

2011-2012

Monterey Institute of International Studies

HEALTH INSURANCE

Domestic/International

studentinsurance.wellsfargo.com

Underwritten by:
Anthem Blue Cross Life and Health Insurance Company
Policy #175132

Brokered by:
Wells Fargo Insurance Services USA, Inc.
Student Insurance Division

Anthem. 
blue Cross



Your student health insurance coverage, offered by Anthem Blue Cross Life and Health Insurance Company, may not meet the minimum standards proposed by title XXVII of the Public Health Service Act. Specifically, the coverage will not be renewed when you are no longer enrolled as a student at Monterey Institute of International Studies; and the restrictions on annual dollar limits on your benefits may not be the same as other types of coverage. If you have any questions or concerns about this notice, contact Wells Fargo Insurance Services USA, Inc., Student Insurance Division, (800)853-5899.

INTRODUCTION

WHY DO I NEED INSURANCE? Having health insurance is important because, while medical care in the United States is excellent, the costs may be very high. Health insurance coverage helps minimize the risk that could force an interruption to your education because of a financially devastating injury or sickness. It may help you focus on your studies instead of worrying about what would happen if faced with overwhelming medical bills.

For these reasons, the Monterey Institute of International Studies selected a plan underwritten by Anthem Blue Cross Life and Health Insurance Company to meet this need.

ELIGIBILITY

Students enrolled at the Monterey Institute of International Studies for six (6) or more credit hours for Fall or Spring and four (4) or more credit hours for Summer semesters are required to be insured. Spring students will pay for Spring/Summer coverage at the beginning of the spring semester. All international students, possessing and maintaining a current passport and valid visa status (J-1), engaged in educational activities at the Institute who are temporarily located outside their home country and have not been granted permanent residency status, are required to be insured. Waiver may only be granted to people already insured under equivalent plans. Coverage is available to students engaged in practical training, on campus internships, and off campus internships located at school approved locations. Contact Student Services for more information. Please note that course credits received from TV, internet, video, satellite or any other off-campus classes do not fulfill the eligibility requirements.

To be an Insured under the Policy, the student must have paid the required premium and his/her name, student number and date of birth must have been included in the declaration made by the School or the Administrative Agent to the Insurer. All students must actively attend classes for the first 45 consecutive days following their effective date for the term purchased and/or pursuant to their visa requirements for the period for which coverage is purchased, except in the case of medical withdrawal or during school authorized breaks.

The Company maintains its right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever the Company discovers that the Policy eligibility requirements have not been met, its only obligation is a refund of unused premium.

Eligible students who involuntarily lose coverage under another group insurance plan are also eligible to purchase the Student Health Insurance Plan. 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 the student enrolls and pays the premium or the day after prior coverage ends.

DEPENDENT COVERAGE - Eligible Insured Students may also purchase Dependent coverage at the time of student's enrollment in the plan; or within 31 days of one of the following qualified events: marriage, addition of domestic partner, birth, or adoption. Eligible dependents are the spouse or legally registered and valid domestic partner which resides with the Insured Student and the student's, the spouse's, or the domestic partner's unmarried natural child, stepchild or legally adopted child under nineteen years of age, who are not self-supporting and reside with the Insured Student. A "Newborn" will automatically be covered for Injury or Sickness from birth until 31 days old, providing that the student is covered under this plan. Coverage may be continued for that child when the Company is notified in writing within 31 days from the date of birth and by payment of any additional premium. **Dependents must be enrolled for the same term of coverage for which the Insured Student enrolls. Dependent coverage expires concurrently with that of the Insured Student and Dependents must re-enroll when coverage terminates to maintain coverage.**

WHEN COVERAGE BEGINS

Coverage under the Plan will become effective at 12:01 a.m. on **the later of:**

- ♦ The 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 the Company, 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.*

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

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

- The date the policy terminates for all Insured Persons; or
- The end of the period of coverage for which premium has been paid; or
- The date the Insured Person ceases to be eligible for the insurance; or
- The date the Insured Person enters military service.
- For International Students, the date the Insured Person departs the Country of Assignment for his or her Home Country, except for school authorized breaks; or
- For International Students, the date the Insured student ceases to meet visa requirements.

