage is unlimited. Applies to In-Network. Visit limits are combined across both outpatient and other professional visits.</i>	\$20 copay per visit deductible does not apply	Not covered
Acupuncture	\$20 copay per visit deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Other services in an Office:</b>		
Allergy Testing	\$20 copay per visit after deductible is met	Not covered
Chemo/Radiation Therapy	10% coinsurance after deductible is met	Not covered
Hemodialysis	10% coinsurance after deductible is met	Not covered
Drugs Administered in the Office <i>For the drugs itself dispensed in the office through infusion/injection.</i>	10% coinsurance after deductible is met	Not covered
<b>Diagnostic Services</b>		
<b>Lab:</b>		
Office	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
<b>X-Ray:</b>		
Office	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
<b>Advanced diagnostic imaging (for example, MRI/PET/CAT scans):</b>		
Office	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
<b>Emergency and Urgent Care</b>		
<b>Urgent Care</b>	\$20 copay per visit deductible does not apply	Not covered
<b>Emergency Room Facility Services</b> <i>Copay waived if admitted.</i>	\$150 copay per visit plus 10% coinsurance, deductible does not apply	Covered as In-Network
<b>Emergency Room Doctor and Other Services</b>	10% coinsurance after deductible is met	Covered as In-Network
<b>Emergency Ambulance Transportation</b>	10% coinsurance after deductible is met	Covered as In-Network
<b>Outpatient Mental Health and Substance Use Disorder</b>		
<b>Doctor Office Visit and Online Visit</b>	\$20 copay per visit deductible does not apply	Not covered
<b>Facility visit:</b>		
Facility fees	10% coinsurance after deductible is met	Not covered
Doctor Services	10% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Outpatient Surgery</b>		
<b>Facility fees:</b>		
Hospital	\$150 copay per visit plus 10% coinsurance after deductible is met	Not covered
Freestanding Surgical Center	\$150 copay per visit plus 10% coinsurance after deductible is met	Not covered
<b>Doctor and Other Services</b>		
Hospital	10% coinsurance after deductible is met	Not covered
Freestanding Surgical Center	10% coinsurance after deductible is met	Not covered
<b>Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)</b>		
<b>Facility fees (for example, room &amp; board)</b> <i>Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 100 days combined per benefit period.</i>	\$150 copay per visit plus 10% coinsurance after deductible is met	Not covered
<b>Doctor and other services</b>	10% coinsurance after deductible is met	Not covered
<b>Recovery &amp; Rehabilitation</b>		
<b>Home Health Care</b> <i>Coverage is limited to 100 visits per year combined with home health services.</i>	10% coinsurance after deductible is met	Not covered
<b>Rehabilitation services (for example, physical/speech/occupational therapy):</b>		
Office	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
<b>Habilitation services (for example, physical/speech/occupational therapy):</b>		
Office	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
<b>Cardiac rehabilitation</b>		
Office	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
<b>Skilled Nursing Care (in a facility)</b> <i>Coverage is limited to 100 days combined per benefit period.</i>	\$250 copay per visit; then no additional charge	Not covered
<b>Hospice</b>	10% coinsurance after deductible is met	Not covered
<b>Durable Medical Equipment</b>	10% coinsurance after deductible is met	Not covered



## Pharmacy

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	None	Not applicable
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Not covered
<b>Prescription Drug Coverage</b> <i>This Plan uses a Traditional Drug List. Drugs not on this list are not covered.</i> <i>This product has a 90-day Retail Pharmacy Network available. A 90-day supply is available at most retail pharmacies.</i>		
<b>Tier 1 - Typically Generic</b> <i>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). No coverage for non-formulary drugs.</i>	\$20 copay per prescription (retail); \$40 copay per prescription (home delivery)	Not covered
<b>Tier 2 - Typically Preferred Brand</b> <i>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). No coverage for non-formulary drugs.</i>	\$30 copay per prescription (retail); \$60 copay per prescription (home delivery)	Not covered
<b>Tier 3 - Typically Non-Preferred Brand</b> <i>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). No coverage for non-formulary drugs.</i>	\$50 copay per prescription (retail); \$100 copay per prescription (home delivery)	Not covered





