

2024-2025

# Anthem

Helping keep you at your personal best



## University of Missouri Kansas City - Domestic

Student Health Insurance Plan

<https://student.anthem.com/student/schools/umkc>



### **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 [student.anthem.com/student/schools/umkc](http://student.anthem.com/student/schools/umkc).

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# Welcome to Anthem Student Advantage

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

## What you need to know about Anthem Student Advantage



### Who is eligible?

- All enrolled in-person and online degree-seeking undergraduate students taking a minimum of 6 credit hours per semester are eligible to enroll in the plan.
- Enrolled graduate students, those holding assistantships, and students participating in internships or other practical training programs are also eligible to enroll in the plan. Please reach out to the school for further details.
- Covered students may also enroll their lawful spouse and/or dependent children up to the age of 26.



### Coverage is available for dependents, too.

If you are covered by Anthem Student Advantage through University of Missouri - Kansas City, you may enroll your lawful spouse, domestic partner or dependent children under the age of 26.



### Withdraw policy

If you withdraw from classes under a school-approved leave of absence, your coverage will remain for the end of the period for which payment has been received and no premiums will be refunded.

If you withdraw from classes other than under a school-approved leave of absence within 31 days after the policy effective date, you will be considered ineligible for coverage, your coverage will be terminated retroactively and any premiums collected will be refunded. If the withdrawal is more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which payment has been received and no premiums will be refunded.

# 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.

## What it costs Coverage dates and costs\*

	Annual 8/15/24 – 8/14/25	Fall 8/15/24 – 1/14/25	Spring/Summer 1/15/25 – 8/14/25	Summer 6/1/25-8/14/25
<b>Enrollment Deadline</b>	9/6/24	9/6/24	2/7/25	6/5/25
<b>Student</b>	\$2,560	\$1,073	\$1,487	\$526
<b>Student &amp; Spouse</b>	\$5,120	\$2,146	\$2,974	\$1,052
<b>Student &amp; Child(ren)</b>	\$5,120	\$2,146	\$2,974	\$1,052
<b>Student, Spouse &amp; Child(ren)</b>	\$7,680	\$3,219	\$4,461	\$1,578

\*Rates and Benefits are pending Missouri Department of Insurance approval. Benefits overview and cost of care

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

\*Rates pending approval with the state and subject to change.



# Enrollment



To enroll, visit <https://student.anthem.com/student/schools/umkc> and select “Enroll”. You will have the option to enroll both yourself and your dependents. For enrollment questions call **1-833-332-0798**.

# Keep in touch with your benefits information



## UMKC Student Health and Wellness

**Address:**

Volker Campus  
5110 Oak St., Brookside 51 Building, Suite 237  
Kansas City, MO 64112  
Phone: 816-235-6133

**Email:** [studenthealth@umkc.edu](mailto:studenthealth@umkc.edu)

**Website:** <https://www.umkc.edu/studenthealth/index.html>

Hours: M, Th, F: 8:30 am - Noon; 1:30-4:30 pm

Tu: 8:30 am - Noon; 1:30-6:30 pm

W: 8:30 am - Noon; 1:30-5:00 pm



## Claims, benefits, eligibility and enrollment

Phone: 833-332-0798

Anthem Blue Cross Life and Health Insurance Company



## UMKC Counseling Services

**Address:**

Volker Campus  
5110 Oak St., Brookside 51 Building, Suite 201  
Kansas City, MO 64112

**Phone:** 816-235-1635

**Website:** <https://info.umkc.edu/counseling-services/>

To schedule an Initial Consultation appointment, please contact the office

# Your Student Health Services



## University of Missouri – Kansas City Student Health and Wellness (SHW)



### Health Services

The student health insurance plan is designed to work with your campus student health center. Out-of-pocket costs are generally lower at the student health center and the location is ideal for students to seek care. The mission of Student Health and Wellness (SHW) is to provide quality health care, health promotion, and health education that maximizes student learning potential. SHW provides healthcare on acute illnesses, stable chronic health problems, and health promotion/prevention strategies. SHW personnel include nurse practitioners, registered nurses and support staff. There is no visit charge for currently enrolled UMKC students; additional services or laboratory testing may involve a charge. These additional charges can be paid for with cash, check or charged to the student's UMKC account.

