2015-2016 Student Health Insurance

Soka University of America

studentinsurance.wellsfargo.com

Underwritten by:
Anthem Blue Cross Life and Health Insurance Company
Policy #277956

Plan Brokered by:
Wells Fargo Insurance Services USA, Inc.
CA License No. 0D08408
HEALTH CARE REFORM NOTICE

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Review Services, we may be required to make additional changes to this summary of benefits.

STUDENT HEALTH PLAN

Promotion of good health for our students has always been our concern. This brochure summarizes how the Student Health Insurance Plan works, what it covers and how the plan will help you with medical costs. After you’ve read about the Student Health Insurance Plan, keep these important facts in mind:

• Keep your insurance card with you at all times, and show it to the doctor or hospital when you seek medical treatment.
• Learn about your College’s Student Health Center (SHC), its location, hours of operation, and the types of services it offers. Whenever possible, go first to your College’s SHC for treatment during their regular hours of operation. They can help you locate medical providers when you need additional care or specialists.
• You may choose any provider you wish, but if you would like to use a Prudent Buyer provider, you can locate them on the web at www.anthem.com/ca or call (800) 888-2108. Choosing a Prudent Buyer provider may lower your out-of-pocket costs significantly.

The insurance covers expenses arising from covered Accidents and Sickness, whether sustained at the College or elsewhere, during the entire policy term. The insurance also provides benefits for hospital treatment or surgery. Health insurance is the best way to protect your budget from health care costs. Even a short hospital stay can cost more than an entire year’s tuition. This will help relieve the parent or student of the financial drain which normally accompanies this type of unanticipated expense. The Master Policy has some limitations and these should be noted.

WHEN COVERAGE BEGINS

Coverage under the Plan once premium has been collected will become effective at 12:01 a.m. on the later of; but no sooner than:

• The Master Policy effective date;
• The beginning date of the term for which premium has been paid;
• The day after the Enrollment Form (if applicable) and premium payment are received by Wells Fargo Insurance, Authorized Agent or University; or
• The day after the date of postmark if the Enrollment Form is mailed.

IMPORTANT NOTICE - Premiums will not be pro-rated if the Insured Person enrolls past the first date of coverage for which he or she is applying.

The below enrollments will be allowed a 30-day grace period from the term start date to enroll whereby the effective date will be backdated a maximum of 30 days to the earlier of; the term start date or up to 30 days prior to the effective date as otherwise determined above (no policy shall ever start prior to the term start date):

1. All hard-waiver and mandatory (insurance is required as a condition of enrollment on campus) insurance programs.
2. All re-enrollments into the same exact policy if re-enrollment occurs within 30 days of the prior policy termination date.

WHEN COVERAGE ENDS

Insurance of all Insured Persons terminates at 12:01 a.m. on the earlier of:

• On the date this Policy is terminated; or
• On the premium due date if the required premium for the Insured Person is not paid, except as a result of inadvertent error; or
• As of the date the Insured Person enters military service, in which case a pro-rata refund of premium will be made to such Insured Person; or
• On the date the Insured Person no longer qualifies under the Description of Class as shown in the Schedule of Eligible Classes; or
• On the last day the Insured Student is required to be on campus at the Policyholder or, if the Policyholder has so elected, the anniversary of the Policyholder’s Policy.

COVERAGE IS NOT AUTOMATICALLY RENEWED. Eligible Persons must re-enroll when coverage terminates to maintain coverage. No notification of plan expiration or renewal will be sent.

You can view the standard Summary of Benefits & Coverage (SBC) which is required by Health Care Reform. It summarizes your coverage in a format that all insurance companies now use. To view your plan SBC, go to: studentinsurance.wellsfargo.com or call 800-853-5899 to request a paper copy free of charge.
PREMIUM REFUND/CANCELLATION

Refund requests should be directed to Wells Fargo Insurance at (800) 853-5899 or via email at studentinsurance@wellsfargo.com. A refund of premium will be granted for the reasons listed below only. No other refunds will be granted.

1. If you withdraw from school within the first 45 days of the coverage period, you and your insured dependents will receive a full refund of the insurance premium provided that you and your insured dependents did not file a medical claim during this period. Written proof of withdrawal from the school must be provided. If you withdraw after 45 days of the coverage period, your and your insured dependents coverage will remain in effect until the end of the term for which you have paid the premium.

2. If you or your insured dependents enter the armed forces of any country you and your insured dependents will not be covered under the Master Policy as of the date of such entry. If you enter the armed forces the policy will be cancelled. If your dependent enters the armed forces, a pro-rata refund of premium will be made for such person, upon written request received by Wells Fargo Insurance Services within 45 days of entry into service.

3. Refunds will be granted for insured dependents in case of a qualifying event such as legal separation, divorce or death within 31 days of the occurred event, provided that your insured dependents did not file a medical claim during the insured period. Written proof of such qualifying event must be submitted. Refunds will not be prorated.

INSURANCE PAYMENTS WITH PERSONAL CHECK

(Note: personal checks are not always a payment option. Please check your school’s enrollment form for available payment options.) If you make your or your dependents’ insurance payment via personal check payable to Wells Fargo Insurance and we are unable to process the check (due to insufficient funds, closure of account, etc.), your and your dependents insurance coverage will be terminated retroactive to the effective date of the enrolled term.

NOTE: COVERAGE IS FOR STUDENTS ONLY. DEPENDENTS ARE NOT COVERED.

Rates include premium payable to Anthem Blue Cross Life and Health Insurance Company, as well as administrative fees payable to Wells Fargo Insurance. Rates also include Medical Evacuation and Repatriation and Worldwide Emergency Travel Assistance benefits/services provided through On Call International and its contracted underwriting companies.

<table>
<thead>
<tr>
<th>PLAN COST</th>
<th>ANNUAL</th>
<th>FALL</th>
<th>SPRING/SUMMER</th>
<th>BRIDGE PROGRAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Term Dates</td>
<td>8/1/15 - 8/1/16</td>
<td>8/1/15 - 2/1/16</td>
<td>2/1/16 - 8/1/16</td>
<td>6/1/16 - 8/1/16</td>
</tr>
<tr>
<td>Student only</td>
<td>$1,704.18</td>
<td>$852.09</td>
<td>$852.09</td>
<td>$284.03</td>
</tr>
</tbody>
</table>

ELIGIBILITY

All international and study abroad students are required and automatically enrolled in this insurance plan at registration, and the premium for coverage is added to their tuition billing.