## Adult Vision

Blue View Vision plan benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Routine Eye Exam</b>		
A comprehensive eye examination once every plan year	\$10 copay	Up to \$42 reimbursement
<b>Eyeglass Frames</b>		
One pair of eyeglass frames once every two plan years	\$130 allowance, then 20% off any balance	Up to \$45 reimbursement
<b>Eyeglass Lenses (<i>instead of contact lenses</i>)</b>		
One pair of standard plastic prescription lenses:		
Single vision lenses once every plan year	\$10 copay	Up to \$40 reimbursement
Bifocal lenses once every plan year	\$10 copay	Up to \$60 reimbursement
Trifocal lenses once every plan year	\$10 copay	Up to \$80 reimbursement
<b>Eyeglass Lens Enhancements<sup>1</sup></b>		
Transitions Lenses (for a child under age 19) same as covered eyeglass lenses	\$0 copay	No allowance when obtained out-of-network
Standard polycarbonate (for a child under age 19) same as covered eyeglass lenses	\$0 copay	No allowance when obtained out-of-network
Factory scratch coating same as covered eyeglass lenses	\$0 copay	No allowance when obtained out-of-network
<b>Contact Lenses<sup>2</sup> (<i>instead of eyeglass lenses</i>)</b>		
Elective conventional (non-disposable); OR once every plan year	\$130 allowance, then 15% off any balance	Up to \$105 reimbursement
Elective disposable; OR once every plan year	\$130 allowance ( <i>no additional discount</i> )	Up to \$105 reimbursement
Non-elective (medically necessary) Once every plan year	Covered in full	Up to \$210 reimbursement

<sup>1</sup> When obtaining covered eyewear from a Blue View Vision provider, members may choose to add any of the listed lens enhancements at no extra cost.

<sup>2</sup> Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.

## Additional savings available from in-network providers

Description	Member cost
When obtaining covered eyewear from a Blue View Vision provider, members may choose to upgrade their new eyeglass lenses at a discounted cost. Costs shown are after any applicable eyeglass lens copayment.	
<b>Progressive Lenses</b>	
Standard	\$55
Premium Tier 1	\$85
Premium Tier 2	\$95
Premium Tier 3	\$110
Premium Tier 4	\$175
<b>Anti-Reflective Coating</b>	
Standard	\$45
Premium Tier 1	\$57
Premium Tier 2	\$68
Premium Tier 3	\$85
<b>Transitions lenses (Adults)</b>	\$75
<b>Standard Polycarbonate lenses (Adults)</b>	\$40
<b>UV Coating</b>	\$15
<b>Tint (Solid and Gradient)</b>	\$15
<b>Other lens upgrades and add-ons</b>	20% off retail price
<b>Retinal Imaging (obtained at same time as covered eye exam)</b>	Up to \$39
<b>Standard contact lens fitting and follow-up after comprehensive eye exam</b>	Up to \$55
<b>Premium contact lens fitting and follow-up after comprehensive eye exam</b>	10% off retail price
<b>Additional supplies of conventional contact lenses after benefits have been used</b>	15% off retail price
<b>Additional complete pairs of eyeglasses</b>	40% off retail price
<b>Eyeglass materials purchased separately</b>	20% off retail price
<b>Other items including most non-prescription sunglasses, eyewear accessories such as lens cleaning supplies, contact lens solutions, eyeglass cases, etc.</b>	20% off retail price

## Other discount offers on LASIK surgery and much more are available through our SpecialOffers program.

This information is intended to be a brief outline of plan benefits. The most detailed description of benefits, exclusions, and restrictions can be found in the Certificate of Coverage. Discounts are subject to change without notice. Laws in some states may prohibit network providers from discounting products and services that are not covered benefits under the plan. Discounts will not apply when a manufacturer has imposed a no discount policy on the item.

Transitions and the swirl are registered trademarks of Transitions Optical, Inc.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

## Adult Dental

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Annual Benefit Maximum</b>		
Plan Year		
Per insured person	\$1,000	\$1,000
<b>Annual Deductible</b>		
Plan Year		
Per insured person/Family maximum	\$50 Individual	\$50 Individual
<b>Deductible Waived for Diagnostic/Preventive Services</b>	Yes	Yes
<b>Diagnostic and Preventive Services</b>		
Periodic oral exam 2 per 12 months	0% Coinsurance	0% Coinsurance
Teeth cleaning (prophylaxis) 2 per 12 months; w/periodontal maintenance	0% Coinsurance	0% Coinsurance
Bitewing X-rays: 1 set per 12 months	0% Coinsurance	0% Coinsurance
Full-mouth or Panoramic X-rays: 1 per 60 months	0% Coinsurance	0% Coinsurance
Fluoride application: 1 per 12 months through age 18	0% Coinsurance	0% Coinsurance
Sealants 1 per 60 months; through age 18	0% Coinsurance	0% Coinsurance
<b>Basic Services</b>		
Consultation (second opinion) 1 per 12 months	20% Coinsurance	20% Coinsurance
Amalgam (silver-colored) Filling 1 per tooth per 24 months	20% Coinsurance	20% Coinsurance
Composite (tooth-colored) Filling posterior (back) fillings covered as composites 1 per tooth per 24 months	20% Coinsurance	20% Coinsurance
Brush Biopsy (cancer test) Covered, 1 per 12 months; all ages	20% Coinsurance	20% Coinsurance
Space Maintainers 1 per lifetime through age 18; posterior teeth	20% Coinsurance	20% Coinsurance
<b>Endodontics (Non-Surgical)</b>		
Root Canal and retreatments 1 per tooth per lifetime	Not Covered	Not Covered
<b>Endodontics (Surgical)</b>		
Apicoectomy and apexification 1 per tooth per lifetime	Not Covered	Not Covered
<b>Periodontics (Non-Surgical)</b>		
Periodontal Maintenance 2 per 12 months; w/teeth cleaning	20% Coinsurance	20% Coinsurance
Scaling and root planing 1 per quadrant per 24 months	20% Coinsurance	20% Coinsurance

