

45. **Varicose Vein Treatment.** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.
46. **Lifestyle Programs.** Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.
47. **Clinical Trials.** Services and supplies in connection with clinical trials, except as specifically stated in the "Clinical Trials" provision under the section MEDICAL CARE THAT IS COVERED.
48. **Sports Related Conditions.** Expenses incurred for treatment of sport-related *accidental injury* resulting from interscholastic, intercollegiate, club or professional sports.
49. **Accidental Death and Dismemberment.** For loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.

## GGH Benefits

# MiraCosta College

2015 – 2016

## Student Health Insurance Plan for International Students

Administered by:

### GGH Benefits

d/b/a Worldwide Insurance Services Agency  
100 Matsonford Road  
One Radnor Corporate Center, Suite 100  
Radnor, PA 19087 USA  
Call: 610.254.8700/Fax: 610.293.3529  
Customer Service: 1.888.850.4770

Local Representative



CA License # 0G55426  
Tel: 1.800.537.1777  
Fax: 1.310.394.0142

For plan information, please visit:  
[www.4studenthealth.com](http://www.4studenthealth.com)

Underwritten by:



This pamphlet contains a brief summary of the features and benefits for insured participants covered under Policy No. B-1108-15. This policy has been updated to comply with federal & state requirements, including applicable provisions of the recently enacted federal health care reform laws. Please see the Certificate of Insurance on file with MiraCosta College for more information. If there is a difference between this program description and the certificate wording, the certificate controls.

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark. © The Blue Cross name and symbol are registered marks of the Blue Cross Association.

# How the Plan Works

## Who is eligible for coverage?

All full time international students, visiting faculty, scholars or other persons possessing and maintain a current passport and valid visa status (F-1, J-1 or M-1, etc.) engaged in education activities at MiraCosta College who are temporarily located outside their home country and have not been granted permanent residency status.

## When does coverage start?

Coverage for an Eligible Participant starts at 12:00:01 a.m. on the latest of the following:

1) The Coverage Start Date shown on the Insurance Identification Card; 2) The date the Eligibility requirements are met; or 3) The date the premium and completed enrollment form, if any, are received by the Insurer or the Administrator.

## When does coverage end?

Coverage for an Eligible Participant will automatically terminate on the earliest of the following dates: 1) The date the Policy terminates; 2) The Organization's or Institution's Termination Date; 3) The date of which the Eligible Participant ceases to meet the Individual Eligibility Requirements; 4) The end of the term of coverage specified in the Eligible Participant's enrollment form; 5) The date the Eligible Person permanently leaves the Country of Assignment for his/her or her Home Country; 6) The date the Eligible Participant requests cancellation of coverage (the request must be in writing); or 7) The premium due date for which the required premium has not been paid, subject to the Grace Period provision. 8) The end of any Period of Coverage.

## [gghstudents.com](http://gghstudents.com)

Once Eligible Participants receive their Medical Insurance ID card from GGH Benefits, they should visit [gghstudents.com](http://gghstudents.com), and using the certificate number on the front of the card, sign in to the site for comprehensive information and services relating to this plan. Participants can track claims, search for a doctor, view plan information, download claim forms and read health and security information.

## Claims Submission

For questions regarding benefits or claims, please call: 1.800.695.1164

## Please mail claims to:

Anthem Blue Cross Life and Health Insurance Company  
P.O. Box 60007  
Los Angeles, CA 90060