All students from the United States are automatically enrolled in this insurance plan at registration and the premium for coverage is added to their tuition billing unless proof of comparable coverage is furnished.

Students must actively attend classes for at least the first 45 days after the date for which coverage is purchased. Please note that course credits received from TV, internet, video, satellite or any off-campus classes do not fulfill the eligibility requirements.

Enrollment must be accompanied by confirmation of Practical Training from the insured in the form of a copy of your EAD. Contact Wells Fargo Insurance Services’ Customer Service for more details. If Anthem Blue Cross and/or Wells Fargo Insurance discover the Eligibility requirements have not been met, the only obligation is a refund of premium. Eligible students who involuntarily lose coverage under another group insurance plan are also eligible to purchase the Student Health Insurance Plan within 30 days of loss of coverage. These students must provide Wells Fargo Insurance Services with proof that they have lost insurance through another group (certificate and letter of ineligibility) within 30 days of the qualifying event. The effective date would be the later of the date after the student enrolls and pays the premium or the date after prior coverage ends.
ONLINE STUDENT ASSISTANCE PROGRAM

Everyone experiences challenges in life. Usually, we can find our own solutions. But when we can’t, those problems can affect our daily lives. This plan includes the Anthem Blue Cross OnLine Student Assistance Program. With OnLine, helpful information and resources for the everyday problems of living are just a mouse click away.

When you need solutions, Anthem Blue Cross OnLine can help.

With the OnLine Student Assistance Program, you and your family can access an online library of valuable articles covering mental and physical health, relationships/family issues, stress and emotional concerns and substance abuse. Browse the legal and financial resource center for general information on these topics. OnLine also provides important links to some of the most valuable Web resources available, as well as pertinent reading lists and helpful self-assessment tools.

How to access the Anthem Blue Cross OnLine Program

You and your family members can take advantage of this online resource by going to www.AnthemEAP.com. Simply enter your Program Name: SOKA University of America for access to helpful information and resources to assist you with the normal challenges of living. Many of the OnLine resources are also available in Spanish.

OES - ONLINE ENROLLEE SERVICES

Setting up your OES Account:
1. Go to studentinsurance.wellsfargo.com
2. Click on “Access My Account Online”
3. Enter the requested information to create your personal account

After setting up your account you can:
- View a summary of your plan information
- Update your address and phone number
- Request a new ID card
- View your plan brochure
- View Other Insurance Plans such as: Short term Plans, Dental Plans, Vision Plans, and Travel Coverage
- Print a letter of creditable coverage
- View Frequently Asked Questions

PPO PRUDENT BUYER NETWORK

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. Covering all California ZIP codes, the Prudent Buyer network is the most geographically extensive PPO network in the state. The suitcase icon on your Medical ID card indicates that this plan can be used outside of California. The PPO network allows Insured’s easy access to a wide range of medical providers. Insured’s have the option to receive care from a provider who is not participating in the PPO network. The trade-off is higher out-of-pocket expenses.

Participating providers (PPO Providers) agree to provide services to covered persons at discounted rates as payment in full. This is the incentive for Insured’s to use PPO providers and protects them from being balance-billed (except for coinsurance, co-payments and deductible amounts). Providers working within a PPO facility (e.g., a hospital) may not always be PPO providers. You should request that all of your provider services be performed by a PPO Provider when you use a PPO facility. When Non-PPO providers are used, you may be subject to higher out-of-pocket expenses.

Additionally, PPO physicians agree to admit their patients to network hospitals, guaranteeing that discounted charges and utilization management savings will occur. With no claim forms to file, Insured’s can focus on their health, not paperwork.

Insured’s can find a PPO physician in their area by calling Anthem at (800) 888-2108, or by accessing the “Find a Doctor” link on www.anthem.com/ca.

MANDATED BENEFITS

The following benefits are mandated coverages in the state of California. They will be included in all School plans issued under The Master Policy. Unless specified otherwise, all such coverage will be subject to any deductible, co-payment and co-insurance conditions of the Plan, as well as all other terms and conditions applicable to any other Covered Sickness.

Mandated benefits as required by the state in which The Master Policy is issued include: PKU Treatment Benefit; Hospital Dental Procedures; Mastectomy-Reconstructive Surgery and Rehabilitation; Laryngectomy-Prosthetic Devices; Osteoporosis Benefit; Experimental or Investigational Therapies Treatment; Diabetes Equipment, Supplies and Service; Severe Mental Illness Treatment Benefit, which is a separate benefit from Mental and Nervous Disorders; and Pervasive Developmental Disorder or Autism. See The Master Policy on file with the school for further details on these benefits.

GUIDELINES FOR CANCER SCREENING TESTS

Anthem Blue Cross Life and Health will pay the charges incurred for the following cancer screening tests, subject to any deductibles, co-payments or co-insurance:

1. Screening mammogram performed according to the following schedule: a) A baseline mammogram for women age 35 to 39 inclusive; b) A mammogram for women age 40 to 49, inclusive, every two years or more frequently based on a Physician’s recommendation; or c) A mammogram every year for women age 50 and over.

2. PAP tests for women 18 years of age and older as recommended by a Physician;

3. Prostate cancer screening, including digital rectal examinations and prostate-specific antigen tests if recommended by a Physician, at least once a year for men 50 years of age and older until age 72.

Other generally accepted cancer screening tests, subject to all terms and conditions that would otherwise apply.
**DEFINITIONS**

**Contracting Hospital:** is a Hospital that has a contract with Anthem Blue Cross Life and Health to provide care to covered persons; however, this does not necessarily make it a Participating Hospital. Verify participation with your Physician.

**Co-payment:** is a part of the Maximum Allowed Amount you are responsible for paying. Co-payment does not include charges for services that are not Covered Services or charges in excess of the Maximum Allowed Amount.

**Covered Services:** are services that are Medically Necessary services or supplies which are listed in the benefit section of this brochure and for which you are entitled to receive benefits.