Student Health and Wellness services include:

- Well-woman exams, blood pressure
- First aid (non-emergency);
- Immunizations (including Hepatitis shots);
- Physical examinations;
- STD testing and treatment;
- Travel consultation;
- Allergy injections with student-furnished
- Tuberculosis screening



Please refer to the SHS website for details regarding services offered:  
<https://www.umkc.edu/studenthealth/services-and-info/index.html>



# 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.



## 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.



## 24/7 NurseLine

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



## Find Care Tool

Use **<https://www.anthem.com/find-care/?alphaprefix=102>** to find the right doctor or facility close to where you are.



## Anthem Student Advantage University of Missouri (Kansas City) website

Use **[student.anthem.com/student/schools/umkc](http://student.anthem.com/student/schools/umkc)** to see your health plan information, including providers, benefits, claims, covered drugs

<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 plan details

## Anthem Blue Cross and Blue Shield

Student Health Insurance Plan:  
University of Missouri - Kansas City

Your network:  
MO PREFERRED-CARE BLUE (KC)  
(SELECT NETWORK)

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.

### Plan Overview

#### Student Health Referral

Get treated at the UMKC Student Health and Wellness first. If a referral is needed to an outside provider your deductible will be waived. You will still be responsible for any applicable copays and coinsurance.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Overall Deductible</b>		
When the Deductible applies, you must pay it before benefits begin.	\$400 per person	\$800 per person
<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.	\$7,500 student /\$15,000 family	Unlimited student /Unlimited family
<b>Preventive care/screening/immunization</b>		
In-network preventive care is not subject to deductible, if your plan has a deductible. Immunizations for children prior to their 6th birthday have No Cost Share for In-Network and Non-Network Charges. This applies to childhood immunizations only, not other preventive care.	No charge	30% coinsurance after deductible is met
<b>Doctor Home and Office Services</b>		
Primary Care Office Visit to treat an injury or illness	\$20 copay per visit; 20% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist Care Office Visit	\$40 copay per visit; 20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prenatal and Post-natal Care In-Network preventive prenatal services are covered at 100%.	No charge	30% coinsurance after deductible is met
<b>Other Practitioner Visits:</b>		
Retail Health Clinic	\$20 copay per visit; 20% coinsurance after deductible is met	50% coinsurance after deductible is met
Preferred On-line Visit Medical	\$20 copay per visit; 20% coinsurance after deductible is met	50% coinsurance after deductible is met
Preferred On-line Visit Includes Mental/Behavioral Health and Substance Abuse	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p>Chiropractor Services Coverage is limited to 26 visits per benefit period. Treatment beyond 26 visits may require precertification. Does not include manipulation by a professional provider other than a chiropractor.</p>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Other Services in an Office:</b>		
Allergy Testing	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.
Chemo/Radiation Therapy	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hemodialysis	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<p>Prescription Drugs For the drugs itself dispensed in the office through infusion/injection.</p>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Diagnostic Services</b>		
<b>Lab:</b>		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>X-Ray</b>		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):</b>		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Emergency and Urgent Care</b>		
Urgent Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<p>Emergency Room Facility Services Copay waived if admitted.</p>	\$200 copay per visit; 20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Emergency Ambulance (Air and Ground)	20% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Outpatient Mental/Behavioral Health and Substance Abuse</b>		
Doctor Office Visit	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Facility visit: Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Outpatient Surgery</b>		
Facility visit: Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)</b>		
Facility fees (for example, room & board)	\$200 copay per admission; 20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Recovery &amp; Rehabilitation</b>		
Home Care Visits Coverage is unlimited per benefit period.	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Rehabilitation services (for example, physical/speech/occupational therapy):</b>		
Office Coverage for Occupational Rehabilitation services is unlimited visits per benefit period. Coverage for Physical Rehabilitation services is unlimited per benefit period.	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital Coverage for Occupational Rehabilitation services is unlimited visits per benefit period. Coverage for Physical Rehabilitation services is unlimited per benefit period.	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Habilitation services (for example, physical/speech/occupational therapy):</b>		
Office Coverage for Occupational Habilitation services is unlimited visits per benefit period. Coverage for Physical Habilitative services is unlimited per benefit period.	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital Coverage for Occupational Habilitation services is unlimited visits per benefit period. Coverage for Physical Habilitative services is unlimited per benefit period.	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Cardiac rehabilitation</b>		
Office Visit Coverage is unlimited visits per benefit period.	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital Coverage is unlimited visits per benefit period.	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) Physical Medicine, Rehab & Skilled Nursing Facility unlimited per benefit period.	\$200 copay per admission; 20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices Coverage for Wigs after cancer treatment is limited to one (1) per benefit period In-Network Providers and Out-of-Network Providers combined. Coverage for hearing aids services in each ear is limited to 1 unit every 12 months. Limit is combined In-Network and Out-of-Network.	20% coinsurance after deductible is met	50% coinsurance after deductible is met