COVERAGE IS NOT AUTOMATICALLY RENEWED. *Eligible Persons must re-enroll when coverage terminates to maintain coverage.*

CONTINUATION OF BENEFITS AFTER TERMINATION

Anthem Blue Cross Life and Health will extend benefits under the Plan 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 Plan and 2) under a physician'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.

EFFECTIVE & TERMINATION DATES

	ANNUAL	FALL	SPR/SUM 1	SPR/SUM 2	SUMMER
	8/29/11-8/29/12	8/29/11-1/29/12	1/1/12-8/29/12	1/29/12-8/29/12	6/1/12-8/29/12
Student*	\$ 1,725	\$ 748	\$ 1,118	\$ 978	\$ 421
Spouse**	\$ 3,538	\$ 1,535	\$ 2,287	\$ 2,003	\$ 860
Per Child**	\$ 2,045	\$ 888	\$ 1,322	\$ 1,156	\$ 498

*Premium includes travel assistance and administrative services.

**Premium includes travel assistance services.

REFUNDS

REFUNDS - A refund of premium will be granted for the reasons 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 Policy as of the date of such entry. A pro-rata refund of premium will be made for such person, upon written request received by WFIS within 45 days of entry into service.

Refund requests should be directed to Wells Fargo Student Insurance at 800-853-5899. Approved refunds will be assessed a \$25 processing fee.

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 63 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 Services USA, Inc.

ARBITRATION AGREEMENT

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this plan or the 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.

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 (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..

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 the amount of Covered Expenses you are responsible for paying. Co-payment does not include charges for services that are not Covered Services or charges in excess of Covered Expenses.

Covered Expense: is the expense you incur for Covered Services, but for some services the amount of Covered Expenses will be limited to a maximum amount that is described in the benefit section of this brochure.

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.

Customary and Reasonable Charge: as determined annually by Anthem Blue Cross Life and Health, is a charge which falls within the common range of fees billed by a majority of Physicians for a procedure in a given geographic region. If it exceeds that range, the expense must be justified based on the complexity or severity of treatment for a specific case.

The Company: is Wells Fargo Insurance Services USA, Inc. which administers the Plan.

Deductible: means the amount of Covered Expense you must pay for Covered Services before any benefits are available to you under this plan. Your Plan Year Deductible is stated on page 5.

Emergency: is a sudden, serious and unexpected acute illness, injury, 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.

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.

Negotiated Rate: means the amount a Prudent Buyer Provider will accept as payment in full for Covered Services.

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 Covered Expense. The Insured will be responsible for any billed charges over the amount allowed under this plan.

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 Covered Expense. The Insured will be responsible for any billed charges over the amount allowed under this plan.

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, is providing a service within the scope of that license, and such license is required to render that service, is providing a service for which benefits are specified in this brochure, and when benefits would be payable if the services were provided by a Physician as defined above:

- ♦ A dentist (D.D.S. or D.M.D.);
- ♦ An optometrist (O.D.);
- ♦ A dispensing optician;
- ♦ A podiatrist or chiroprapist (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

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 home infusion therapy provider
- ♦ A facility which provides diagnostic imaging services
- ♦ A Home Health Agency

SCHEDULE OF BENEFITS

In addition to dollar and percentage co-pays, insured persons (students & dependents) 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 Policy.

Explanation of Covered Expense

Plan payments apply to the lesser of the charges billed by the provider or the following:

PPO Providers — PPO negotiated rates. Insured persons are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-PPO Providers & Other Health Care Providers (*includes those not represented in the PPO provider network*) — The customary & reasonable charge for professional services or the reasonable charge for institutional services.

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 & percentage co-pay.

School Plan year deductible for all providers	\$500/insured person; \$1,500/family
Deductible for non-PPO hospital or residential treatment center	\$500/admission (<i>waived for emergency admission</i>)
Deductible for non-PPO hospital or residential treatment center if services not preauthorized	\$500/admission (<i>waived for emergency admission</i>)
Deductible for emergency room services	\$250/visit (<i>waived if admitted directly from ER</i>)

Annual Out-of-Pocket Maximums

For all providers \$5,000/insured person/year

The following do not apply to out-of-pocket maximums: deductibles listed above; dollar co-pays; percentage co-pays for mental or nervous disorders & substance abuse; non-covered expense. After an insured person reaches the out-of-pocket maximum, the insured person remains responsible for dollar co-pays; percentage co-pays for mental or nervous disorders & substance abuse; and, for non-PPO providers & other health care providers, costs in excess of the covered expense.

