

Student Health Insurance California Maritime Academy Domestic & International

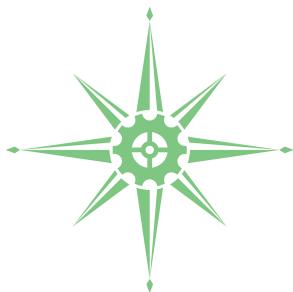
2012-2013



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



Underwritten by:
Anthem Blue Cross Life and Health Insurance Company
Policy #175125



HEALTH CARE REFORM NOTICE:

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

CSU STUDENT HEALTH PLAN

Due to the special nature of the educational experience at California Maritime Academy, which includes a training cruise, often involving international travel, students are required to be covered by health insurance. The promotion of good health for our students has always been our concern. This brochure summarizes how the Student Health Insurance Plan works, what it covers and how the plan will help you with medical needs and costs. After you've read about the Student Health Insurance Plan, keep these important facts in mind:

- ♦ To enroll in this insurance plan students must meet the eligibility requirements as listed below.
- ♦ Keep your insurance card with you at all times, and show it to the physician or hospital when you seek medical treatment.
- ♦ Learn about your Academy's Student Health & Wellness Center (SHWC), its location, hours of operation, and the types of services it offers. If possible, go first to your Academy's SHWC for treatment during their regular hours of operation. SHWC can help you locate medical providers when you need additional care or specialists.
- ♦ You may choose any provider you wish, but if you would like to use an Anthem Blue Cross Life and Health provider, you can locate them on the web at www.anthem.com/ca or call (800) 888-2108 (see page 3, PPO Prudent Buyer Network).
- ♦ Complete all forms accurately and respond promptly to requests for information from the claims department.

WHO IS ELIGIBLE TO ENROLL?

All matriculated students who are actively attending classes at the Academy and taking 6 or more credits are eligible and must be enrolled in the plan on a hard waiver basis, unless proof of comparable coverage (CMA Minimum Requirements to Waive) and an online waiver form is submitted by the deadline. Students are also required to have and maintain Travel Assistance Benefits. All students who complete an online waiver, will be automatically enrolled in the CMA Travel Assistance plan.

- ♦ Open University students who choose to enroll in this insurance plan must pay the Cal Maritime Student Health & Wellness Center's mandatory semester fees.
- ♦ All international students possessing and maintaining a current passport and valid visa (F-1, J-1, or M-1, etc.), engaged in educational activities at the Academy who are temporarily located outside their home country and have not been granted permanent residency status, are required to be insured under the Policy.
- ♦ Eligible dependents of students enrolled in the plan may participate in the plan on a Voluntary basis.
- ♦ Please note that course credits received from TV, internet video, satellite or any off-campus classes do not fulfill the eligibility requirement (exceptions are cruise courses when enrolled through Cal Maritime).

All students must actively attend classes for 45 days following the date of enrollment in this plan for the period for which coverage is purchased, except in the case of

medical withdrawal or during school authorized breaks. To be an Insured Person under the Plan, 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. **INSURED ARE COVERED ANYWHERE IN THE WORLD 24-HOURS A DAY. NO REFUNDS ARE ISSUED IF THE POLICY HAS BEEN UTILIZED PRIOR TO A WITHDRAWAL.**

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

DEPENDENT COVERAGE – Eligible Insured Students may also purchase Dependent coverage within 31 days of notification of students enrollment by CMA; or within 31 days of one of the following qualified events: marriage, addition of domestic partner, birth, adoption or arrival in the U.S. 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 natural child, stepchild or legally adopted child under 26 years of age. 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.**

CMA MINIMUM REQUIREMENTS TO WAIVE

In order to qualify for a waiver, your current medical insurance coverage must meet the requirements below:

- ♦ Minimum benefit of \$100,000 per year
- ♦ Mental Health Coverage of 12 days at 80% in-network/ 50% out-of-network
- ♦ Annual deductible is equal to or less than \$1,500 per year
- ♦ 80% in-network/ 50% out-of-network coverage for Hospitalization/ Professional fees
- ♦ World-wide coverage
- ♦ Policy includes benefits for all California mandated benefits
- ♦ The plan is not an HMO without providers in the campus community

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.

WHEN COVERAGE BEGINS (CONTINUED)

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.