## Pharmacy

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Not applicable	Not applicable
<b>Prescription Drug Coverage</b> Traditional Drug List This product has a 30-day Retail Pharmacy Network available. A 30 day supply is available at most retail pharmacies.		
<b>Tier 1 - Typically Generic</b> Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.	\$15 copay per prescription (retail only). \$30 copay per prescription (home delivery only).	\$15 copay per prescription (retail only).
<b>Tier 2 – Typically Preferred Brand</b> Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.	\$40 copay per prescription (retail only). \$80 copay per prescription (home delivery only).	\$40 copay per prescription (retail only).
<b>Tier 3 - Typically Non-Preferred Brand</b> Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.	\$65 copay per prescription (retail only). \$130 copay per prescription (home delivery only).	\$65 copay per prescription (retail only).
<b>Tier 4 – Typically Specialty (brand and generic)</b> Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program), No coverage for non-formulary drugs.	\$100 copay per prescription (retail only). \$100 copay per prescription (home delivery only).	\$100 copay per prescription (retail only).

**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
<p>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.</p>		
<p>Children's Vision Essential Health Benefits (up to age 19) Limited to covered persons under the age of 19.</p>		
Child Vision Deductible	\$0	\$0
<p>Vision exam Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.</p>	No charge	Reimbursed Up to \$30
<p>Frames Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</p>	No charge	Reimbursed Up to \$45
<p>Lenses Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</p>	No charge	\$25 Reimbursement for Single, \$45 Reimbursement for Bifocal, \$55 Reimbursement for Trifocal Vision Lens and \$70 for Lenticular lens
<p>Elective contact lenses Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</p>	No charge	Reimbursed Up to \$60
<p>Non-Elective contact lenses Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</p>	No charge	Reimbursed Up to \$210





**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
<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>		
<p>Children's Dental Essential Health Benefits (up to age 19) Limited to covered persons under the age of 19.</p>		
<p>Diagnostic and preventive Includes cleanings, exams, x-rays, sealants, fluoride.</p>	<p>No charge</p>	<p>No charge</p>
<p>Basic services Includes filling and simple extractions</p>	<p>20% coinsurance</p>	<p>20% coinsurance</p>
<p>Major services/Prosthodontic</p>	<p>50% coinsurance</p>	<p>50% coinsurance</p>
<p>Endodontic, Periodontics, Oral Surgery</p>	<p>50% coinsurance</p>	<p>50% coinsurance</p>
<p>Medically Necessary Orthodontia</p>	<p>50% coinsurance</p>	<p>50% coinsurance</p>
<p>Deductible</p>	<p>Not applicable</p>	<p>Not applicable</p>





## Medical Evacuation and Repatriation Services


OFFERED IN COORDINATION WITH  
BLUE CROSS BLUE SHIELD Anthem Student Advantage

Your institution provides you access to Medical Evacuation and Repatriation Companion services from GeoBlue®.

Program Name: Anthem Student Advantage  
University of Missouri

GeoBlue's 24/7/365 Global Service Center is here to support members experiencing medical emergencies. GeoBlue coordinates emergency services with our strategic resources located around the world. Members in need of life-saving medical intervention are treated at the nearest appropriate medical facility.