31. **Chronic Pain.** Treatment of chronic pain, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED.
32. **Health Club Memberships.** Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a *physician*. This exclusion also applies to health spas.
33. **Personal Items.** Any supplies for comfort, hygiene or beautification.
34. **Educational or Academic Services.** This plan does not cover:
  - a. Educational or academic counseling, remediation, or other services that are designed to increase academic knowledge or skills.
  - b. Educational or academic counseling, remediation, or other services that are designed to increase socialization, adaptive, or communication skills.
  - c. Academic or educational testing.
  - d. Teaching skills for employment or vocational purposes.
  - e. Teaching art, dance, horseback riding, music, play, swimming, or any similar activities.
  - g. Teaching manners and etiquette or any other social skills Teaching and support services to develop planning and organizational skills such as daily activity planning and project or task planning.
35. **Food or Dietary Supplements.** Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.
36. **Telephone, Facsimile Machine, and Electronic Mail Consultations.** Consultations provided using telephone, facsimile machine, or electronic mail.
37. **Routine Exams or Tests.** Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated in the "Preventive Care Services" provision of MEDICAL CARE THAT IS COVERED.
38. **Acupuncture.** Acupuncture treatment except as specifically stated in the "Acupuncture" provision of MEDICAL CARE THAT IS COVERED. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.
39. **Eye Surgery for Refractive Defects.** Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.
40. **Physical Therapy or Physical Medicine.** Services of a *physician* for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy" or "Physical Therapy, Physical Medicine and Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED. This exclusion also does not apply to the *medically necessary* treatment of *severe mental disorders*.
41. **Outpatient Prescription Drugs and Medications.** Any drug or medicine requiring or dispensed with a written *prescription* of a *physician*, including insulin, except as specifically stated in the "Home Infusion Therapy", "Prescription Drug for Abortion" and "Prescription Drugs and Medications" provisions of MEDICAL CARE THAT IS COVERED. Non-*prescription*, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.
42. **Contraceptive Devices.** Contraceptive devices prescribed for birth control except as specifically stated in the "Contraceptives" provision in MEDICAL CARE THAT IS COVERED.
43. **Diabetic Supplies.** Prescription and non-prescription diabetic supplies, except as specifically stated in "YOUR PRESCRIPTION DRUG BENEFITS" section of this booklet.
44. **Private Duty Nursing.** Private duty nursing services.

17. **Hearing Aids or Tests.** Hearing aids. Routine hearing tests, except as specifically provided under the "Preventive Care Services" provisions of MEDICAL CARE THAT IS COVERED.
18. **Optometric Services or Supplies.** Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except when provided as part of a routine exam under the "Preventive Care Services" provision of MEDICAL CARE THAT IS COVERED and as specifically stated in the section VISION SERVICES FOR INSURED PERSONS THROUGH AGE 18. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED and as specifically stated in the section VISION SERVICES FOR INSURED PERSONS THROUGH AGE 18.
19. **Outpatient Occupational Therapy.** Outpatient occupational therapy, except by a *home health agency, hospice or home infusion therapy provider* as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy", or "Physical Therapy, Physical Medicine And Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED.
20. **Outpatient Speech Therapy.** Outpatient speech therapy except as stated in the "Outpatient Speech Therapy" provision of MEDICAL CARE THAT IS COVERED.
21. **Cosmetic Surgery.** Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.
22. **Scalp hair prostheses.** Scalp hair prostheses, including wigs or any form of hair replacement.
23. **Commercial Weight Loss Programs.** Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as stated in the "Bariatric Surgery" provision of MEDICAL CARE THAT IS COVERED.
24. **Transgender Services.** Services and supplies in connection with transgender services, except as specifically stated in the "Transgender Services" provision under the section MEDICAL CARE THAT IS COVERED.
25. **Sterilization Reversal.** Reversal of sterilization.
26. **Infertility Treatment.** Any services or supplies furnished in connection with the diagnosis and treatment of *infertility*, including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.
27. **Surrogate Mother Services.** For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
28. **Orthopedic Supplies.** Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.
29. **Air Conditioners.** Air purifiers, air conditioners, or humidifiers.
30. **Custodial Care or Rest Cures.** Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy. *Custodial care* or rest cures, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a *skilled nursing facility*, except as specifically stated in the "Skilled Nursing Facility" provision of MEDICAL CARE THAT IS COVERED.

## What is covered by the plan?

### Schedule of Benefits

THE BENEFITS OF THIS CERTIFICATE ARE PROVIDED ONLY FOR SERVICES WHICH ARE CONSIDERED TO BE MEDICALLY NECESSARY. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS THE SERVICE DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY OR COVERED.

This summary provides a brief outline of your benefits. You need to refer to the entire certificate for complete information about the benefits, conditions, limitations and exclusions of your *plan*.