Maximums

Club Sports	\$10,000/insured person/year
J-1 International Students	\$51,000/illness or injury minimum
All others	\$51,000/insured person/year

Covered Services	PPO: Per Insured Person Co-pay	Non-PPO: Per Insured Person Co-pay
Hospital Services (<i>preauthorization required; waived for emergency admissions</i>)		
Semi-private room, meals & special diets, & ancillary services	20%	50% ¹
Outpatient medical care, surgical services & supplies (<i>hospital care other than emergency room care</i>)	20%	50% ¹
Ambulatory Surgical Centers		
Outpatient surgery, services & supplies	20%	50% (<i>limited to \$350/day</i>)
Related Outpatient Medical Services & Supplies		
Ground or air ambulance transportation, services & disposable supplies		20% ²
Blood transfusions, blood processing & the cost of unreplaced blood & blood products		20% ²
Autologous blood (<i>self-donated blood collection, testing, processing & storage for planned surgery</i>)		20% ²
Emergency Care		
Emergency room services & supplies (<i>\$250 deductible waived if admitted</i>)	20%	20%
Inpatient hospital services & supplies	20%	20% first 48 hours; 50% ¹ after 48 hours (<i>unless insured person can't be moved safely</i>)
Physician services	20%	20%
Physician Medical Services		
Office & home visits	\$35/visit ³ (<i>deductible waived</i>)	50%
Hospital & skilled nursing facility visits	20%	50%
Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	50%
Adult Preventive Services (<i>including mammograms, pap smears, & prostate cancer screenings</i>)	20% (<i>deductible waived</i>)	50% (<i>deductible waived</i>)
Diagnostic X-ray & Lab		
(<i>pre-authorization required for CT scans, MRA scans, MRI scans, MRS scans, NC scans & PET scans</i>)	20%	50%
Mental or Nervous Disorders - 12 days per year		
Facility-based care (<i>preauthorization required; waived for emergency admissions; limited to \$500/day</i>)	20% ⁴	50% ^{1,4}
Inpatient or outpatient physician visits for psychotherapy & psychological testing (<i>limited to \$40/visit</i>)	20% ⁴	50% ⁴

SCHEDULE OF BENEFITS (Continued)

Covered Services	PPO: Per Insured Person Co-pay	Non-PPO: Per Insured Person Co-pay
Substance Abuse Facility-based care (preauthorization required; waived for emergency admissions; limited to \$500/day & 12 days/benefit year; the 12 days/calendar year limit does not apply to inpatient detoxification) Inpatient or outpatient physician visits (limited to \$40/visit & 12 visits/benefit year)	20%	50% ¹
Outpatient Drugs and Medications Drugs and medication, including oral contraceptives & insulin, when dispensed by a physician or licensed pharmacist (30 day supply only) (\$1,000 benefit year maximum retail and mail combined) See page 9 for Prescription Rx details	Co-pays: \$20/Generic; \$40/Brand name formulary	Co-pays: \$20/Generic; \$40/Brand name formulary; plus 50% of the maximum allowed amount plus any amounts exceeding the maximum amount
Mail Service Drugs and Medications Generic or brand name drugs and medications (90-day supply)	\$40/Generic; \$80/Brand name formulary	
Well Baby & Well-Child Care for Dependent Children Routine physical examinations (birth through age six) Immunizations (birth through age six) & immunizations for Hepatitis B & Varicella Zoster (Chicken Pox) (ages 7 through 18)	\$35/exam (deductible waived) No co-pay (deductible waived)	50% (limited to \$20/exam) 50% (limited to \$12/immunization)
Preventive Care for Students Only Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam for employment and internship purposes only (limited to \$250/benefit year)	\$35/visit (deductible waived)	Not covered
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services (limited to \$500/benefit year; additional visits may be authorized)	20%	50% (limited to \$25/visit)
Speech Therapy Outpatient speech therapy following injury or organic disease	20%	50%
Acupuncture Services for the treatment of disease, illness or injury (limited to \$30/visit & 12 visits/benefit year)	20% ⁵	50% ⁵
Temporomandibular Joint Disorders Splint therapy & surgical treatment	20%	50%
Pregnancy & Maternity Care (services cover insured student, spouse or domestic partner & dependent daughters) Physician office visits Elective Abortion limited to \$500/benefit year Prescription drug for elective abortion (mifepristone)	\$35/visit ³ (deductible waived) 20%	50% 50%
Normal delivery, cesarean section, complications of pregnancy & abortion (newborn routine nursery care covered when natural mother is insured student or insured spouse or domestic partner) Inpatient physician services Hospital & ancillary services	20% 20%	50% 50% ¹
Organ & Tissue Transplants (preauthorization required; specified organ transplants covered only when performed at a Center of Expertise [COE]) Inpatient services provided in connection with non-investigative organ or tissue transplants Physician office visits (including specialists and consultants) Transplant travel expense for an authorized, specified transplant at a COE (recipient & companion transportation limited to 6 trips/episode & \$250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & \$100/day for 21 days/trip, other expenses limited to \$25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode & \$250 for round-trip coach airfare, hotel limited to \$100/day for 7 days, other expenses limited to \$25/day for 7 days)	20% \$35/visit ³ (deductible waived) No co-pay (deductible waived)	
24/7 NurseLine 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.	No co-pay (deductible waived)	

