2019-2020
Soka University of America
Domestic & International Student Health Insurance Plan

https://studentinsurance.usi.com

Anthem BlueCross

IMPORTANT CONTACTS			
Benefits and claims questions: Anthem Blue Cross Life and Health Insurance Company P.O. Box 60007 Los Angeles, CA 90060 **(800) 888-2108** (Toll-Free) *www.anthem.com/ca* **Underwritten by:** Anthem Blue Cross Life and Health Insurance Company **Policy #277956**	**To find a doctor or health care provider:** PPO Prudent Buyer Plan **(800) 888-2108** (Toll-Free) *www.anthem.com/ca* **Prescriptions:** Pharmacy Benefits Manager **(800) 700-2541** *www.anthem.com/ca*	**24/7 NurseLine:** **(800) 977-0027** **24/7 Emergency Travel Assistance:** *On Call International 24/7 Emergency Travel Assistance Services* **(877) 318-6901** (within U.S.). If outside the U.S., call collect by dialing the U.S. access code plus **(603) 328-1909** *www.oncallinternational.com*	**Eligibility, enrollment, and general questions:** USI Student Insurance **(800) 853-5899** Mon-Fri, 8am-5pm PST Fax: (877) 612-7966 Email: studentinsurance@usi.com *https://studentinsurance.usi.com* **Plan brokered by:** USI Insurance Services, LLC CA License No. 0G11911

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: *https://studentinsurance.usi.com* and select Find Your School's Plan.

IMPORTANT NOTICE

This is just a brief description of your benefits. For information regarding the full Master Policy (which includes plan benefits, exclusions and limitations, and information about refund requests, how to file a claim, mandated benefits and other important information) please call Anthem Blue Cross Life and Health Insurance Company at **800-888-2108**. You will be able to obtain a copy of the full Master Policy as soon as it is available. If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will govern and control the payment 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.

Eligibility

All international 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. Coverage is also available for students engaged in "Practical Training." Enrollment must be accompanied by confirmation of Practical Training from the insured in the form of a copy of your EAD. Contact USI Student Insurance Customer Service for more details. If Anthem Blue Cross and/or USI Student 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 USI Student Insurance 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.

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 USI Student 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 enrolls past the first date of coverage for which he or she is applying. Final decisions regarding coverage effective dates are made by Anthem Blue Cross Life and Health.

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**. 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.

Plan Cost - Note: Coverage is for students only. Dependents are not covered.

	ANNUAL	FALL	SPRING/SUMMER	BRIDGE PROGRAM
Term Dates	8/1/19 - 7/31/20	8/1/19 - 1/31/20	2/1/20 - 7/31/20	6/1/20 - 7/31/20
Student	$1,724.50	$862.25	$862.25	$287.77

Rates include premium payable to Anthem Blue Cross Life and Health Insurance Company, as well as administrative fees payable to USI Student 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.

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.

Continuation of Benefits

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.

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 USI Student 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.

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 USI Student Insurance.

Coordination of Benefits

If you are covered by more than one group health plan, your benefits under this plan will be coordinated with the benefits of those other plans. These coordination provisions apply separately to each member, per benefit year, and are largely determined by California law.

For more information or questions around coordination of benefits, please contact Anthem Blue Cross Customer Service at **1-800-888-2108**.

Insurance Waiver Information

All Soka students **must have** health insurance. All **international students** are **required to purchase** the school's health insurance plan. **Domestic students** may waive the health insurance fee by submitting a waiver and providing a current copy of the student's insurance card.

You must annually submit a Health Insurance Election/Waiver form to indicate whether you will be enrolling or waiving the Soka health insurance plan. If you are waiving, you must submit a copy of your health insurance card. Otherwise you will **automatically be enrolled** in Soka's health insurance.

For more information, visit: *http://www.soka.edu/student_life/student-services/health_services/insurance_and_health_forms.aspx*

Premium Refund/Cancellation

Refund requests should be directed to USI Student Insurance at **(800) 853-5899** or via email at *studentinsurance@usi.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 will receive a full refund of the insurance premium provided that you 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 coverage will remain in effect until the end of the term for which you have paid the premium.
2. If you enter the armed forces of any country you 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.