**Deductible:** is a part of the Maximum Allowed Amount you must pay for Covered Services before any benefits are available to you under this plan. If applicable, your Plan Year Deductible is stated on page 8.

**Emergency:** is a sudden, serious and unexpected acute illness, injury, condition (including without limitation sudden and unexpected severe pain), or a psychiatric emergency medical condition, which the insured person reasonably perceives could permanently endanger health if medical treatment is not received immediately. Anthem Blue Cross Life and Health will have sole and final determination as to whether services were rendered in connection with an emergency.

**The Insurer:** is Anthem Blue Cross Life and Health Insurance Company.

**Insured Person:** is the student or dependent.

**Maximum Allowed Amount:** is the maximum amount of reimbursement that is allowed for covered medical services and supplies under the plan.

**Medically Necessary:** are procedures, supplies, equipment or services that are considered to be:

- Appropriate and necessary for the diagnosis or treatment of a medical condition, and
- Provided for the diagnosis or direct care and treatment of the medical condition, and
- Within the standards of good medical practice within the organized medical community, and
- Not primarily for the convenience of the patient’s Physician or another provider, and
- The most appropriate procedure, supply, equipment or service which can be safely provided that must satisfy the following requirements: 1) there must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the patient with the particular medical condition being treated than other possible alternatives; and 2) generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and 3) for Hospital stays, acute care as an inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

**Non-Contracting Hospital:** is a Hospital that does not have a standard contract nor a Prudent Buyer Participating Agreement with Anthem Blue Cross Life and Health. Only a portion of the amount which a Non-Contracting Hospital charges for services will be considered covered. The Insured will be responsible for any billed charges over the Maximum Allowed Amount.

**Non-Prudent Buyer Provider (Non-PPO):** is a provider who does NOT have a Prudent Buyer Plan Participating Provider Agreement with Anthem Blue Cross Life and Health in effect at the time services are rendered. Only a portion of the amount which a Non-Prudent Buyer Provider charges for services will be considered covered. The Insured will be responsible for any billed charges over the Maximum Allowed Amount.

**Physician** means:

1) A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice where the care is provided, or
2) One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, such license is required to render that service, and is providing a service for which benefits are specified in this brochure:

- A physician assistant
- A licensed professional clinical counseling (L.P.C.C.)*
- A nurse practitioner
- A dentist (D.D.S. or D.M.D.);
- A registered dietician (R.D.)* for the provision of diabetic medical nutrition therapy only
- An optometrist (O.D.);
- A dispensing optician;
- A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.);
- A licensed clinical psychologist;
- An acupuncturist (A.C.);
- A chiropractor (D.C.);
- An audiologist*;
- A licensed clinical social worker (L.C.S.W.);
- A marriage and family therapist (M.F.T.);
- A physical therapist (P.T. or R.P.T.);
- A speech pathologist*;
- An occupational therapist (O.T.R.)*;
- A respiratory care practitioner (R.C.P.)*;
- A licensed qualified autism service provider
- A speech language pathologist (S.L.P.)*
- A Skilled Nursing Facility
- A facility which provides diagnostic imaging services
- A home health agency
- A home infusion therapy provider
- An urgent care center
- An optometrist (O.D.);
- An ambulatory surgical center
- A durable medical equipment outlet
- A home health agency
- A hospice
- A dispensing optician
- A licensed qualified autism service provider
- A registered dietician (R.D.)* for the provision of diabetic medical nutrition therapy only

**Note:** The providers indicated by asterisks (*) are covered only by referral of a Physician (M.D. or D.O.) as defined in 1 above.

**Prudent Buyer Provider (PPO):** is one of the following providers which has a Prudent Buyer Plan Participating Provider Agreement with Anthem Blue Cross Life and Health in effect at the time services are rendered.

- A Hospital
- A Physician
- An Ambulatory Surgical Center
- A durable medical equipment outlet
- A clinical laboratory
- A Skilled Nursing Facility
- A facility which provides diagnostic imaging services
- A home health agency
- A home infusion therapy provider
- An urgent care center
- A hospice
- A licensed qualified autism service provider
- A registered dietician (R.D.)* for the provision of diabetic medical nutrition therapy only

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**SOKA UNIVERSITY OF AMERICA**
In addition to dollar and percentage copays, insured persons are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service.

Insured persons are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of The Master Policy. Plan maximums and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of The Master Policy.

Plan payments are based on the Maximum Allowed Amount:

- **PPO Providers** — The rate the provider has agreed to accept as reimbursement for covered services. Insured Persons are not responsible for the difference between the provider’s usual charges & the Maximum Allowed Amount.
- **Non-PPO Providers & Other Health Care Providers** (includes those not represented in the PPO provider network) — Reimbursement amount is based on the Insurer’s rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. Insured Persons are responsible for the difference between the provider’s usual charges & the Maximum Allowed Amount.

When using Non-PPO and Other Health Care Providers, insured persons are responsible for any difference between the covered expense & actual charges, as well as any deductible & co-pay.