Medical Benefits	Insured Person
Benefit Year Maximum	Unlimited
Benefit Year Deductible*	\$50
Emergency Room Deductible*	\$150
<p><b>*Exceptions:</b> In certain circumstances, one or more of these Deductibles may not apply, as described below:</p> <ul style="list-style-type: none"> <li>The Benefit Year Deductible will not apply to benefits for Preventive Care Services provided by a <i>participating provider</i>.</li> <li>The Benefit Year Deductible will not apply to hospice care services provided by a <i>physician</i> who is a <i>participating provider</i>.</li> <li>The Benefit Year Deductible will not apply to office visits to the <i>Recognized Student Health Center</i></li> <li>The Benefit Year Deductible will not apply to office visits to a <i>physician</i> who is a <i>participating provider</i>.</li> </ul> <p><b>Note:</b> This exception only applies to the charge for the visit itself. It does not apply to any other charges made during that visit, such as for testing procedures, surgery, etc.</p> <ul style="list-style-type: none"> <li>The Benefit Year Deductible will not apply to diabetes education program services provided by a <i>physician</i> who is a <i>participating provider</i>.</li> <li>The Benefit Year Deductible will not apply to transplant travel expenses authorized by us in connection with a specified transplant procedure provided at a designated <i>CME</i>.</li> <li>The Benefit Year Deductible will not apply to bariatric travel expense in connection with an authorized bariatric surgical procedure provided at a designated <i>CME</i>.</li> <li>The Benefit Year Deductible will not apply to transgender travel expense in connection with an approved transgender surgery.</li> <li>The Emergency Room Deductible will not apply if you are admitted as a hospital inpatient immediately following emergency room treatment.</li> </ul>	
Co-Insurance*	After you have met your Benefit Year Deductible and any other applicable deductible, you will be responsible for the following percentages of the <i>maximum allowed amount</i> :
– <i>Participating Providers</i>	0%
– <i>Recognized Student Health Center</i>	0%
– <i>Other Health Care Providers</i>	20%

– <i>Non-Participating Providers</i>	30%
– <i>Prescription drugs dispensed by physicians and retail pharmacies</i>	50% Co-Payment per 30 Day Supply
– <i>Prescription Contraceptives (Generic or single source contraceptives only)</i>	No Co-Payment
<b>Note:</b> In addition to the Co-Payment shown above, you will be required to pay any amount in excess of the maximum allowed amount for the services of another health care provider or non-participating provider.	

7. **Work-Related.** Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits will be provided subject to our right of recovery and reimbursement under California Labor Code Section 4903, and as described in REIMBURSEMENT FOR ACTS OF THIRD PARTIES.
8. **Government Treatment.** Any services actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this *plan* is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.
9. **Services of Relatives.** Professional services received from a person who lives in your home or who is related to you by blood or marriage, except as specifically stated in the "Home Infusion Therapy" provision of MEDICAL CARE THAT IS COVERED.
10. **Voluntary Payment.** Services for which you are not legally obligated to pay. Services for which you are not charged. Services for which no charge is made in the absence of insurance coverage, except services received at a non-governmental charitable research *hospital*. Such a *hospital* must meet the following guidelines:
  - a. It must be internationally known as being devoted mainly to medical research;
  - b. At least 10% of its yearly budget must be spent on research not directly related to patient care;
  - c. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
  - d. It must accept patients who are unable to pay; and
  - e. Two-thirds of its patients must have conditions directly related to the *hospital's* research.
11. **Not Specifically Listed.** Services not specifically listed in this *plan* as covered services.
12. **Private Contracts.** Services or supplies provided pursuant to a private contract between the *insured person* and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.
13. **Inpatient Diagnostic Tests.** Inpatient room and board charges in connection with a *hospital stay* primarily for diagnostic tests which could have been performed safely on an outpatient basis.
14. **Nicotine Use.** Smoking cessation programs or treatment of nicotine or tobacco use, if the program is not affiliated with Anthem. Smoking cessation *drugs*, except as specifically stated under PRESCRIPTION DRUG COVERED EXPENSE..
15. **Orthodontia.** Braces and other orthodontic appliances or services, except as specifically stated in the "Reconstructive Surgery" or "Dental Care" provisions of MEDICAL CARE THAT IS COVERED, and as specifically stated in the section DENTAL SERVICES FOR INSURED PERSONS THROUGH AGE 18.
16. **Dental Services or Supplies.** For dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventive care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:
  - a. Extraction, restoration, and replacement of teeth;
  - b. Services to improve dental clinical outcomes.  
This exclusion does not apply to the following:
    - a. Services which we are required by law to cover;
    - b. Services specified as covered in this certificate;