Covered Services	PPO: Per Insured Person Co-pay	Non-PPO: Per Insured Person Co-pay
Diabetes Education Programs (<i>requires physician supervision</i>) Teach insured persons & their families about the disease process, the daily management of diabetic therapy & self-management training	\$35/visit (deductible waived)	50%
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 Insureds with diabetes	20%	50%
Durable Medical Equipment (DME) Rental or purchase of DME including hearing aids, dialysis equipment & supplies (<i>limited to \$2,000/benefit year</i>)	20%	50%
Skilled Nursing Facility (<i>preauthorization required</i>) Semi-private room, services & supplies (<i>medical conditions & severe mental disorders limited to 100 days/benefit year; treatment of substance abuse limited to 12 days/benefit year</i>)	20%	50%
Hospice Care Inpatient or outpatient services for insured persons with up to one year life expectancy; family bereavement services		20% ²
Home Health Care (<i>preauthorization required</i>) Services & supplies from a home health agency (<i>limited to 100 visits/benefit year, one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care</i>)	20%	50%
Home Infusion Therapy (<i>preauthorization required</i>) Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	50% (<i>limited to \$600/day</i>)

¹ For California facilities, a discount applies if the facility has a contract with us for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher out-of-pocket costs for insured persons.

² These providers are not represented in the PPO network.

³ The dollar co-pay applies only to the visit itself. An additional 20% co-pay applies for any services performed in office (i.e., X-ray, lab, surgery).

⁴ These limitations, co-pays and benefit maximums do not apply to severe mental disorders, including schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, bulimia, and serious emotional disturbances of children as defined in California state law (other than primary substance abuse or developmental disorder). Severe mental disorders are subject to the same co-pays and benefit maximums applicable to other medical conditions for covered services. In order to receive maximum benefits, services must be rendered by a Participating behavioral health provider. Please see the Certificate for complete information.

⁵ 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 AND LIMITATIONS

- Not Medically Necessary.** Services or supplies that are not medically necessary, as defined.
- Experimental or Investigative.** Any experimental or investigative procedure or medication. But, if 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.
- 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 or an emergency.
- Crime or Nuclear Energy.** Conditions that result from: (1) your commission of or attempt to commit a felony as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.
- Uninsured.** Services received before the insured person's effective date. Services received after the insured person's coverage ends, except as specified as covered in the Certificate.
- Excess Amounts.** Any amounts in excess of covered expense or the benefit year maximum.
- 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.
- Government Treatment.** Any services you received if you are not required to pay for them or they are given to you for free that were provided by a local, state, or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or state law.
- 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.
- 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:
 - it must be internationally known as being devoted mainly to medical research;
 - at least 10% of its yearly budget must be spent on research not directly related to patient care;
 - at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
 - it must accept patients who are unable to pay; and
 - two-thirds of its patients must have conditions directly related to the hospital's research.