### What should I do in the event of a medical emergency?

 **Go immediately to the nearest physician or hospital and then contact us.**

- Call collect: **+1-833-511-4763**
- GeoBlue's medical assistance team will contact your treating physician and closely monitor your case to determine if a medical evacuation is necessary

### When you call GeoBlue, please be prepared to provide the following information:

- The insured person's name
- The ID number located on the front of your Blue Cross Blue Shield Medical ID card
- The program name as listed above and school name
- Detailed information regarding the nature of the emergency
- If applicable, the name and contact details for the treating physician and/or hospital
- The insured person's specific location in the country. Utilize a GPS if available

## Benefits


Use of benefits must be coordinated and approved by GeoBlue

Emergency Medical Evacuation	Actual Cost of the Evacuation & Repatriation
Repatriation of Remains	Actual Cost of the Repatriation of Mortal Remains
Emergency Family Travel Arrangements	Maximum Benefit up to \$5,000 per Coverage Year
Accidental Death & Dismemberment	Maximum Benefit up to \$10,000 per Covered Person
Emergency Family Reunion Arrangement	Maximum Benefit up to \$1,500 per Covered Year

**TAKE A SCREENSHOT OF THE CARD OR CUT IT OUT TO KEEP WITH YOU AT ALL TIMES.**


**PROGRAM NAME:** Anthem Student Advantage  
University of Missouri

**GEOBLUE MEDICAL EVACUATION AND REPATRIATION SERVICES**

 **Go immediately to the nearest physician or hospital and then contact GeoBlue at +1-833-511-4763**

**When you call GeoBlue, please be prepared to provide the following information:**

- The insured person's name
- The ID number located on the front of your Blue Cross Blue Shield Medical ID card
- The program name as listed above and school name
- Detailed information regarding the nature of the emergency
- If applicable, the name and contact details for the treating physician and/or hospital
- The insured person's specific location in the country. Utilize a GPS if available

**GeoBlue** 

If you need medical or travel assistance, regardless of the nature or severity of your situation, please contact GeoBlue 24/7/365

**Call Collect  
+1-833-511-4763**



**Reach out to your program administrator for further details and to review your certificate of coverage.**

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 in the District of Columbia by 4 Ever Life International Limited, Bermuda, an independent licensee of the Blue Cross Blue Shield Association. This coverage is offered to the members of the Global Citizens Association, Washington, D.C.

# Your benefits go with you

With the BlueCard PPO and Blue Cross Blue Shield Global Core programs



If you're away from home and you need care right away, as an Anthem member, you have access to care across the country through the BlueCard® preferred provider organization (PPO) program. This includes 1.7 million doctors and hospitals — more than any other insurer.<sup>1</sup>

## How to access care across the U.S.:



Call 911 or go to the nearest hospital in an emergency.<sup>2</sup>



Log in to [anthem.com](https://www.anthem.com) and use the Find a Doctor tool to search for a doctor or hospital in the BlueCard PPO program.



Use the [Sydney<sup>SM</sup> Health](#) app to search for a BlueCard PPO program doctor or hospital. Get turn-by-turn directions to the nearest doctor, urgent care center, or emergency room.



Call Member Services at the number on your health plan ID card.

When you're outside the U.S., the Blue Cross Blue Shield Global® Core program gives you access to preferred doctors and hospitals in nearly 190 countries and territories around the world.<sup>3</sup>

## Need care outside the U.S.? You can:



Go straight to the nearest hospital in an emergency.



Go to [bcbsglobalcore.com](https://www.bcbsglobalcore.com) to search for a doctor or hospital.



Use the Blue Cross Blue Shield Global Core app to find a doctor or hospital.



Call the Blue Cross Blue Shield Global Core Service Center 24/7 at **800-810-2583 (BLUE)** or call collect at **804-673-1177**. They can help you set up a doctor visit or hospital stay.

## Download the Blue Cross Blue Shield Global Core app today

### With it, you can:

- Search for a doctor or hospital.<sup>4</sup>
- Submit claims.
- Get translations for medical terms — including symptoms and phrases — and even use an audio feature to play the translation.<sup>4</sup>
- Find a drug's generic name and local brand name, and check whether it's available.
- Learn how to find and contact a U.S. embassy.