### Deductible for emergency room services
$100/visit (waived if admitted directly from ER)

### Out of Pocket Maximums
$5,000 per Insured per Policy Year

### Benefit Year Maximum (Domestic and International Students)
Unlimited

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**Covered Services**

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>PPO: Per Insured Person Co-pay</th>
<th>Non-PPO: Per Insured Person Co-pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Services <em>(subject to utilization review for inpatient and certain outpatient services; waived for emergency admissions)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-private room, medically necessary services &amp; supplies</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Outpatient medical care, surgical services &amp; supplies <em>(hospital care other than emergency room care)</em></td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>*<em>Ambulatory Surgical Centers, (certain surgeries are subject to utilization review)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery, services &amp; supplies</td>
<td>0%</td>
<td>30%</td>
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<tr>
<td>(benefit limited to $350/admit)</td>
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<td></td>
</tr>
<tr>
<td><strong>Related Outpatient Medical Services &amp; Supplies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground or air ambulance transportation, services &amp; disposable supplies <em>(air ambulance in a non-medical emergency is subject to utilization review)</em></td>
<td>0%</td>
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<tr>
<td>Blood transfusions, blood processing &amp; the cost of unreplaced blood &amp; blood products</td>
<td>20%</td>
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<tr>
<td>Autologous blood <em>(self-donated blood collection, testing, processing &amp; storage for planned surgery)</em></td>
<td>20%</td>
<td></td>
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<tr>
<td><strong>Emergency Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room services &amp; supplies, $100 deductible <em>(waived if admitted)</em></td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Physician Services</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Physician Medical Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office &amp; home visits</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Hospital &amp; skilled nursing facility visits</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Surgeon &amp; surgical assistant; anesthesiologist or anesthetist</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Diagnostic X-ray &amp; Lab</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Mental or Nervous Disorders and Substance Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility-based care <em>(subject to utilization review; waived for emergency admissions)</em></td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Inpatient physician visits</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility-based care <em>(subject to utilization review; waived for emergency admissions)</em></td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Outpatient physician visits <em>(Behavioral Health treatment will be subject to pre-service review)</em></td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Physical Therapy, Physical Medicine &amp; Occupational Therapy including Chiropractic</strong> <em>(limited to 24 visits/benefit year additional visits may be authorized)</em></td>
<td>0%</td>
<td>30%</td>
</tr>
</tbody>
</table>
### Covered Services

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>PPO: Per Insured Person Co-pay</th>
<th>Non-PPO: Per Insured Person Co-pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Drugs and Medications</strong>, see page 12 for Prescription Drug Benefit details. Drugs and medication, including oral contraceptives &amp; insulin, when dispensed by a retail pharmacy (Benefit is on a reimbursement basis in a 30 day supply only)</td>
<td>Co-pays: $10/generic; $20/formulary; $40/non-formulary; $40/compound</td>
<td></td>
</tr>
<tr>
<td><strong>Home delivery drugs and medications - Generic or brand name</strong> (90-day supply)</td>
<td>Co-pays: $20/generic; $40/formulary; $80/non-formulary</td>
<td></td>
</tr>
<tr>
<td><strong>Acupuncture</strong> Services for the treatment of disease, illness or injury (12 visits/benefit year)</td>
<td>0% 30%</td>
<td>30%²</td>
</tr>
<tr>
<td><strong>Pregnancy &amp; Maternity Care</strong> (services cover insured student) Physician office visits Prescription drug for elective abortion (mifepristone) Normal delivery, cesarean section, complications of pregnancy &amp; abortion</td>
<td>0% 0%</td>
<td>30% 30%</td>
</tr>
<tr>
<td><strong>24/7 NurseLine</strong> A 24-hour service that connects insured persons to a nurse or audio library with a toll-free call. The number is (800) 977-0027.</td>
<td>No co-pay (deductible waived)</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes Education Programs</strong> (requires physician supervision) Teach insured persons &amp; their families about the disease process, the daily management of diabetic therapy &amp; self-management training</td>
<td>0% 30%</td>
<td></td>
</tr>
<tr>
<td><strong>Prosthetic Devices</strong> Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; &amp; therapeutic shoes &amp; inserts for members with diabetes</td>
<td>0% 30%</td>
<td></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong> (may be subject to utilization review) Rental or purchase of DME (breast pump and supplies are covered under preventive care at no charge for in-network)</td>
<td>0% 30%</td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong> (subject to utilization review) Semi-private room, services &amp; supplies (limited to 100 days/calendar year)</td>
<td>0% 30%</td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care</strong> (subject to utilization review; one visit by a home health aide equals four hours or less) Service &amp; supplies from a home health agency</td>
<td>0% 30%</td>
<td></td>
</tr>
<tr>
<td><strong>Home Infusion Therapy</strong> (subject to utilization review) Includes medication, ancillary services &amp; supplies; caregiver training &amp; visits by provider to monitor therapy; durable medical equipment; lab services</td>
<td>0% 30% (benefit limited to $600/day)</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care Services</strong>, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration.</td>
<td>0% 30%</td>
<td></td>
</tr>
</tbody>
</table>

1. These providers are not represented in the PPO network.
2. Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).
EXCLUSIONS & LIMITATIONS

1. **Not Medically Necessary.** Services or supplies that are not medically necessary, as defined.

2. **Experimental or Investigative.** Any experimental or investigatory procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigatory, the member may request an independent medical review, as described in the Certificate.

3. **Outside the United States.** Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care, an emergency, or while participating in a school sponsored study abroad program.

4. **Crime or Nuclear Energy.** Conditions that result from (1) the member’s 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 the treatment of illness or injury arising from the release of nuclear energy.

5. **Uninsured.** Services received before the member’s effective date. Services received after the member’s coverage ends, except as specified as covered in the Certificate.

6. **Excess Amounts.** Any amounts in excess of covered expense or the benefit maximum.

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, whether or not the member claims those benefits.

8. **Government Treatment.** Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

9. **Services of Relatives.** Professional services received from a person living in the member’s home or who is related to the member by blood or marriage, except as specified as covered in the Certificate.

10. **Voluntary Payment.** Services for which the member is not legally obligated to pay. Services for which the member is 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:
   1. it must be internationally known as being devoted mainly to medical research;
   2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
   3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
   4. if must accept patients who are unable to pay; and
   5. two-thirds of its patients must have conditions directly related to the hospital’s research.

11. **Not Specifically Listed.** Services not specifically listed in the plan as covered services.

12. **Private Contracts.** Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under 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. **Orthodontia.** Braces, other orthodontic appliances or orthodontic services, except services for members under age 18.

15. **Dental Services or Supplies** (this does not apply to members under age 18). For dental treatment, regardless of origin or cause, except as specified below. “Dental treatment” includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:
   1. Extraction, restoration, and replacement of teeth;
   2. Services to improve dental clinical outcomes.
   **This exclusion does not apply to the following:**
   1. Services which we are required by law to cover;
   2. Services specified as covered in this booklet;
   3. Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.

16. **Hearing Aids or Tests.** Hearing aids and routine hearing tests, except as specified as covered in the Certificate.

17. **Optometric Services or Supplies.** Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except routine eye screenings provided as specified as covered in the Certificate. Eyeglasses or contact lenses, except as specified as covered in the Certificate.

18. **Outpatient Occupational Therapy.** Outpatient occupational therapy, except by a home health agency, hospice, or infusion therapy provider, except as specified as covered in the Certificate.