EXCLUSIONS AND LIMITATIONS (Continued)

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 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.
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. **Mental or Nervous Disorders.** Academic or educational testing, counseling, and remediation. Mental or nervous disorders and alcohol or drug dependence, including rehabilitative care in relation to these conditions, except as specified as covered in the Certificate.
15. **Nicotine Use.** Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs.
16. **Orthodontia.** Braces other orthodontic appliances or orthodontic services.
17. **Dental Services or Supplies.** Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, or treatment to the teeth or gums, or treatment to or for any disorders for the jaw joint, except as specifically stated. Cosmetic dental surgery or other dental services for beautification.
18. **Hearing Aids or Tests.** Hearing aids and routine hearing tests, except as specified as covered in the Certificate.
19. **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.
20. **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.
21. **Outpatient Speech Therapy.** Outpatient speech therapy, except as specified as covered in the Certificate.
22. **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.
23. **Scalp hair prostheses.** Including wigs or any form of hair replacement.
24. **Clinical Trials.** Services and supplies in connection with clinical trials, except as specified as covered in the Certificate.
25. **Commercial Weight Loss Programs.** Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered under the 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, including Bariatric Surgery is not covered.
26. **Sex Transformation.** Procedures or treatments to change characteristics of the body to those of the opposite sex.
27. **Sterilization Reversal.**
28. **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.
29. **Orthopedic Supplies.** Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related feet complications, except as specified as covered in the Certificate.
30. **Air Conditioners.** Air purifiers, air conditioners or humidifiers.
31. **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.
32. **Chronic Pain.** Treatment of chronic pain, except as specified as covered in the Certificate.
33. **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.
34. **Personal Items.** Any supplies for comfort, hygiene or beautification.
35. **Education or Counseling.** Educational services or nutritional counseling, or any services that are educational, vocational, or training in nature, except as specified as covered in the Certificate.
36. **Food or Dietary Supplements.** Nutritional and/or dietary supplements, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.
37. **Telephone and Facsimile Machine Consultations.** Consultations provided by telephone or facsimile machine.
38. **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.
39. **Acupuncture.** Acupuncture treatment, as specified as covered in the Certificate. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.
40. **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.
41. **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.
42. **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.
43. **Contraceptive Devices.** Contraceptive devices prescribed for birth control except as specified as covered in the Certificate.
44. **Diabetic Supplies.** Prescription and non-prescription diabetic supplies except as specified as covered in the Certificate.
45. **Private Duty Nursing.** Inpatient or outpatient services of a private duty nurse.

- 46. **Lifestyle Programs.** Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.
- 47. **Sports-Related Conditions.** Expenses incurred for treatment of sport-related accidents resulting from interscholastic, intercollegiate, club or professional sports, except as specified as covered in the Certificate.
- 48. **Anthem Blue Cross Life and Health Medical Evacuation.** Benefit for International Students - not covered.
- 49. **Anthem Blue Cross Life and Health Repatriation.** Benefit for International Students - not covered.

PRE-EXISTING CONDITION LIMITATION

Benefits are not payable for a pre-existing condition during the first six (6) months following the effective date of a Covered Person's coverage. However, this limitation will not apply if, during the period immediately preceding the effective date of coverage under this plan, a Covered Person was covered under a prior creditable coverage as defined below, for six (6) consecutive months. Prior creditable coverage of less than six (6) months will be credited toward satisfying the pre-existing condition limitation. This waiver of the pre-existing condition limitation will be effective provided a Covered Person becomes eligible under this plan within 63 days of termination of a creditable coverage and applies for coverage under the Plan within 31 days of his or her eligibility date.

CREDITABLE COVERAGE means any individual or group plan that provides medical, hospital, and surgical coverage, including continuation or conversion coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefit Plan, programs of the Indian Health Services or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps. Creditable coverage does not include accident only, credit, coverage for onsite medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable coverage is used to reduce the length of pre-existing under this plan and/or to set up eligibility rules for children who cannot get a self-sustaining job due to a physical or mental condition.

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. 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.

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 Services 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.

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 family member 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 healthcare information at **(800) 977-0027**.



PRESCRIPTION Rx DRUG BENEFITS

To get a prescription filled, you will only need to take your prescription to a participating pharmacy and present your medical 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.

The Anthem Blue Cross Life and Health 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 under the Pharmacy section. You or your provider may also contact Customer Service at (800) 700-2541.