**Unless it's an emergency, call the Global Core Service Center before getting care outside the U.S.** Global Core will work with the doctor and Anthem to approve and accept a Guarantee of Payment (GOP). If you get care from a doctor or hospital that has not accepted a GOP, you will need to:

- 1 Pay the full cost of your care upfront.
- 2 Download an international claim form at [bcbsglobalcore.com](https://bcbsglobalcore.com) or request a form by calling Member Services at the number on your ID card.
- 3 Fill out the claim form and send it with the original bills to the Blue Cross Blue Shield Global Core Service Center. You can submit them through the mobile app, email, or postal mail.



### Traveling? Here's what you need to know:

- Before leaving the country, ask Member Services if your international benefits are different.
- Ask for approval before getting care. This is “preapproval” and helps you find care covered by your plan. To see if you need preapproval, call Member Services at the number on your ID card.
- Save money by seeing a BlueCard program doctor or hospital. You only pay your usual out-of-pocket amounts (such as deductible, your percentage of costs, or copay). If you go to a doctor or hospital outside the program, you'll need to pay the entire bill upfront.
- Show your Anthem ID card so the doctor or hospital can check your benefits and send us a claim for processing.

### Remember to carry your ID card

The “PPO-in-a-suitcase” symbol shows you can get care from BlueCard PPO program doctors and hospitals.



<sup>1</sup> Blue Cross Blue Shield Association: *The Blue Cross Blue Shield System* (accessed May 20, 2024): [bcbs.com](https://bcbs.com).

<sup>2</sup> You or a family member need to call the Member Services number on your ID card within 24 hours (48 hours for members in Indiana) after going to the hospital or as soon as you can.

<sup>3</sup> GeoBlue: *More than 25 years as a leader in international healthcare* (accessed May 20, 2024): [about.geo-blue.com](https://about.geo-blue.com).

<sup>4</sup> Using the Blue Cross Blue Shield Global Core app itself does not require an internet connection. However, using GPS for mapping or downloading an audio translation does require an internet connection. See [bcbsglobalcore.com/home/mobileapp/#features](https://bcbsglobalcore.com/home/mobileapp/#features).

Sydney Health is offered through an arrangement with Caredon Digital Platforms, a separate company offering mobile application services on behalf of your health plan.

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## Designed with you in mind

Offering you healthy support  
and convenient benefits to  
help you stay focused on your  
education and your future.

## Exclusions

### Notes

- Please reference the master policy for details.
- Exclusions and limitations apply.

### What's not covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

1. Abortion Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery.  
This Exclusion does not apply to therapeutic abortions, which are abortions performed to save the life of the mother.
2. Acts of War, Disasters, or Nuclear Accidents In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.  
Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, or release of nuclear energy.
3. Administrative Charges
  - a. Charges to complete claim forms,
  - b. Charges to get medical records or reports,
  - c. Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
4. Aids for Non-verbal Communication Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.
5. Alternative / Complementary Medicine Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
  - a. Acupuncture,
  - b. Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body,
  - c. Holistic medicine,
  - d. Homeopathic medicine,
  - e. Hypnosis,
  - f. Aroma therapy,
  - g. Massage and massage therapy,
  - h. Reiki therapy,
  - i. Herbal, vitamin or dietary products or therapies,
  - j. Naturopathy,
  - k. Thermography,
  - l. Orthomolecular therapy,
  - m. Contact reflex analysis,
  - n. Bioenergetic synchronization technique (BEST),
  - o. Iridology-study of the iris,
  - p. Auditory integration therapy (AIT),
  - q. Colonic irrigation,
  - r. Magnetic innervation therapy,
  - s. Electromagnetic therapy
6. Applied Behavioral Treatment (including, but not limited to, Applied Behavior Analysis and Intensive Behavior Interventions) for all indications except as described under Autism Services in the "What's Covered" section.
7. Autopsies Autopsies and post-mortem testing.
8. Before Effective Date or After Termination Date Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
9. Certain Providers Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
10. Charges Not Supported by Medical Records Charges for services not described in your medical records
11. Charges Over the Maximum Allowed Amount Charges over the Maximum Allowed Amount for Covered Services.
12. Clinical Trial Non-Covered Services Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
13. Clinically-Equivalent Alternatives Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at [www.anthem.com](http://www.anthem.com).  
If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.
14. Complications of/or Services Related to Non-Covered Services Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service. This Exclusion does not apply to Emergency Services or problems resulting from Complications of Pregnancy.