19. **Outpatient Speech Therapy.** Outpatient speech therapy, except as specified as covered in the Certificate.

20. **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.

21. **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 will be covered only when criteria is met as recommended by our Medical Policy.
22. Sterilization Reversal. Reversal of Sterilization

23. 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.

24. 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).

25. Orthopedic Supplies. Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient or therapeutic shoes and inserts designed to treat foot complications due to diabetes, except as specified as covered in the Certificate.

26. Air Conditioners. Air purifiers, air conditioners or humidifiers.

27. Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. 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 or custodial care or rest cures, except as specified as covered in the Certificate.

28. 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.

29. Personal Items. Any supplies for comfort, hygiene or beautification.

30. Education or Counseling. This plan does not cover:
   - Educational or academic counseling, remediation, or other services that are designed to increase academic knowledge or skills.
   - Educational or academic counseling, remediation, or other services that are designed to increase socialization, adaptive, or communication skills.
   - Academic or educational testing.
   - Teaching skills for employment or vocational purposes.
   - Teaching art, dance, horseback riding, music, play, swimming, or any similar activities.
   - 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.
   - This exclusion does not apply to the medically necessary treatment of pervasive developmental disorder or autism, to the extent stated.

31. Food or Dietary Supplements. Nutritional and/or dietary supplements and counseling, 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.

32. Telephone, Facsimile, and Electronic Mail Machine Consultations. Consultations provided using telephone, facsimile machine, or electronic mail.

33. 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 specified as covered in the Certificate.

34. 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.

35. 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 specified as covered in the Certificate.

36. Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the Certificate. Any non-prescription, over the counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.


38. Private Duty Nursing. Private duty nursing services.

39. 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.

40. Wigs.

41. 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.

42. Clinical Trials. Services and supplies in connection with clinical trials, except as specified as covered in the Certificate.

43. Sports-Related Conditions. Expenses incurred for treatment of sport-related accidents resulting from interscholastic, intercollegiate, club or professional sports.

44. 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.

45. 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).
CERTIFICATE OF CREDITABLE COVERAGE
Your coverage under this Insurance Plan is creditable coverage under Federal Law. When your coverage terminates, you can request a Certificate of Creditable Coverage, which is evidence of your coverage under this health insurance plan. You need such certificate if you become covered under a group health plan or other health plan within 62 days after your coverage under this health insurance plan terminates. If the subsequent health plan excludes or limits coverage for medical conditions you have before you enroll, this certificate may be used to reduce or eliminate those exclusions or limitations. A Certificate of Creditable Coverage may be requested in writing from Wells Fargo Insurance.

CONTINUOUS COVERAGE
This Plan may be replacing a Prior Plan with another insurer. Prior Plan means (a) the Student Health Insurance policy or policies issued to the California State University immediately before the current Policy; (b) other policies providing Creditable Coverage as defined in this Plan. Injury or Sickness shall include an Injury sustained, or a Sickness first manifesting itself, while the Insured Person is continuously insured under the Prior Plan and became insured under this Plan without a break in coverage. But no benefits shall be payable for such Injury or Sickness to the extent that such benefits are payable under the Prior Plan for the same expenses. This will apply even though the Prior Plan provided that it will not duplicate the benefits under another Policy. Also, the total amount of benefits payable for Injury or Sickness under this Plan and the Prior Plan cannot exceed the Per Condition Aggregate Maximum.

EXCESS COVERAGE
The Insurer will reduce the amount payable under The Master Policy to the extent expenses are covered under any Other Plan. The Insurer will determine the amount of benefits provided by Other Plans without reference to any coordination of benefits, non-duplication of benefits, or other similar provisions. The amount from Other Plans includes any amount to which the Covered Person is entitled, whether or not a claim is made for the benefits. The Master Policy is secondary coverage to all other policies.

ID CARDS
Medical ID cards may be shipped before or within 3 weeks of your policy effective date. New ID cards will not be sent if you are renewing coverage with Anthem Blue Cross Life and Health and there are no benefit changes between plan years. Providers need your Member ID # from your ID card to identify you, verify your coverage and bill Anthem Blue Cross Life and Health. If you need to seek medical treatment prior to receiving your ID card, please use the temporary card and write in your Member # or call Wells Fargo Insurance at (800) 853-5899 to obtain your Member #. Renewing students will maintain the same Member #. Without a Member ID you can still seek medical treatment and submit a claim form for reimbursement.

CONTINUATION OF BENEFITS AFTER TERMINATION
Anthem Blue Cross Life and Health will extend benefits under The Master Policy for 30 days after the Insured’s coverage would otherwise end if on that date he or she is 1) Hospital Confined for an Injury or Sickness covered by The Master Policy, and 2) under a doctor’s care. Any benefits payable under this provision will not exceed the benefit maximums shown in the Schedule of Benefits. The cost of the Continuation of Benefits is one month’s premium.

HOW DO I FILE A CLAIM?
Usually, all providers of healthcare will bill Anthem Blue Cross Life and Health directly for services to Insureds. This is the preferred procedure - you are not bothered with claim forms, and Anthem Blue Cross Life and Health often needs more details than are ordinarily provided on bills to patients.

But sometimes a physician or an ambulance company may not bill Anthem Blue Cross Life and Health and may send the bill directly to you. Also, your Student Health Services and pharmacies will not bill Anthem Blue Cross Life and Health. In these instances, Anthem Blue Cross Life and Health has no way of knowing about your claim. So, you must mail the bills to Anthem Blue Cross Life and Health within 90 days of treatment and include a claim form. Claim forms are available at www.anthem.com/ca You are urged to send Anthem Blue Cross Life and Health each bill immediately upon receipt. Mail to:

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

Complete instructions for use of the claim form are on the form.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES
Under some circumstances, an insured person may need services under this plan for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation. In that event, the insurer will provide the benefits of this plan subject to the following:

1. The Insurer will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party’s insurer, or the third party’s guarantor. The lien will be in the amount of benefits the Insurer has paid under this plan for the treatment of the illness, disease, injury or condition for which the third party is liable.