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 insurance payment via personal check payable to USI Insurance Services and we are unable to process the check (due to insufficient funds, closure of account, etc.), your insurance coverage will be terminated retroactive to the effective date of the enrolled term.

Reimbursements 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.

How to 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. 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 and include a claim form. Please contact Anthem Blue Cross Life and Health at **(800) 888-2108** to confirm the filing limit for your claim. 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.

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 Insurance Company 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 Insurance Company 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 Insurance Company. 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 Insurance Company, or by order of the court, if the insured person and Anthem Blue Cross Life and Health Insurance Company cannot agree. The arbitration shall be held in the State of California.

Complaint Notice

Should you have any complaints or questions regarding your coverage, you may 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*

Member Discounts

Save money with discounts at www.anthem.com/ca

Vision and Hearing

Glasses.com™ and 1-800 CONTACTS®— Get the latest brand-name frames for just a fraction of the cost at typical retailers — every day. Plus, you get an additional $20 off orders of $100 or more, free shipping and free returns.

EyeMed — Get 30% off a new pair of glasses, 20% off nonprescription sunglasses and 20% off all eyewear accessories.

Premier LASIK — Save $800 on LASIK when you choose any 'featured' Premier LASIK Network provider. Save 15% with all other in-network providers.

TruVision — Save up to 40% on LASIK eye surgery at more than 1,000 locations (over 6.5 million procedures performed in the network).

Nations Hearing — Get hearing screenings and in-home service at no additional cost. All hearing aids start at $599 each, powered by the Beltone network.

Hearing Care Solutions — Digital instruments start at $500. Plus, get a free hearing exam. Hearing Care Solutions has 3,100 locations and eight manufacturers, and offers a three-year warranty, two years of batteries and unlimited visits for one year.

Amplifon — Get 25% off, plus an extra $50 off one hearing aid; $125 off two.

Fitness and Health

Active&Fit Direct™ — Active&Fit Direct allows you to choose from more than 9,000 participating fitness centers nationwide for $25 a month (plus a $25 enrollment fee and applicable taxes). Offered through American Specialty Health Fitness, Inc.

FitBit — Get fit your way with Fitbit trackers and smartwatches that fit with your lifestyle, budget and goals. Save up to 22% on select Fitbit devices.

Garmin — Get 25% off select Garmin wellness devices.

Jenny Craig — Take advantage of a free, three-month program (food not included) plus $120 in food savings (purchase required), or save 50% off premium programs (food cost separate).

ChooseHealthy — Get discounts on acupuncture, chiropractic, massage and fitness clubs.

Global Fit — Get discounts on gym memberships, fitness equipment, coaching and more.

Medicine and Treatment

SelfHelpWorks — Choose one of the online Living programs and save 15% on coaching to help you lose weight, stop smoking, manage stress or diabetes, restore sound sleep or face an alcohol problem.

Brevena — Enjoy a 41% discount on BREVENA® skin care creams and balms for smooth, rejuvenated skin from face to foot.

Puritan's Pride — Choose from a large selection of discounted vitamins, minerals and supplements from Puritan's Pride.

24-Hour Nurse Advice Line

Students 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 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 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.

Online Enrollee Services (OES)

Setting up your OES Account:

1. Go to https://studentinsurance.usi.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

Where Do I Go for Care?

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 (ex. 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.

IMPORTANT NOTICE

This is just a brief description of your benefits. For information regarding the full Master Policy (which includes plan benefits, exclusions and limitations, and information about refund requests, how to file a claim, mandated benefits and other important information) please call Anthem Blue Cross Life and Health Insurance Company at **800-888-2108** or call USI Student Insurance at **800-853-5899**. You will be able to obtain a copy of the full Master Policy as soon as it is available. If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will govern and control the payment of benefits.

Schedule of Benefits

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. Benefits are subject to all terms, conditions, limitations, and exclusions of The Master Policy.

Explanation of Covered Charges

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.