15. Compound Drugs Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants
16. Cosmetic Services Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy (including reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance). It also does not apply to care and treatment necessary to correct birth defects and birth abnormalities.
17. Court Ordered Testing Court ordered testing or care unless Medically Necessary.
18. Crime Treatment of an injury or illness that results from a felony you committed, or tried to commit, or treatment required because of your engagement in an illegal occupation. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
19. Cryopreservation Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.
20. Custodial Care Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
21. Delivery Charges Charges for delivery of Prescription Drugs.
22. Dental Devices for Snoring Oral appliances for snoring.
23. Dental Services
  - a. Dental Services for Members age 19 or older.
  - b. Dental Services or health care services not specifically covered in this Booklet (including any Hospital charges, Prescription Drug charges and dental services or supplies that do not have an American Dental Association Procedure Code, unless covered by the medical benefits of this Booklet).
  - c. Services of anesthesiologists, unless required by law or listed as covered in the "Dental Services (All Members / All Ages)" section of this Booklet.
  - d. Anesthesia Services (such as intravenous or non-intravenous conscious sedation or general anesthesia), are not covered when given separate from complex surgical services, except as required by law or when listed as covered in the "Dental Services (All Members / All Ages)" section of this Booklet.
  - e. Analgesia, analgesia agents, oral sedation and anxiolysis nitrous oxide, unless listed as covered in the "Dental Services (All Members / All Ages)" section of this Booklet.
  - f. Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion. Includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
  - g. Dental services or supplies provided solely for the purpose of improving the appearance of the tooth when the tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
  - h. Case presentations and office visits.
  - i. Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
  - j. Enamel microabrasion and odontoplasty.
  - k. Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.
  - l. Biological tests for determination of periodontal disease or pathological agents, unless covered by the medical benefits of this Booklet.
  - m. Collection of oral cytology samples via scraping of the oral mucosa, unless covered by the medical benefits of this Booklet.
  - n. Separate services billed when they are an inherent component of another covered service.
  - o. Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
  - p. Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bars, stress breakers and precision attachments.
  - q. Provisional splinting, temporary procedures or interim stabilization.
  - r. Pulp vitality tests.
  - s. Adjunctive diagnostic tests.
  - t. Incomplete root canals.
  - u. Cone beam images.
  - v. Temporary anchorage devices.
  - w. Sinus augmentation.
  - x. Oral hygiene instructions.
  - y. Repair or replacement of lost or broken appliances.
  - z. Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials and the procedures used to prepare and place materials in the canals (tooth roots).
    - aa. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
    - ab. The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
    - ac. Services to treat temporomandibular joint disorder (TMJ), unless covered by the medical benefits of this Booklet.
    - ad. Athletic mouth guards.
24. Drugs Contrary to Approved Medical and Professional Standards Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
25. Drugs Over Quantity or Age Limits Drugs which are over any quantity or age limits set by the Plan or us.
26. Drugs Over the Quantity Prescribed or Refills After One Year Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
27. Drugs Prescribed by Providers Lacking Qualifications/ Registrations/Certifications Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by Anthem.

28. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
29. **Educational Services** Educational Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.
30. **Emergency Room Services for non-Emergency Care** Services provided in an emergency room for conditions that do not meet the definition of Emergency. This includes, but is not limited to, suture removal in an emergency room. For non-emergency care please use the closest network Urgent Care Center or your Primary Care Physician.
31. **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.  
The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational.
32. **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.
33. **Eye Exercises** Orthoptics and vision therapy.
34. **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
35. **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
36. **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
  - a. Cleaning and soaking the feet.
  - b. Applying skin creams to care for skin tone.
  - c. Other services that are given when there is not an illness, injury or symptom involving the foot.
37. **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.
38. **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
39. **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services you get from Workers Compensation, and services from free clinics.  
If your Group is not required to have Workers Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
40. **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
41. **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
42. **Home Care**
  - a. Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
  - b. Food, housing, homemaker services and home delivered meals.
43. **Hospital Services Billed Separately** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.
44. **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).
45. **Infertility Treatment** Testing or treatment related to infertility.
46. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
47. **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to "Habilitative Services" as described in the "What's Covered" section.
48. **Medical Equipment, Devices, and Supplies**
  - a. Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
  - b. Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
  - c. Non-Medically Necessary enhancements to standard equipment and devices.
  - d. Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.
  - e. Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section.]
49. **Medicare** For which benefits are payable under Medicare Parts A and/or B, except as required by law, as described in the section titled "Medicare" in "General Provisions".
50. **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
51. **Non-Approved Drugs** Drugs not approved by the FDA.