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Periodontics (Surgical)</b>		
Periodontal Surgery (osseous, gingivectomy, graft procedures) 1 per quadrant per 36 months	50% Coinsurance	50% Coinsurance
<b>Oral Surgery (Simple)</b>		
Simple Extractions 1 per tooth per lifetime	50% Coinsurance	50% Coinsurance
<b>Oral Surgery (Complex)</b>		
Surgical Extractions 1 per tooth per lifetime	50% Coinsurance	50% Coinsurance
<b>Major (Restorative) Services</b>		
Crowns, onlays, veneers 1 per tooth per 84 months	Not Covered	Not Covered
<b>Prosthodontics</b>		
Dentures and bridges 1 per tooth per 84 months	50% Coinsurance	50% Coinsurance
Dental Implants Covered, 1 per tooth per 84 month	50% Coinsurance	50% Coinsurance
<b>Prosthodontic Repairs/Adjustments</b>		
Crown, denture, bridge repairs 1 per 12 months; 6 months after placement	Not Covered	Not Covered
Denture and bridge adjustments: 2 per 12 months; 6 months after placement	Not Covered	Not Covered
<b>Orthodontic Services</b>		
None	Not Covered	Not Covered

**Additional Limitations & Exclusions. Below is a partial listing of non-covered services under your dental plan. Please see your policy for a full list.**

**Services provided before or after the term of this coverage** - Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate

**Orthodontics** (unless included as part of your dental plan benefits) including orthodontic braces, appliances and all related services

**Cosmetic dentistry** (unless included as part of your dental plan benefits) provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

**Drugs and medications** including intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

**Analgesia, analgesic agents, and anxiolysis nitrous oxide**, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

**Waiting periods** for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan.

There is a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.



**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
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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.

Pediatric Vision Essential Health Benefits (up to age 19)		
<b>Pediatric Vision Deductible</b>	\$0	\$0
<b>Routine Eye Exam</b> <i>A comprehensive eye examination once per benefit period.</i>	\$0 Copay	\$0 Copay up to Maximum Allowed Amount
<b>Eyeglass Frames</b> <i>One pair of eyeglass frames per benefit period.</i>	\$0 copay, formulary	\$0 Copay up to Maximum Allowed Amount
<b>Eyeglass Lenses (instead of contact lenses)</b> <i>One pair of standard glass or plastic prescription lenses per benefit period.</i>		
<i>Single vision lenses</i>	\$0 copay	\$0 Copay up to Maximum Allowed Amount
<i>Bifocal lenses</i>	\$0 copay	
<i>Trifocal lenses</i>	\$0 copay	
<i>Lenticular lenses</i>	\$0 copay	
<i>Progressive lenses (standard, premium, select, ultra)</i>	\$0 copay	
<b>Eyeglass Lens Enhancements (instead of contact lenses)</b> <i>When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost</i>		
<i>Transitions lenses (for a child under age 19)</i>	\$0 copay	\$0 Copay up to Maximum Allowed Amount
<i>Standard polycarbonate (for a child under age 19)</i>	\$0 copay	
<i>Factory Scratch Coating</i>	\$0 copay	
<b>Contact Lenses (one year supply of contacts instead of eyeglass lenses)</b> <i>Contact lens allowance will only be applies toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.</i>		
<i>Elective conventional (non-disposable)</i>	\$0 copay, formulary	\$0 Copay up to Maximum Allowed Amount
<i>OR</i>		
<i>Elective disposable</i>	\$0 copay, formulary	
<i>OR</i>		
<i>Non-elective (medically necessary)</i>	\$0 copay	
Adult Vision (age 19 and older)		
<b>Adult Vision Coverage</b> <i>Limited to certain vision screenings required by Federal law and covered under the "Preventive Care" benefit.</i>	See "Preventive Care" benefit	See "Preventive Care" benefit



**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 a Non-Network Provider
<p>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.</p>		
<b>Children's Dental Essential Health Benefits (up to age 19)</b>		
<b>Diagnostic and preventive</b> <i>Includes cleanings, exams, x-rays, sealants, fluoride.</i>	No charge	No charge
<b>Basic services</b> <i>Includes filing and simple extractions</i>	20% coinsurance	20% coinsurance
<b>Major services/Prosthodontic</b>	50% coinsurance	50% coinsurance
<b>Endodontic, Periodontics, Oral Surgery</b>	50% coinsurance	50% coinsurance
<b>Medically Necessary Orthodontia</b>	50% coinsurance	50% coinsurance
<b>Deductible</b>	Not applicable	Not applicable
<b>Adult Dental</b>	Not covered	Not covered

# Benefits that go with you



You can count on medical coverage anywhere worldwide with GeoBlue.<sup>1</sup> 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.