Deductibles & Maximums	
Pediatric Dental Deductible	$60 per Insured per Policy Year
Out of Pocket Maximums	$4,000 per Insured per Policy Year $1,000 per Insured per Policy Year for Pediatric Dental
Benefit Year Maximum (Domestic and International Students)	Unlimited

Covered Services	PPO Providers & Other Health Care Providers	Non-PPO Providers
Hospital Medical Services, (subject to utilization review for inpatient and certain outpatient services; waived for emergency admissions)		
Semi-private room, medically necessary services & supplies	0%	30%
Outpatient medical care, surgical services & supplies (hospital care other than emergency room care)	0%	30%
Emergency Care, Emergency room services & supplies, ($100 copay, waived if admitted)	0%	0%
Physician services	0%	0%
Ambulatory Surgical Centers, Outpatient surgery, services & supplies (certain surgeries are subject to utilization review)	0%	30%
Diagnostic X-ray & Lab	0%	30%
Physical Therapy, Physical Medicine & Occupational Therapy	0%	30%
Chiropractic Services	0%	30%
Acupuncture, Services for the treatment of disease, illness or injury	0%	30%[2]
Mental or Nervous Disorders and Substance Abuse		
INPATIENT CARE Facility-based care (subject to utilization review; waived for emergency admission)	0%	30%
Inpatient physician visits	0%	30%
OUTPATIENT CARE Facility-based care (subject to utilization review; waived for emergency admission)	0%	30%
Outpatient physician visits (Behavioral Health treatment will be subject to pre-service review)	0%	30%
Physician Medical Services		
Office & home visits	0%	30%
Hospital & skilled nursing facility visits	0%	30%
Surgeon & surgical assistant; anesthesiologist or anesthetist	0%	30%

Schedule of Benefits (continued)

Covered Services	PPO Providers & Other Health Care Providers	Non-PPO Providers
Preventive Care Services, 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.	0%	30%
Pregnancy & Maternity Care (services cover insured student)		
Physician office visits	0%	30%
Prescription drug for elective abortion (mifepristone) Normal delivery, cesarean section, complications of pregnancy & abortion	0%	30%
Well Woman Visits, Breastfeeding support, supplies and counseling*, Prescription contraceptives (birth control) and counseling for women, Permanent surgical contraception (sterilization) for women, Counseling for sexually transmitted infections, Counseling and screening for HIV, Screening and counseling for interpersonal and domestic violence, Screening for gestational diabetes, HPV testing *Breast pumps must be purchased from an in-network durable medical equipment (DME) outlet to get 100% coverage	0%	30%
Diabetes Education Programs (requires physician supervision), Teaches insured persons & their families about the disease process, the daily management of diabetic therapy and self-management training	0%	30%
Prosthetic Devices, 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; & therapeutic shoes & inserts for insured persons with diabetes	0%	30%
Durable Medical Equipment, (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)	0%	30%
Related Outpatient Medical Services & Supplies		
Ground or air ambulance transportation, services & disposable supplies (air ambulance in a non-medical emergency is subject to utilization review)	0%[1]	
Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%[1]	
Autologous blood (self-donated blood collection, testing, processing & storage for planned surgery)	20%[1]	
Skilled Nursing Facility, (subject to utilization review) Semi-private room, services & supplies (limited to 100 days per benefit period)	0%	30%
Home Health Care (subject to utilization review; one visit by a home health aide equals four hours or less, limited to 100 visits per benefit period) Service & supplies from a home health agency	0%	30%
Home Infusion Therapy (subject to utilization review) Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	0%	30%

Prescription Medications	PPO Providers
Outpatient Drugs and Medications, see page 8 for Prescription Drug Benefit details. Drugs and medication, including oral contraceptives & insulin, when dispensed by a retail pharmacy (Benefit is on a reimbursement basis in a 30 day supply only)	Co-pays/Coinsurance: $10/Tier 1; $20/Tier 2; $40/Tier 3; 20% up to $150/Tier 4
Home delivery drugs and medications - Generic or brand name (90-day supply) See page 8 for Prescription Drug Benefit details.	Co-pays/Coinsurance: $10/Tier 1; $40/Tier 2; $80/Tier 3; 20% up to $300/Tier 4

[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.).

Prescription Drug Benefits

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/co-insurance – will be determined by the tiers detailed below.

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**.

Prescription drug co-pays are separate from the medical co-pays of the medical plan and are not applied toward the Annual Out-of-Pocket Maximums.