2. You must advise the Insurer in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as the Insurer may require to facilitate enforcement of their rights. You must not take action which may prejudice the insurer’s rights or interests under your plan. Failure to give the Insurer such notice or to cooperate with the Insurer, or actions that prejudice the Insurer’s rights or interests will be a material breach of this plan and will result in your being personally responsible for reimbursing the Insurer.

3. The Insurer will be entitled to collect on their lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.
MEMBER DISCOUNTS
SpecialOffers — Online Discounts that Connect to You
To help support your healthy lifestyle the Insurer provides information on discounts on a variety of dental, vision, fitness, massage therapy, yoga and hypnotherapy products and services offered by independent vendors. Here are a few examples of potential savings:
- Up to 30% off, frames, lenses and special savings on LASIK
- 25% up to 60% off health club memberships at nationally recognized health clubs and up to 50% off weight loss programs
- 5% off non-prescription items at drugstore.com and up to 15% off allergen avoidance products at natallergy.com
- Up to 40% off of smoking cessation, stress management, alcohol management and other self-help programs up to 40% off of wellness products
The independent vendors participating in the Anthem SpecialOffers program offer you choice, flexibility and freedom through discounts that save you money! Discounts advertised may change without notice, for a current listing and more information about specific vendors and discounts log onto our website www.anthem.com/ca and click on “Discounts”.

24-HOUR NURSE ADVICE LINE
Students and insured dependents may utilize the 24/7 NurseLine anytime they need confidential medical advice. Callers must be enrolled in the Student Health Insurance Plan in order to be eligible to utilize the 24/7 NurseLine program. This program gives access to a toll-free nurse information line, or an audio library, 24 hours a day, 7 days a week.

HERE’S HOW EASY IT IS:
1. The insured student or insured dependent calls the 24/7 NurseLine.
2. A registered nurse asks questions and assesses the caller’s condition.
3. If you speak a language other than English or Spanish, the registered nurse can utilize an interpreter, that will work with the nurse and the member.
4. The nurse provides information regarding care options to help the caller develop a proactive plan which could include: proceed to an urgent care or emergency facility, follow-up with your primary care provider, or develop a home care plan.
5. The nurse can provide information about your PPO network providers in the geographic area closest to your school.
One toll-free phone call is all it takes to access a wealth of useful health care information at (800) 977-0027.

ONLINE HEALTHCARE ADVISOR
Subimo™ is an innovative and interactive website that provides valuable tools to help covered persons make informed decisions regarding their specific healthcare needs. Covered persons link to Subimo from the Anthem Blue Cross Life and Health website through “Member Services” located on the home page at www.anthem.com/ca and logging in to the Secure Member Services site. First time users will need to register.

COMPLAINT NOTICE
Should you have any complaints or questions regarding your coverage, you should first contact Anthem Blue Cross Life and Health at:

Anthem Blue Cross Life and Health Insurance Company
(Anthem Blue Cross Life and Health)
Customer Service
21555 Oxnard Street
Woodland Hills, CA 91367
(800) 888-2108

If the problem is not resolved, you may also contact the California Department of Insurance at:

California Department of Insurance
Claims Service Bureau, 11th Floor
300 South Spring Street
Los Angeles, California 90013
(800) 927-HELP (4357) — In California
(213) 897-8921 — Out of California
(800) 482-4833 — Telecommunication Device for the Deaf
E-mail Inquiry: “Consumer Services” link at www.insurance.ca.gov

ARBITRATION AGREEMENT
Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this plan or The Master Policy or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort, or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute or claim within the jurisdictional limits of the small claims court will be resolved in such court.
The Federal Arbitration Act will govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision.
The insured person and Anthem Blue Cross Life and Health agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.
The insured person and Anthem Blue Cross Life and Health agree to give up the right to participate in class arbitration against each other.
The arbitration findings will be final and binding except to the extent that California or Federal law provides for the judicial review of arbitration proceedings.
The arbitration is begun by the insured person making written demand on Anthem Blue Cross Life and Health. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”) according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the insured person and Anthem Blue Cross Life and Health, or by order of the court, if the insured person and Anthem Blue Cross Life and Health cannot agree. The arbitration shall be held in the State of California.

SOKA UNIVERSITY OF AMERICA •11•
To get a prescription filled, you will only need to take your prescription to a participating pharmacy and present your member ID card. The amount you pay for a covered prescription — your co-pay — will be determined by whether the drug is a brand-name or generic medication and whether it is a formulary or non-formulary medication.

A generic drug contains the same effective ingredients, meets the same standards of purity as its brand-name counterpart and typically costs less. In many situations, you have a choice of filling your prescription with a generic medication or a brand-name medication.

The plan’s formulary is a list of approximately 600 recommended brand and generic medications. These medications have undergone extensive review for therapeutic value for a particular medical condition, safety and cost. Copies of the formulary list are furnished to your providers and are available online at www.anthem.com/ca. You or your provider may also contact Anthem Blue Cross Life and Health’s Customer Service at (800) 700-2541.

The Prescription Drug Benefit covers the following:

- Outpatient prescription drugs and medications which the law restricts to sale by prescription. Formulas prescribed by a physician for the treatment of phenylketonuria. These formulas are subject to the co-pay for brand name drugs.
- Insulin. Syringes when dispensed for use with insulin and other self-injectable drugs or medications.
- Prescription contraceptives; including oral contraceptive, diaphragms, and patches. Contraceptives may be covered as preventive care services. In order to be covered as preventive care, the contraceptives must be generic drugs or single source brand name drugs that you get from a Retail Pharmacy or through the home delivery program.
- Injectable drugs which are self-administered by the subcutaneous route (under the skin) by the patient or family member. Drugs that have Food and Drug Administration (FDA) labeling for self-administration.
- All compound prescription drugs that contain at least one covered prescription ingredient.
- Diabetic supplies (i.e., test strips and lancets).
- Prescription drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
- Inhaler spacers and peak flow meters for the treatment of pediatric asthma, subject to the brand name co-pay.
- Certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

![Image](image-url)