52. Non-Approved Facility Services from a Provider that does not meet the definition of Facility.
53. Non-Medically Necessary Services Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
54. Nutritional Formulas or Dietary Supplements Nutritional formulas and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
55. Off label use Off label use, unless we must cover it by law or if we approve it.
56. Personal Care, Convenience and Mobile/Wearable Devices
- Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
  - First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
  - Home workout or therapy equipment, including treadmills and home gyms,
  - Pools, whirlpools, spas, or hydrotherapy equipment.
  - Hypo-allergenic pillows, mattresses, or waterbeds,
  - Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
  - Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.
57. Private Duty Nursing Private Duty Nursing Services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the benefit.
58. Prosthetics Prosthetics for sports or cosmetic purposes. This does not apply to breast prostheses (whether internal or external) after a mastectomy, as required by state and federal law.
59. Residential accommodations Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:
- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
  - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
  - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
60. Routine Physicals and Immunizations Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Error! Reference source not found." benefit.
61. Sanctioned or Excluded Providers Any service, Drug, Drug regimen, treatment, or supply, furnished, ordered, or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to Emergency Care.
62. Sexual Dysfunction Services or supplies for male or female sexual problems.
63. Sport, Contest, or Competition Injury sustained while:
- Participating in any intercollegiate or professional sport, contest or competition.
  - Traveling to or from such sport, contest or competition as a participant.
  - Participating in any practice or conditioning program for such sport, contest or competition.
64. Stand-By Charges Stand-by charges of a Doctor or other Provider.
65. Sterilization Services to reverse an elective sterilization.
66. Surrogate Mother Services Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
67. Travel Costs Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
68. Vein Treatment Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
69. Vision Services
- Vision services for Members age 19 or older, unless listed as covered in this Booklet.
  - For safety glasses and accompanying frames.
  - For two pairs of glasses in lieu of bifocals.
  - Plano lenses (lenses that have no refractive power)
  - Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
  - Vision services not listed as covered in this Booklet.
  - Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically stated as covered in this booklet.
  - For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
  - For Members through age 18, no benefits are available for frames or contact lenses not on the Anthem formulary.
  - Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed provider.
  - Blended lenses.

70. Waived Cost-Shares Out-of-Network For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.
71. Weight Loss Programs Programs, whether or not under medical supervision, unless listed as covered in this Booklet. This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
72. Weight Loss Surgery Bariatric surgery performed for the purposes of weight loss, including revision of a prior bariatric surgery to a new procedure. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. With the exception of Emergency Services, complications of such procedures, directly related to bariatric surgery, that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Certificate. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure.
73. Wilderness or other outdoor camps and/or programs.

# Access help in your language

If you have questions about this document, you have the right to help and information in your language at no cost. To talk to an interpreter, call **1-833-332-0798**.

**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

شادخ مجرب لصرتا. أناجم لتغلب تدعاسجل او نتاوجل علما هذه ولع لوصول لال قحى  
تدعاسجل لال كلب تصاخلا (TTY/TDD: 711) فيرعتلا تقاطب ولع دوجولما ءاضعلا

## 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)

## 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 resewva 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 n1 ahoot'i' t'11 ni nizaad k'ehj7 n7k1 a'doowof t'11 j77k'e. Naaltsos bee  
atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8'  
hod77lnih. Naaltsos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77  
b44sh bee hane'7 bik11' 1aj8' hod77lnih. (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 ਮੁਫਤ 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 makakuha 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, DC. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-697) 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, we're here to help.

Call 1-833-332-0798 or visit us at student.  
[student.anthem.com/student/schools/umkc](http://student.anthem.com/student/schools/umkc).



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