In addition to the medical benefits outlined in this document, each insured member also has coverage for:	
<b>Medical Evacuation</b>	If a Covered Person sustains an Injury or suffers a sudden Sickness while traveling outside his/her Home Country, the Insurer will pay the Medically Necessary expenses incurred, up to the Maximum Limit for all medical evacuations of \$50,000 per Lifetime, for a medical evacuation to the nearest Hospital, appropriate medical facility or back to the Covered Person's Home Country.
<b>Repatriation of Remains</b>	If a Covered Person dies, the Insurer will pay the necessary expenses actually incurred, up to the Maximum Limit of \$25,000, for the repatriation of the Covered Person's remains to his/her Home Country. This benefit covers the legal minimum requirements for the transportation of the remains. It does not include the transportation of anyone accompanying the body or visitation or funeral expenses.
<b>Bedside Visit</b>	If the Covered Person is Hospital Confined due to an Injury or Sickness for more than seven (7) days while traveling outside his/her Home Country, the Insurer will pay up to a maximum benefit of \$1,000 for the cost of one economy round-trip air fare ticket to, and the hotel accommodations in, the place of the Hospital Confinement for one person designated by the Covered Person.
<b>Accident Death &amp; Dismemberment</b>	The maximum payable under this benefits is the Principal Sum up to \$10,000 for the Participant. There is no coverage for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.

## MEDICAL CARE THAT IS NOT COVERED

No payment will be made under this *plan* for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

- Not Medically Necessary.** Services or supplies that are not *medically necessary*, as defined.
- Experimental or Investigative.** Any *experimental* or *investigative* procedure or medication. But, if you are denied benefits because it is determined that the requested treatment is *experimental* or *investigative*, you may request an independent medical review as described in REVIEW OF DENIALS OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT.
- Crime or Nuclear Energy.** Conditions that result from: (1) your commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.
- Uninsured.** Services received before your *effective date* or after your coverage ends.
- Non-Licensed Providers.** Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed *physician*, except as specifically provided or arranged by us.
- Excess Amounts.** Any amounts in excess of *maximum allowed amounts* or any Medical Benefit Maximum or any Benefit Year Maximum.

- There will be no Co-Payment for any covered services provided by a participating provider under the Preventive Care benefit.
- There will be no Co-Payment for any covered services provided by a Recognized Student Health Center.
- Your Co-Payment for durable medical equipment and supplies will be 50% of the maximum allowed amount.
- There will be no Co-Payment for any covered services provided by a participating provider under the Hospice Services benefit.
- Your Co-Payment for non-participating providers will be the same as for participating providers for the following services. You may be responsible for charges which exceed the maximum allowed amount.
  - All emergency services;
  - An authorized referral from a physician who is a participating provider to a non-participating provider;
  - Charges by a type of physician not represented in the Prudent Buyer Plan network; or
  - Cancer Clinical Trials.
- Your Co-Payment for office visits to a physician who is a participating provider will be \$10. This Co-Payment will not apply toward the satisfaction of any deductible. Note: This exception applies only to the charge for the visit itself. It does not apply to any other charges made during that visit, such as testing procedures, surgery, etc.
- Your Co-Payment for diabetes education program services provided by a physician who is a participating provider will be \$10. This Co-Payment will not apply toward the satisfaction of any deductible.
- Your Co-Payment for chiropractic services provided by a physician who is a participating provider will be \$10. This Co-Payment will not apply toward the satisfaction of any deductible.
- Your Co-Payment for acupuncture services provided by a physician who is a participating provider will be \$10. This Co-Payment will not apply toward the satisfaction of any deductible.
- Your Co-Payment for specified transplants (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) determined to be medically necessary and performed at a designated CME will be the same as for participating providers. Services for specified transplants are not covered when performed at other than a designated CME.
 

NOTE: No Co-Payment will be required for the transplant travel expenses authorized by us in connection with a specified transplant performed at a designated CME. Transplant travel expense coverage is available when the closest CME is 75 miles or more from the recipient's or donor's residence.
- Your Co-Payment for bariatric surgical procedures determined to be medically necessary and performed at a designated CME will be the same as for participating providers. Services for bariatric surgical procedures are not covered when performed at other than a designated CME.
 