**Covered Services**

<table>
<thead>
<tr>
<th>Outpatient prescriptions only</th>
<th>Per Member Co-pay for Each Prescription or Refill</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail Participating Pharmacy</strong> (exception: Preventive immunizations administered by a retail pharmacy &amp; prescription contraceptives per insured co-pay is no charge)</td>
<td>Tier 1 drugs $10 (includes diabetic supplies) Tier 2 drugs $20 Tier 3 drugs $40 (includes compound drugs) Tier 4 drugs 20% of prescription drug maximum allowed amount (maximum $150 copay per fill)</td>
</tr>
<tr>
<td><strong>Home Delivery</strong> (exception: prescription contraceptives per insured co-pay is no charge)</td>
<td>Tier 1 drugs $10 (includes diabetic supplies) Tier 2 drugs $40 Tier 3 drugs $80 Tier 4 drugs 20% of prescription drug maximum allowed amount (maximum $300 copay per fill)</td>
</tr>
<tr>
<td><strong>Specialty Pharmacy Program</strong> Certain specialty pharmacy drugs must be obtained through the specialty pharmacy program and are limited to a 30-day supply.</td>
<td>Applicable co-pay applies Please contact customer service number on the back of your ID card to see if your drug is on the specialty pharmacy program or you can get a list of drugs required to be dispensed by our specialty pharmacy program at anthem.com/ca. From our home page: Click on Customer Care; Then select “I need to: Choose: Download Forms”; In the pharmacy library section, click on “Specialty Drug List.”</td>
</tr>
<tr>
<td><strong>Supply Limits</strong> Retail Pharmacy (participating and non-participating)</td>
<td>30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double co-pay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)</td>
</tr>
<tr>
<td><strong>Home Delivery</strong> Specialty Pharmacy</td>
<td>90-day supply 30-day supply</td>
</tr>
</tbody>
</table>

1. Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program.
2. Preferred Generic Program. If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost of that type of prescription drug. The Preferred Generic Program does not apply when the physician has specified “dispense as written” (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.
3. Compound drugs are not covered through home delivery; only covered through certain retail participating pharmacies.
4. Supply limits for certain drugs may be different. Please refer to the EOC/Certificate for complete information.
**Prescription Exclusions**

1. Immunizing agents, biological sera, blood, blood products or blood plasma.
2. Hypodermic syringes &/or needles, except when dispensed for use with insulin & other self-injectable drugs or medications.
3. Drugs & medications dispensed or administered in an outpatient setting, including outpatient hospital facilities and physicians’ offices.
4. Professional charges in connection with administering, injecting or dispensing drugs.
5. Drugs & medications that may be obtained without a physician’s written prescription, except insulin or niacin for cholesterol lowering and certain over-the-counter drugs approved by the Pharmacy and Therapeutics Process to be included in the prescription drug formulary.
6. Drugs & medications dispensed by or while confined in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility.
7. Durable medical equipment, devices, appliances & supplies, even if prescribed by a physician, except contraceptive diaphragms, as specified as covered in the EOC/Certificate.
8. Services or supplies for which the member is not charged.
10. Cosmetics & health or beauty aids. However, health aids that are medically necessary and meet the requirements as specified as covered in the EOC/Certificate.
11. Drugs labeled “Caution, Limited by Federal Law to Investigational Use,” or experimental drugs.
12. Drugs or medications prescribed for experimental indications.
13. Any expense for a drug or medication incurred in excess of the prescription drug maximum allowed amount.
14. Drugs which have not been approved for general use by the Food and Drug Administration. This does not apply to drugs that are medically necessary for a covered condition.
15. Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of drug for medically necessary treatment of a medical condition other than one that is cosmetic.
16. Drugs used primarily to treat infertility (including, but not limited to, Clomid, Pergonal and Metrodin), unless medically necessary for another condition.
17. Anorexiants and drugs used for weight loss, except when used to treat morbid obesity (e.g., diet pills & appetite suppressants).
18. Drugs obtained outside the U.S, unless they are furnished in connection with urgent care or an emergency.
19. Allergy desensitization products or allergy serum.
20. Infusion drugs, except drugs that are self-administered subcutaneously.
21. Herbal supplements, nutritional and dietary supplements.
22. Formulas and special foods for the treatment of phenylketonuria (PKU).
23. Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was ineffective.
24. Compound medications unless:
   a. There is at least one component in it that is a prescription drug; and
   b. It is obtained from a participating pharmacy. Member will have to pay the full cost of the compound medications if member obtains drug at a non-participating pharmacy.
25. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but which are obtained from a retail pharmacy are not covered by this plan. Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that member should have obtained from the specialty pharmacy program.
26. Off label prescription drugs
Information that’s important to you
Every year, we’re required to send you specific information about your rights, your benefits and more. This can use up a lot of trees, so we’ve combined a couple of these required annual notices. Please take a few minutes to read about:

- State notice of privacy practices
- HIPAA notice of privacy practices
- Breast reconstruction surgery benefits

Want to save more trees? Go to anthem.com/ca and sign up to receive these types of notices by e-mail.

State notice of privacy practices
As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your personal information
We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter. We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company — without your OK in some cases. If we take part in an activity that would require you to give us a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity. You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgements about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you. A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

HIPAA notice of privacy practices
This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully. We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information
We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor’s office to confirm your benefits.

For health care operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents). PHI can also be shared with certain other persons or entities, such as doctors, hospitals or any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

Your rights
Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information
We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure. We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password protecting computers, and locking...
storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, wherever required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential impact of other applicable laws

HIPAA (the federal privacy law) generally does not preempt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact information

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Breast reconstruction surgery benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your benefits comply with the Women’s Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance. Contact Customer Service for more information.
Emergency Assistance Services  
Provided by On Call International

GLOBAL RESPONSE CENTER:  
(877) 318-6901 (Toll-free within the U.S.)  
(603) 328-1909 (Outside the U.S.)  
One Delaware Drive  
Salem, NH 03079  
E-mail: mail@oncallinternational.com  
www.oncallinternational.com

On Call International does not replace your medical insurance. All medical costs incurred should be submitted to your health plan and are subject to The Master Policy limits of your health coverage. All assistance services must be arranged and provided by On Call International. Claims for reimbursement will not be accepted.