Covered Services (outpatient only)	**Per Member Co-pay** for each Prescription or Refill
Retail Participating Pharmacy **30 day supply** (exception: Preventive immunizations administered by a retail pharmacy & generic prescription contraceptives per insured co-pay is no charge)	Tier 1 drugs: $10 (includes diabetic supplies) Tier 2 drugs[2]: $20 Tier 3 drugs[2]: $40 (includes compound drugs) Tier 4 drugs[1]: 20% of prescription drug maximum allowed amount (maximum $150 copay per fill)
Home Delivery **90 day supply** (exception: prescription contraceptives per insured co-pay is no charge)	Tier 1 drugs: $10 (includes diabetic supplies) Tier 2 drugs[2]: $40 Tier 3 drugs[2,3]: $80 Tier 4 drugs[1]: 20% of prescription drug maximum allowed amount (maximum $300 copay per fill)
Specialty Pharmacy Program Certain specialty pharmacy drugs must be obtained through the specialty pharmacy program and are limited to a 30 day supply.	Applicable copay 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: *http://file.anthem.com/05282CAMENABC.pdf*
Supply Limits[4] Retail Pharmacy (participating and non-participating) Home Delivery **Specialty Pharmacy**	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 copay; 6 tablets or units/30-day period for impotence and/ or sexual dysfunction drugs (available only at retail pharmacies) 90-day supply **30-day supply**

[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.

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.

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.
9. Oxygen.
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.

Continued on next page

Prescription Drug Benefits (continued)

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.

Exclusions and Limitations

This list is only a partial list. Please refer to the School's Certificate of Coverage for a complete list of exclusions.

The Master Policy does not cover nor provide benefits for:

1. **Not Medically Necessary.** Services or supplies that are not medically necessary, as defined.
2. **Experimental or Investigative.** Any experimental or investigative procedure or medication. But, if insured person is denied benefits because it is determined that the requested treatment is experimental or investigative, the insured person may request an independent medical review, as described in the Certificate.
3. **Crime or Nuclear Energy.** Conditions that result from (1) the insured person's commission of or attempt to commit a felony; 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.
4. **Not Covered.** Services received before the insured person's policy effective date. Services received after the insured person's coverage ends, except as specified as covered in the Certificate.
5. **Excess Amounts.** Any amounts in excess of the maximum allowed amount or the Benefit Year Maximum.
6. **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 insured person claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the Certificate.
7. **Government Treatment.** Any services the insured person 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 insured person is not required to pay for them or they are given to the insured person for free.
8. **Services of Relatives.** Professional services received from a person living in the insured person's home or who is related to the insured person by blood or marriage, except as specified as covered in the Certificate.
9. **Voluntary Payment.** Services for which the insured person has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan 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.
10. **Not Specifically Listed.** Services not specifically listed in the plan as covered services.
11. **Private Contracts.** Services or supplies provided pursuant to a private contract between the insured person 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.
12. **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.
13. **Orthodontia.** Braces, other orthodontic appliances or orthodontic services, except as specified in the Certificate for members under age 19.
14. **Dental Services or Supplies.** 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, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:
    - Extraction, restoration, and replacement of teeth;
    - Services to improve dental clinical outcomes.

    This exclusion does not apply to the following:
    - Services which we are required by law to cover;
    - Services specified as covered in this booklet;
    - Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer. *Services for members under age 19.
15. **Hearing Aids or Tests.** Hearing aids and routine hearing tests, except as specified as covered in the Certificate.
16. **Optometric Services or Supplies.** Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, eyeglasses or contact lenses, except as specified as covered in the Certificate.
17. **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.
18. **Outpatient Speech Therapy.** Outpatient speech therapy, except as specified as covered in the Certificate.
19. **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.

