Custom PPO Student Health Plan with Student Health Center (& Rx)

In addition to dollar and percentage copays, insured persons (students) 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.

Certain covered services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your deductible has been met.

Plan maximums and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of the policy.

Referral Requirements
A referral from Tang Center is required for all students. Except in specific instances (e.g. emergency care or urgent care), a referral is required from Tang Center prior to receiving treatment outside of the Tang Center.

A separate per visit/per service referral is required for each individual condition at the beginning of each semester prior to receiving care for ongoing conditions. Referrals for outpatient mental health counseling are required once per policy year. If a referral is not obtained prior to treatment, benefits are not payable. A referral is not required in the following circumstances:

- Treatment is for an emergency medical condition,
- Treatment is for an emergency mental health condition,
- Services in an urgent care setting,
- Obstetric and gynecological treatment
- Preventive/routine services (services considered preventive according to Health Care Reform and/or services rendered not to diagnose or treat an Accident or Sickness).

This plan includes care needed when the student health center is closed, care during break or vacation periods or care needed when student is more than 50 miles from campus.

Explanation of Maximum Allowed Amount
Maximum allowed amount is the total reimbursement payable under the plan for covered services received from participating and non-participating providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.

PPO Providers—The rate the provider has agreed to accept as reimbursement for covered services. Students and dependents are not responsible for the difference between the provider's usual charges & the maximum allowed amount.

Non-PPO Providers—For non-emergency care, reimbursement amount is based on an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. Students and dependents are responsible for the difference between the provider's usual charges & the maximum allowed amount.

For medical emergency care rendered by a non-participating provider or non-contracting hospital, reimbursement is based on the reasonable and customary value. Students, dependents and voluntary plan members may be responsible for any amount in excess of the reasonable and customary value.

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 copay.

Benefit year deductible All Providers	$300/student; $900/family
Copay for Non-PPO Inpatient hospital	$500/admission
Copay for emergency room services	$100/visit *(waived if admitted directly from ER)*
Annual Out-of-Pocket Maximums *(no cross application)*	
PPO Providers & Other Health Care Providers	$3,200/student; $6,400 family
Non-PPO Providers	$6,500/student; $13,000 family

The following do not apply to out-of-pocket maximums: percentage copays for non-covered expense. After an insured person reaches the out-of-pocket maximum, the insured person no longer pays copays, coinsurance or pharmacy copays for the remainder of the year. However, insured person remains responsible for non-PPO providers & other health care providers, costs in excess of the covered expense.

Benefit Year Maximum	**Unlimited**

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
Semi-private room, meals & special diets, & ancillary services	10%	40%[1]
Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	10%	40%[1]
Ambulatory Surgical Centers		
Outpatient surgery, services & supplies	10%	40%
Skilled Nursing Facility *(subject to utilization review)*		
Semi-private room, services & supplies *(limited to 100 days/benefit year; limit does not apply to mental health and substance abuse)*	10%	40%
Hospice Care		
Inpatient or outpatient services; family bereavement services	No copay[2]	No copay[2]
Home Health Care *(subject to utilization review)*		
Services & supplies from a home health agency *(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)*	10%	40%
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	10%	40%
Physician Medical Services		
Office & home visits	$15 copay[3] *(deductible waived)*	40%
Hospital & skilled nursing facility visits	10%	40%
Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	40%
Allergy testing & treatment	10%	40%
Lab and X-ray		
Diagnostic Lab	10%	40%
Diagnostic X-ray	10%	40%
Advanced Imaging (subject to Utilization Management)	10%	40%
Preventive Care Services		
Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision), immunizations, health education, intervention services and HIV testing **This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law*	No copay *(deductible waived)*	40%
Pediatric Preventive Services (up to age 19)		
Dental Deductible *(deductibles are combined; satisfying one helps satisfy the other)*	$60/student/$180 family	$60/student/$180 family
Pediatric Dental OOP Maximum	$1,000 Student/$2000 family;	No maximum Non-PPO
Vision Exam & 1 pair glasses	No co-payment/co-insurance	See separate allowances
Dental Diagnostic & preventive exam	No co-payment/co-insurance	No co-payment/co-insurance
Dental Basic Restorative Care	30%	30%
Dental Major Restorative Care	30%	30%
Orthodontic Care	30%	30%

[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 copay applies only to the visit itself. No additional copay applies for any services performed in office (i.e., X-ray, lab, surgery).