PROGRAM GUIDELINES

U.S. students studying in a U.S. location are eligible for services when traveling more than 100 miles away from their permanent residence or campus location for up to one year. Medical transportation services and repatriation of deceased remains services are available at campus location.*

U.S. students studying abroad are eligible for services both at and away from their new campus location for up to one year.*

Foreign national students studying in the U.S. are eligible for On Call International’s services, both on or away from campus or while traveling in a country that is not their country of origin.*

*Member shall be eligible for services during the term of his/her defined Program as long as his/her program is still effective and the membership fee has been paid prior to departure.

KEY SERVICES

Medical Monitoring
On Call’s medical staff will communicate with the member’s attending physician and obtain a full understanding of the situation. Medical professionals will stay in regular communication with local medical personnel and relay necessary information to the Member and Family.

Emergency Medical Evacuation
If adequate medical facilities are not available locally, On Call will make arrangements to use whatever mode of transport, equipment and medical personnel necessary to evacuate a member to the nearest facility capable of providing a high standard of care.

Medical Repatriation
If after seeking medical attention, it is medically advisable for the member to seek further care at home, On Call will transport the member home or to a medical facility closer to home with a medical or non-medical escort, as necessary.

Compassionate Visit
If a member is traveling alone and will be hospitalized for more than seven days, On Call will provide economy, round-trip, common carrier transportation to the place of hospitalization and arrange lodging for a designated family member or friend.

Care of Minor Children
If a member is traveling with dependent children and is hospitalized as a result of a medical emergency for more than seven days. On Call will arrange for the transportation of the unattended children to their home, with an attendant if necessary.

Return of Deceased Remains
On Call will assist with the logistics of returning a member’s remains home in the event of his or her death. This service includes arranging the preparation of the remains for transport, procuring required documentation, providing the necessary shipping container as well as paying for transport.

Medical, Dental and Pharmacy Referrals
On Call will provide referrals to medical, dental professionals and pharmacies in the given geographic locations of western style medical facilities and English speaking providers in an area served by On Call to the extent possible.

Hospital Admission Guarantee
On Call will guarantee hospital admission by validating a member’s health coverage or by advancing funds to the hospital. (Any advance of funds shall be charged to the member’s credit card at the time of service).

Prescription Assistance
If a member needs a replacement prescription while traveling, On Call will assist in filling that prescription. Any expenses associated with prescription replacement are the member’s responsibility.

Emergency Message Transmission
On Call will receive and transmit authorized emergency messages for members.

Legal Consultation and Referral
If a member is away from home and requires the services of an attorney, On Call shall arrange for an initial telephone consultation with an attorney without charge to the member. If necessary, the member will be referred to a local attorney.

Lost Luggage Assistance
On Call will assist the member with the tracking of luggage lost or delayed in transit.

Lost/Stolen Travel Document Assistance
On Call will provide assistance by arranging for the replacement of passports, visas, airline documents, birth certificates and other travel-related documents. Any expenses related to replacing lost travel documents are the member’s responsibility.

Interpreter & Legal Referrals
On Call will refer members to local translators and interpreters if communication problems cannot be solved via telephone.

Pre-trip Information
On Call offers members reports via email, fax or postal mail including visa, passport and inoculation requirements, cultural information, weather conditions, embassy and consulate referrals, foreign exchange rates, and travel advisories for any destination.

As a member, you can call upon doctors, hospitals, pharmacies and other services whenever traveling 100 miles or more from your permanent address, campus location or abroad, 24 hours a day, 365 days a year. One phone call connects you to a state-of-the-art Global Response Center staffed around-the-clock with trained multilingual professionals to handle medical emergencies quickly and efficiently. As the U.S. member of the International Assistance Group, a 36-partner global network of independent assistance companies, including more than 53 alarm centers, On Call International has immediate response capabilities worldwide with a global network of pre-qualified medical providers, including air and ground ambulance services.
CONDITIONS & EXCLUSIONS

On Call International will not pay for services in the following instances:

* Services rendered without the coordination and approval of On Call
* Intentionally self-inflicted injuries, suicide or any attempted threat except when hospitalized as an inpatient.
* Expenses incurred if the original or ancillary purpose of the member’s trip is to obtain medical treatment.
* Participation in a declared or undeclared act of war, civil disturbance or insurrection or an accident occurring while the member is serving on full-time or active duty in the Armed Forces of any country.
* Participation in an international authority flight in aircraft being used for experimental purpose, or in military aircraft (except the Military Aircraft Command of the United States or similar air transport Services Account of other) or while serving as a member of the crew of any aircraft.
* Use of any alcohol or drug unless prescribed by a physician or except if hospitalized as an inpatient.
* Any services provided to an injured person where the member is entitled to receive reimbursement for such expenses under any group insurance program maintained by the member’s insurance company or employer.
* Routine or non-disabling medical problems, such as simple fractures, or sickness, which can be treated by local doctors and do not prevent the injured person from continuing the trip or returning home.
* Any treatment or expense related to childbirth, miscarriage or pregnancy except for any abnormal pregnancy or vital complication of pregnancy which endangers the life of the mother and/or unborn child during the first twenty-four weeks of pregnancy.

On Call cannot be held responsible for failure to provide services or for delays caused by conditions beyond its control including, but not limited to, flight or weather conditions, strikes, unforeseen changes to airport regulations or restrictions, failure to comply with On Call’s recommendations, or where rendering of service is prohibited by local laws or regulatory agencies.

Member may be required to release On Call or any healthcare provider from liability during emergency evacuation and/or repatriation.

Without limiting the foregoing, On Call’s actions and obligations under this Agreement are ministerial in nature, and all medical care is provided by medical professionals ultimately selected by a Member. On Call is not liable for any malpractice performed by a local doctor, healthcare provider, or attorney.

On Call, at its sole discretion, will assist Members on a fee-for-service basis for interventions falling under the Limitations and Uncovered Services. On Call reserves the right, at its sole discretion, to request additional financial guarantees or pre-payment or indemnification from the Member prior to rendering such service on a fee-for-service basis.

Emergency Assistance Services
Provided by: On Call International
(877) 318-6901 (Toll-free within the U.S.)
(603) 328-1909 (Outside the U.S.)
www.oncallinternational.com
This information is a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in Policy Number 277956 issued to Soka University of America. The Master Policy is subject to the laws of the state in which it was issued. Coverage may not be available in all states or certain terms may be different if required by state law. Please keep this information as a reference.