NOTE: Co-Payments do not apply to bariatric travel expenses authorized by us. Bariatric travel expense coverage is available when the closest CME is 50 miles or more from the insured person's residence.
- Co-Payments do not apply to transgender travel expenses authorized by us. Transgender travel expense coverage is available when the facility at which the surgery or series of surgeries will be performed is 75 miles or more from the insured person's residence.
- Your Co-Payment for orally administered anti-cancer medications will not exceed \$200 for each 30-day supply.

<b>Out-of-Pocket Maximum Amount</b>	After an insured person has made \$5,000 in total out-of-pocket payments for covered services and supplies during a benefit year, that insured person will no longer be required to pay a Co-Payment for the remainder of that year, but will remain responsible for costs in excess of the maximum allowed amount for the services of a non-participating provider or another health care provider.
<b>Exception:</b>	Expense which is applied toward any deductible, which is incurred for non-covered services or supplies, or which is in excess of the maximum allowed amount, will not be applied toward your Out-of-Pocket Amount, and is always your responsibility.

## Medical Benefit Maximum

### Additional Benefits

We will pay, for the following services and supplies, up to the maximum amounts, or for the maximum number of days or visits shown below:	
<b>Skilled Nursing Facility</b>	
<ul style="list-style-type: none"> <li>For covered <i>skilled nursing facility</i> care</li> </ul>	<b>100 days</b> per Benefit Year
<b>Home Health Care</b>	
<ul style="list-style-type: none"> <li>For covered home health services</li> </ul>	<b>100 visits</b> per Benefit Year
<b>Home Infusion Therapy</b>	
<ul style="list-style-type: none"> <li>For all covered services and supplies received during any one day</li> </ul>	<b>\$600*</b>
<i>*Non-participating providers only</i>	
<b>Ambulatory Surgical Center</b>	
<ul style="list-style-type: none"> <li>For all covered services and supplies</li> </ul>	<b>\$350*</b>
<i>*Non-participating providers only</i>	
<b>Outpatient Hemodialysis</b>	
<ul style="list-style-type: none"> <li>For all covered services and supplies</li> </ul>	<b>\$350*</b> per visit
<i>*Non-participating providers only</i>	
<b>Advanced Imaging Procedures</b>	
<ul style="list-style-type: none"> <li>For all covered services</li> </ul>	<b>\$800*</b> per procedure
<i>*Non-participating providers only</i>	
<b>Ambulance</b>	
<ul style="list-style-type: none"> <li>For air ambulance transportation that is not related to an <i>emergency</i></li> </ul>	<b>\$50,000*</b> per trip
<i>*Non-participating providers only</i>	

<b>Chiropractic Services</b>	
<ul style="list-style-type: none"> <li>For covered outpatient services</li> </ul>	24 visits per Benefit Year, additional visits as authorized by us if <i>medically necessary</i>
<b>Vision Services for Insured Persons Through Age 18</b>	
<ul style="list-style-type: none"> <li>For all listed services, including eye exams, lenses, frames, and contact lenses</li> </ul>	See Section 7 for details
See the full Certificate of Insurance for details	
<b>Dental Services for Insured Persons Through Age 18</b>	
<ul style="list-style-type: none"> <li>For all listed services, including diagnostic and preventive, basic restorative, endodontic, periodontic, oral surgery, major restorative, prosthodontic, and orthodontic</li> </ul>	See Section 8 for details
See the full Certificate of Insurance for details	
<b>Transplant Travel Expense</b>	
<ul style="list-style-type: none"> <li>For all travel expenses authorized by us in connection with authorized transgender surgery or surgeries</li> </ul>	up to <b>\$3,000</b> per transplant
<b>Unrelated Donor Searches</b>	
<ul style="list-style-type: none"> <li>For all charges for unrelated donor searches for covered bone marrow/stem cell transplants</li> </ul>	up to <b>\$3,000</b> per transplant
<b>Bariatric Travel Expense</b>	
<ul style="list-style-type: none"> <li>For all travel expenses authorized by us in connection with a specified bariatric surgery performed at a designed CME</li> </ul>	up to <b>\$3,000</b> per surgery
<b>Transgender Travel Expense</b>	
<ul style="list-style-type: none"> <li>For all travel expenses authorized by us in connection with authorized transgender surgery or surgeries</li> </ul>	up to <b>\$3,000</b> per surgery or series of surgeries
<b>Benefit Year Maximum</b>	
<ul style="list-style-type: none"> <li>For all medical benefits</li> </ul>	<b>Unlimited</b>