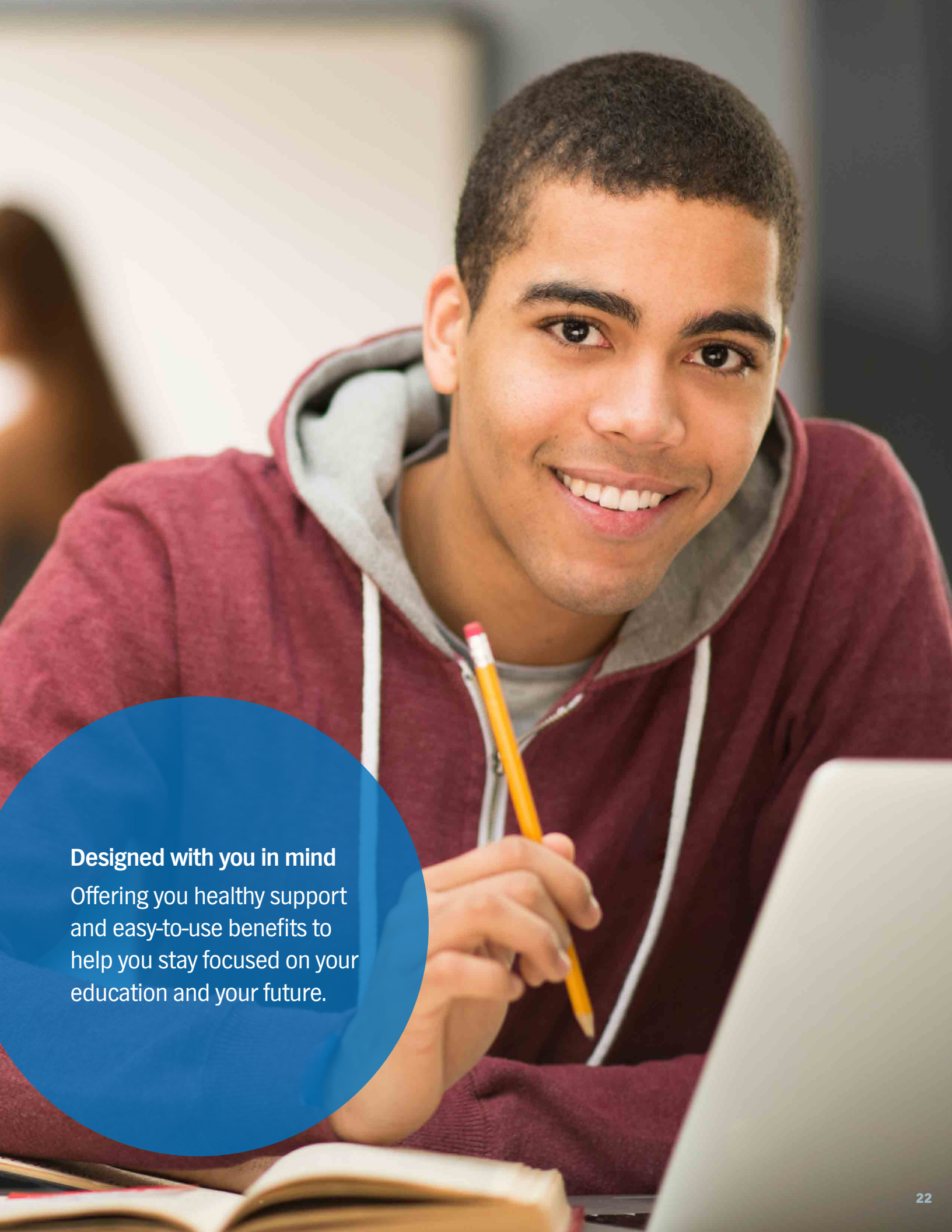
## GeoBlue benefits for the 2022-2023 school year

*Use of benefits must be coordinated and approved by GeoBlue.*

International telemedicine services <sup>2</sup>	
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. <sup>3</sup>
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) <sup>4</sup>	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



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

- › Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help them 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.
- › For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to [https://le.anthem.com/pdf?x=CA\\_SH\\_PPO](https://le.anthem.com/pdf?x=CA_SH_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.*







If you have  
questions, call  
1-800-888-2108  
or visit us at  
[www.anthem.com/  
studentadvantageca](http://www.anthem.com/studentadvantageca).

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