Finding and Using a Participating Pharmacy

You can find a participating pharmacy by going to the Anthem Blue Cross Life and Health website at www.anthem.com/ca. You can substantially control the cost of your prescription drugs by using the extensive network of participating pharmacies. Participating pharmacies have agreed to charge a discounted price or “negotiated rate” and pass along this savings to you.

Using a Non-Participating Pharmacy

If you choose to fill your prescription at a non-participating pharmacy, your costs will increase. You will always need to pay for the entire amount of the prescription and then submit a prescription drug claim form for reimbursement. The pharmacist must sign and complete the appropriate section of the claim form to ensure proper processing of the claim for reimbursement.

Insured Persons who submit claims from non-participating pharmacies are reimbursed based on the prescription drug maximum allowed amount. The prescription drug maximum allowed amount may be considerably less than the cost of the medication. You are responsible for paying any difference.

You may obtain a prescription drug claim form by calling the Pharmacy Customer Service toll-free at (800) 700-2541 or by going to the Anthem Blue Cross Life and Health website at www.anthem.com/ca.

Mail Service Prescription Drug Program

If you take a prescription drug on a regular basis, you may want to take advantage of the Mail Service Program. Ordering your medications by mail is convenient, saves time and depending on your plan design, may even save you money. Besides enjoying the convenience of home delivery, you will also receive a greater supply of medications. To fill a prescription through the mail, simply complete the Mail Service Prescription form. You may obtain the form by calling Customer Service at the toll-free number (800) 700-2541, or by going to the Anthem Blue Cross Life and Health website at www.anthem.com/ca. Once you complete the form, simply mail it with your co-pay and prescription in the envelope attached to the Mail Service brochure. *Please note that not all medications are available through the Mail Service Program.*

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, subject to the copayment for brand name drugs.
- ♦ Insulin. Syringes when dispensed for use with insulin and other self-injectable drugs or medications.
- ♦ Prescription oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms, subject to the copayment for brand name drugs, are limited to one per year.
- ♦ 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 ingredient.
- ♦ Diabetic supplies (i.e., test strips and lancets).
- ♦ All compound prescription drugs which contain at least one covered prescription ingredient.

- ♦ Inhaler spacers and peak flow meters for the treatment of pediatric asthma, subject to the copayment for brand name drugs.
- ♦ Prescription drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.

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 prescriptions only)	Per Insured Person Co-pay for Each Prescription or Refill
Retail Pharmacy	\$20/Generic, \$40/Brand name formulary
Mail Service	\$40/Generic, \$80/Brand name formulary
Non-participating Pharmacies	<i>Insured pays the above co-pay plus: 50% of the maximum amount allowed & any costs in excess of the maximum amount</i>
Supply Limits¹ Retail Pharmacy (participating and non-participating) Mail Service	30-day supply. 90-day supply.
Benefit Year Maximum	\$1,000 per policy year (Combined retail & mail)

¹Supply limits for certain drugs may be different. Please refer to the Evidence of Coverage and Disclosure form (EOC) 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 used to induce spontaneous & non-spontaneous abortions
4. Drugs & medications dispensed or administered in an outpatient setting, including outpatient hospital facilities and physicians' offices
5. Professional charges in connection with administering, injecting or dispensing drugs
6. Drugs & medications that may be obtained without a physician's written prescription, except insulin or niacin for cholesterol lowering
7. Drugs & medications dispensed by or while confined in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility
8. Durable medical equipment, devices, appliances & supplies, even if prescribed by a physician, except contraceptive diaphragms, as specified as covered in the Certificate
9. Services or supplies for which the insured person is not charged
10. Oxygen
11. Cosmetics & health or beauty aids
12. Drugs labeled "Caution, Limited by Federal Law to Investigational Use," or experimental drugs. 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
15. Smoking cessation drugs
16. Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles)
17. Drugs used primarily to treat infertility (including, but not limited to, Clomid, Pergonal and Metrodin)
18. Anorexiants and drugs used for weight loss.
19. Drugs obtained outside the U.S.
20. Allergy desensitization products or allergy serum
21. Infusion drugs, except drugs that are self-administered subcutaneously
22. Herbal, nutritional and dietary supplements except for formulas for the treatment of phenylketonuria.
23. Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin.