Continued on next page

Exclusions and Limitations (continued)

20. **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 described in the Certificate.
21. **Sterilization Reversal.**
22. **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.
23. **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).
24. **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.
25. **Air Conditioners.** Air purifiers, a**ir conditioners or humidifiers.**
26. **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.
27. **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.
28. **Personal Items.** Any supplies for comfort, hygiene or beautification.
29. **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.
30. **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.
31. **Telephone, Facsimile Machine, Consultations.** Consultations provided using telephone, facsimile machine, or electronic mail.
32. **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.
33. **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.
34. **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.
35. **Diabetic Supplies.** Prescription and non-prescription diabetic supplies except as specified as covered in the Certificate.
36. **Private Duty Nursing.** Private duty nursing services.
37. **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.
38. **Wigs.**
39. **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.
40. **Clinical Trials.** Services and supplies in connection with clinical trials, except as specified as covered in the Certificate.
41. **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.
42. **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).

Any exclusion above will not apply to the extent that coverage is specifically provided by name in the Master Policy; or coverage of the charges is required under any law that applies to the coverage.

Definitions

Ambulatory surgical center: is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

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. Payment of the dollar Co-payment will be required at the time services are provided.

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. Your Plan Year Deductible is stated on page 9.

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.

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
- Not more costly than an equivalent service or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of the patient's illness, injury, or condition; 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, and such license is required to render that service, and is providing a service for which benefits are specified in this brochure:
A dentist (D.D.S. or D.M.D.); 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; A chiropractor (D.C.);
An acupuncturist (A.C.); 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 audiologist*; An occupational therapist (O.T.R.)*; A respiratory care practitioner (R.C.P.)*; A psychiatric mental health nurse (R.N.); A nurse midwife; A registered dietician (R.D.)* for the provision of diabetic medical nutrition therapy only A nurse practitioner A physician assistant A licensed educational psychologist for the provision of behavioral health treatment services for the treatment of pervasive developmental disorder or autism 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; A licensed ambulance company; A licensed qualified autism service provider.

Anthem Blue Cross Life and Health Notice of Privacy Practices

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 **www.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 us to give you 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 health care operations: We use and share PHI for our health care operations.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. For example: we keep information about your premium and deductible payments; We may give information to a doctor's office to confirm your benefits; We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes; We may share PHI with your health care provider so that the provider may treat you; 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; We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations or treatment purposes in health information exchanges, please visit: **www.anthem.com/ca** for more information.

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 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: In most cases, if we use or disclose your PHI outside of treatment, payment, operations or research activities, we must get your OK in writing first. We must receive your written OK before we can use your PHI for certain marketing activities. We must get your written OK before we sell your PHI. If we have them, we must get your OK before we disclose your provider's psychotherapy notes. Other uses and disclosures of your PHI not mentioned in this notice may also require your written OK. You always have the right to revoke any written OK you provide. 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 organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law. If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper. If your employer pays your premium or part of your premium, but does not pay your health insurance claims, your employer is not allowed to receive your PHI – unless your employer promises to protect your PHI and makes sure the PHI will be used for legal reasons only.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at 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.

Right to a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or disclosure of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to Anthem Blue Cross (Anthem), Anthem does not have to agree to a restriction (see Your Rights section above). If a law requires the disclosure, Anthem does not have to agree to your restriction.

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, where 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.

Contacting You: We, including our affiliates or vendors, may call or text any telephone numbers provided by you using an automated telephone dialing system and/or a prerecorded message. Without limitations, these calls may concern treatment options, other health-related benefits and services, enrollment, payment or billing.

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.

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Anthem Blue Cross Life and Health Notice of Privacy Practices (continued)

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.
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. 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 and include a claim form. Please contact Anthem Blue Cross Life and Health at **(800) 888-2108** to confirm the filing limit for your claim. 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.

Emergency Assistance Services: On Call International

On Call 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. All care and travel coordinated through OnCall, no retroactive benefits will be granted and no reimbursement will be approved.