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
Physical Therapy, Physical Medicine & Occupational Therapy	$15 copay *(deductible waived)*	40%
Chiropractor Services	$15 copay *(deductible waived)*	40%
Speech Therapy		
Outpatient speech therapy following injury or organic disease	$15 copay *(deductible waived)*	40%
Acupuncture		
Services for the treatment of disease, illness or injury	$15 copay[1] *(deductible waived)*	40%[1]
Temporomandibular Joint Disorders		
Splint therapy & surgical treatment	10%	40%
Pregnancy & Maternity Care		
Physician office visits *(in-network preventive prenatal services are covered at 100%; first post natal visit is also covered at 100%)*	$15 copay[2] *(deductible waived)*	40%
Prescription drug for abortion *(mifepristone)*	10%	40%
Normal delivery, cesarean section, complications of pregnancy & abortion		
Inpatient physician services	10%	40%
Hospital & ancillary services	10%	40%[3]
Ultrasound due to pregnancy	No copay	40%
Gender Reassignment Surgery Benefits		
Hospital-based care *(subject to utilization review)*	10%	40%
Inpatient physician visits	10%	40%
Gender Reassignment travel benefits *(student's transportation to & from facility is limited to $10,000 per surgery)*	No copay *(deductible waived)*	Not covered
Bariatric Surgery *(Subject to utilization review; covered only when performed at a Blue Distinction Center for Specialty Care [BDCSC])*		
Necessary surgery for weight loss, only for morbid obesity	10%	Not covered
Travel expenses for an authorized, specified surgery *(recipient & companion transportation limited to $3,000 per surgery)*	No copay *(deductible waived)*	Not covered

[1] 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.

[2] The dollar copay applies only to the visit itself. No additional copay applies for any services performed in office (i.e., X-ray, lab and surgery).

[3] 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.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
Diabetes Education Programs *(requires physician supervision)*		
Teach insured persons & their families about the disease process, the daily management of diabetic therapy & self-management training	$15 copay *(deductible waived)*	40%
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	10%	40%
Durable Medical Equipment		
Rental or purchase of DME including hearing aids, dialysis equipment & supplies *(hearing aids benefit is available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	10%	40%
Related Outpatient Medical Services & Supplies		
Ground or air ambulance transportation, services & disposable supplies	10%[1]	10%[1]
Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%[1]	20%[1]
Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	20%[1]	20%[1]
Emergency Care		
Emergency room services & supplies *($100 copay waived if admitted; deductible waived)*	$100 copay	Covered as in-network
Physician services	10%	10%
Urgent Care		
Urgent Care *(physician services)*	$50 copay *(deductible waived)*	40%

[1] These providers are not represented in the PPO network.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
Organ & Tissue Transplants *(subject to utilization review; specified transplants covered only when performed at Centers of Medical Excellence [CME] and Blue Distinction Centers for Specialty Care [BDCSC] for California; Blue Distinction Centers for Specialty Care [BDCSC] for out of California)*		
Inpatient services provided in connection with non-investigative organ or tissue transplants	10%	Not covered
Physician office visits *(including specialists and consultants)*	$15/copay *(deductible waived)*	Not covered
Transplant travel expense for an authorized, specified transplant *(recipient & companion transportation limited to $10,000 per transplant)* *Unrelated donor search, limited to $30,000 per transplant	No copay *(deductible waived)*	Not covered
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
Facility-based care *(subject to utilization review; waived for emergency admission*	10%	40%[1]
Inpatient physician visits	10%	40%
Outpatient Care		
Facility-based care *(subject to utilization review; waived for emergency admission*	10%	40%[1]
Outpatient physician visits *(Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)*	$15 copay[2] *(deductible waived)*	40%
Psycho-educational Testing (deductible waived)	10%	40%
Outpatient Drugs and Medications *(not subject to deductible)*		
Retail		
Female oral contraceptives generic and single source brand	No copay	40%
Tier 1 drugs *(includes diabetic supplies)*	$5 copay	$5 copay + 40%
Tier 2 drugs	$25 copay	$25 copay + 40%
Tier 3 drugs	$40 copay	$40 copay + 40%
Supply Limits		
Retail Pharmacy *(participating and non-participating)*	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)	
Specialty Pharmacy	30-day supply	

[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] The dollar copay applies only to the visit itself. No additional copay applies for any services performed in office (i.e., X-ray, lab, surgery).

This Summary of Benefits is a brief review of benefits. Once enrolled, insured persons will receive a Certificate of Insurance, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

PPO Student Health Plan—Prudent Buyer Plan 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) 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.

Not Covered. 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 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 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.

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:

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

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

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.

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.

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.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the Certificate. Cosmetic dental surgery or other dental services for beautification.

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

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.

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.

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

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.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement.

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.

Sterilization Reversal.

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.

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).

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.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

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.

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.

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

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the Certificate. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

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 requirement either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

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.

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.

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.

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.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the Certificate.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Third Party Liability – Anthem Blue Cross Life and Health Insurance Company is entitled to reimbursement of benefits paid if the insured person recovers damages from a legally liable third party.

Excess Coverage – Anthem Blue Cross Life and Health Insurance Company will reduce the amount payable under this plan if expenses are covered under any other plan. We 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 coverage under this policy is secondary coverage to all other policies.

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