ONLINE HEALTH CARE ADVISOR

Subimo™ is an innovative and interactive web-site that provides valuable tools to help covered persons make informed decisions regarding their specific health care needs. Covered persons link to Subimo from the Anthem Blue Cross web-site 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.

EXCESS COVERAGE

The Insurer will reduce the amount payable under the Plan 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 Insured Person is entitled, whether or not a claim is made for the benefits. The Plan is secondary coverage to all other policies. BCR 102 ED 9-2004

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: **MIIS** 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.

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 coinsurance:

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

MANDATED BENEFITS

The following benefits are mandated coverages in the state of California. They will be included in all School plans issued under the Policy. Unless specified otherwise, all such coverage will be subject to any deductible, co-payment and coinsurance 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 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; and Severe Mental Illness Treatment Benefit, which is a separate benefit from Mental and Nervous Disorders. See the policy on file with the school for further details on these benefits.

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 our 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 30% 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 please visit the SpecialOffers link at www.anthem.com/ca.

COMPLAINT NOTICE

Should you have any complaints or questions regarding your coverage, you should first contact Wells Fargo Insurance Services USA, Inc. You may also 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

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

ACCIDENTAL DEATH & DISMEMBERMENT

LOSS BENEFIT

Loss of Life	100% of the Principal Sum
Loss of one hand	50% of the Principal Sum
Loss of one foot	50% of the Principal Sum
Loss of sight of one eye	50% of the Principal Sum
Loss of more than one of the above losses due to one accident	100% of the Principal Sum

CLASS OF INSURED PRINCIPAL SUM

Covered Student	\$ 5,000
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Anthem Blue Cross Life and Health Notice of Privacy Practices

Effective April 1, 2010

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 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 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 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.

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.

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.

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.



**Optional PPO Dental Plus Plan
Includes AD&D, Student Assistance
Program and SpecialOffers Discounts
(Student Only)**

The PPO Dental Plan is an optional benefit plan, and an additional premium must be paid if you choose this coverage. You may enroll online at studentinsurance.wellsfargo.com or call (800) 853-5899.

This PPO Dental Plan (a Preferred Provider Organization plan from Anthem Blue Cross Life and Health) provides you with the freedom to select virtually any licensed dentist. This dental plan also includes Accidental Death & Dismemberment benefits, as well as, access to the online student assistance program and SpecialOffers discounts. You are responsible for the policy year deductible, the Plan's coinsurance for covered services provided by participating dentists, and any amount greater than the maximum payment amount shown in the Reimbursement Schedule for covered services provided by non-participating dentists. A list of covered services and the maximum payment amounts for non-participating dentists are available by calling (800) 627-0004.

PARTICIPATING & NON-PARTICIPATING DENTIST

If you choose a PPO participating dentist, you can take advantage of negotiated rates. The negotiated rate is the amount a participating dentist agrees to accept as payment in full for covered services. The negotiated rate is usually lower than the participating dentist's usual charge. By choosing a participating dentist, you will not be responsible for any amount in excess of the negotiated rate for covered services.

If you choose a non-participating dentist, a licensed dentist who does not participate in the PPO Dental Plan network, you are not eligible for negotiated rates and your out-of-pocket expenses may be greater. You are responsible for any amount over the maximum payment amount that is shown in the Reimbursement Schedule. You may also be asked to pay your portion of the bill at the time of service and submit claim forms for reimbursement. If you have a particular dentist in mind and he or she is not in the directory, you may call the toll-free Customer Service number on your ID card to see if the dentist has recently joined the network.

BENEFIT WAITING PERIOD

You will need to wait six months before you have coverage for simple extractions. However, you are covered immediately for examinations, routine X-rays and fillings.

FILING A CLAIM

When you use a participating dentist, your participating dentist will submit a claim form for covered dental expenses to Anthem Blue Cross Life and Health. Anthem Blue Cross Life and Health will pay the benefits of the plan directly to your dentist. If your dentist is not in the network, you may have to complete and submit your own claim forms.

PRE-AUTHORIZATION

When the anticipated expense for any course of treatment exceeds \$350, it is recommended that you submit a request for pre-authorization. If you use a participating dentist, your dentist will submit the authorization form for you. If your dentist is non-participating, you will have to submit a pre-authorization form to your dentist for completion and then send it to Anthem Blue Cross Life and Health for approval.