Key Services

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.
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.
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

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Emergency Assistance Services: On Call International (continued)

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:

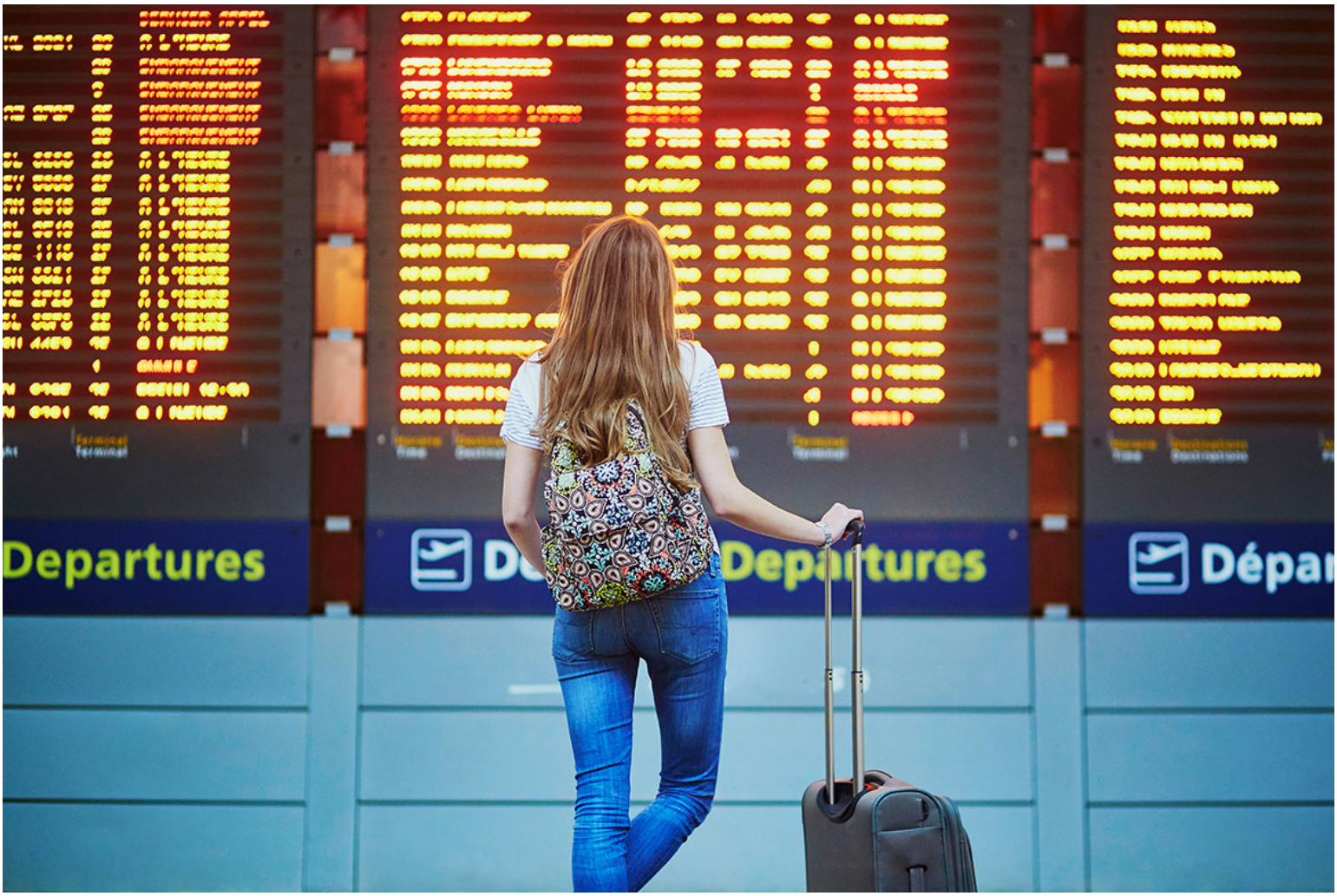
- Services rendered without the coordination and approval of On Call
- Intentionally self-inflicted injuries, suicide or any attempted threat except when hospitalized as an inpatient.
- Expenses incurred if the original or ancillary purpose of the member's trip is to obtain medical treatment.
- Participation 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.
- A member on an organ transplant list prior to enrollment will not be entitled to a transport for that transplant.

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



USI INSURANCE SERVICES PRIVACY INFORMATION

We know that your privacy is important to you and we strive to protect the confidentiality of your personal information. We do not disclose any personal information about our plan participants, except as permitted or required by law (e.g., information you provide to us may be shared with your school to process your insurance transaction). To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. You may obtain a detailed copy of our privacy policy through your school or by calling us at (800) 853-5899 or by visiting us at *http://www.usi.com/privacy*.

IMPORTANT NOTE

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.