CONDITIONS OF SERVICE

Services must be provided by a licensed dentist and must be for the prevention and treatment of dental disease, defect or injury, and are subject to any Exclusions and Limitations or Benefit Maximums specified under the Plan.

BENEFIT MAXIMUMS

Dental benefits are limited to a maximum payment for expenses incurred by each insured person during a policy year. Please refer to the amount on the chart below.

CONTINUING COVERAGE

As required by federal law, certain restrictions and conditions apply to the right to continue coverage and are described in your Certificate of Insurance.

Plan Year Deductible	\$25 per plan year for each insured person for covered services
Annual Maximum Payment	\$500 per plan year for each insured person
Predetermination of Benefits	Charges in excess of \$350
Covered Services	<i>Please refer to the Benefit Schedule.</i>

**PPO DENTAL PLAN
SCHEDULE OF BENEFITS**

The following are the *ONLY* Covered Services:

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
Examination*	100%	Maximum payment amount.
Routine X-Rays	100%	Maximum payment amount.
Regular Cleanings*	100%	Maximum payment amount.
Fluoride Application*	100%	Maximum payment amount.
Fillings	80%	Maximum payment amount.
Simple Extractions**	50%	Maximum payment amount.

* Limited to two per year ** After 6 months waiting period
Resin fillings in posterior teeth covered as an amalgam benefit. Other limitations and exclusions also apply, please refer to the Certificate of Insurance for a complete list.

**ACCIDENTAL DEATH &
DISMEMBERMENT**

The Insurer will pay the benefit stated below if an Insured Person suffers a covered Injury resulting in any of the losses stated below within 365 days after the date the covered Injury is incurred:

LOSS BENEFIT

Loss of Life	100% of the Principal Sum
Loss of one hand	50% of the Principal Sum
Loss of one foot	50% of the Principal Sum
Loss of sight of one eye	50% of the Principal Sum
Loss of more than one of the above losses due to one accident	100% of the Principal Sum

CLASS OF INSURED PRINCIPAL SUM

Covered Student	\$ 5,000
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Please Refer to Enrollment Form for Dental Rates.

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 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.
- * 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



MONTEREY
INSTITUTE

OF INTERNATIONAL STUDIES

An affiliate of Middlebury College

WELLS FARGO INSURANCE SERVICES, INC. PRIVACY POLICY

We know that your privacy is important to you and we strive to protect the confidentiality of your non-public personal information. We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your non-public personal information. You may obtain a detailed copy of our privacy policy through your school, or by calling us toll-free at (800) 853-5899 or by visiting us at studentinsurance.wellsfargo.com.

CLAIMS ADMINISTERED BY:

Claims, Eligibility and Coverage Questions

Anthem Blue Cross Life and Health Insurance Company

(800) 888-2108

www.anthem.com/ca

TO FIND A DOCTOR OR PROVIDER:

Preferred Provider:

PPO Prudent Buyer Plan

(800) 888-2108

www.anthem.com/ca

PRESCRIPTIONS:

Pharmacy Benefits Manager

(800) 700-2541

www.anthem.com/ca

24-HOUR NURSE ADVICE LINE:

24/7 NurseLine

(800) 977-0027

EMERGENCY TRAVEL ASSISTANCE:

*(Provide this information to your
Emergency Contact)*

On Call International

One Delaware Drive

Salem, NH 03079

(877) 318-6901 (Toll-free within the U.S.)

(603) 328-1909 (Outside the U.S.)

www.oncallinternational.com

THE POLICY ADMINISTERED BY:

Enrollment, Complaints, General Questions

**Wells Fargo Insurance Services USA, Inc.
Student Insurance Division**

CA License No. 0D08408

11017 Cobblestone Drive, Suite 100

Rancho Cordova, CA 95670

(800) 853-5899 or (916) 231-3399

Fax: (916) 231-3398

studentinsurance.wellsfargo.com

THE UNDERWRITING COMPANY:

Anthem Blue Cross Life and Health Insurance Company

Anthem Blue Cross Life and Health Insurance Company and Anthem Blue Cross are Independent Licenses of the Blue Cross Association. Anthem Blue Cross is the trade name of Blue Cross of California. © ANTHEM is a registered trademark. The Blue Cross name and symbol are registered service marks of the Blue Cross Association.

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 175132 issued to MHS. The 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.