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 the Company.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

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

1. The Insurer will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits the Insurer has paid under this plan for the treatment of the illness, disease, injury or condition for which the third party is liable.
2. You must advise the Insurer in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as the Insurer may require to facilitate enforcement of their rights. You must not take action which may prejudice the insurer's rights or interests under your plan. Failure to give the Insurer such notice or to cooperate with the Insurer, or actions that prejudice the Insurer's rights or interests will be a material breach of this plan and will result in your being personally responsible for reimbursing the Insurer.
3. The Insurer will be entitled to collect on their lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

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.

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.

DEFINITIONS

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

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

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

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

Deductible: is a part of the Maximum Allowed Amount you must pay for Covered Services before any benefits are available to you under this plan. Your Plan Year Deductible is stated on page 5.

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

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

Insured Person: is the student or dependent.

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

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

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

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

Non-Prudent Buyer Provider (Non-PPO): is a provider who does NOT have a Prudent Buyer Plan Participating Provider Agreement with Anthem Blue Cross Life and Health in effect at the time services are rendered.

Only a portion of the amount which a Non-Prudent Buyer Provider charges for services will be considered covered. The Insured will be responsible for any billed charges over the Maximum Allowed Amount.

Physician means:

1) A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice where the care is provided, or

2) One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, 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 facility which provides diagnostic imaging services

SCHEDULE OF BENEFITS

When medical care is needed, the insured student is strongly encouraged to use the Student Health & Wellness Center (SHWC).

The SHWC will diagnose and treat most illnesses, coordinate all the insured student's health care and provide a referral, when necessary, to a PPO or non-PPO provider (see Schedule of Benefits). The referral does not constitute a guarantee of payment; the services must be medically necessary and a covered benefit under this plan.

The coverage under this Plan is secondary coverage to all other policies. 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 Plan.

Insured dependents are not eligible to use the SHWC. The benefits listed in the Schedule of Benefits are available to the insured dependents.

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 Charges

Plan payments are based on the Maximum Allowed Amount:

PPO Providers — The rate the provider has agreed to accept as reimbursement for covered services. Insured Persons are not responsible for the difference between the provider's usual charges & the Maximum Allowed Amount.

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

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

School Plan year deductible for all providers	\$250/insured person; \$750/family
Deductible for non-PPO hospital, 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	\$100/visit (<i>waived if admitted directly from ER</i>)
Benefit Year Maximum Students & dependents	\$100,000/insured person/benefit year

Covered Services	PPO: Per Insured Person Co-pay	Non-PPO: Per Insured Person Co-pay ¹
Hospital Services (<i>preauthorization required for inpatient services; waived for emergency admissions</i>) Semi-private room, meals & special diets, & ancillary services Outpatient medical care, surgical services & supplies (hospital care other than emergency room care)	20% 20%	50% 50%
Ambulatory Surgical Centers, Outpatient surgery, services & supplies	20%	50%
Related Outpatient Medical Services & Supplies Ground or air ambulance transportation, services & disposable supplies Blood transfusions, blood processing & the cost of unreplaced blood & blood products Autologous blood (self-donated blood collection, testing, processing & storage for planned surgery)		20% ² 20% ² 20% ²
Emergency Care Emergency room services & supplies (\$100 deductible waived if admitted) Inpatient hospital services & supplies Physician Services	20% 20% 20%	20% 20% 20%
Physician Medical Services Office & home visits Hospital & skilled nursing facility visits Surgeon & surgical assistant; anesthesiologist or anesthesiologist* <small>*this benefit is payable at 90% when administered by a nurse anesthesiologist</small>	\$35/visit ³ (<i>deductible waived</i>) 20% 20%	50% 50% 50%
Diagnostic X-ray & Lab (<i>pre-authorization required for CT scans, MRA scans, MRI scans, MRS scans, NC scans & PET scans</i>)	20%	50%

SCHEDULE OF BENEFITS CONTINUED

Covered Services	PPO: Per Insured Person Co-pay	Non-PPO: Per Insured Person Co-pay ¹
Mental or Nervous Disorders Facility-based care (<i>preauthorization required; waived for emergency admissions; limited to 30 days/benefit year</i>) Inpatient or outpatient physician visits for psychotherapy & psychological testing (<i>limited to 12 visits</i>)	20% ⁴ 20% ⁴	50% ⁴ 50% ⁴
Substance Abuse Facility-based care (<i>preauthorization required; waived for emergency admissions; limited to 30 days/benefit year; the 30 days/benefit year limit does not apply to inpatient detoxification</i>) Inpatient or outpatient physician visits (<i>limited to 12 visits/benefit year</i>)	20% 20%	50% 50%
Outpatient Generic Drugs and Medications - <i>Please be aware that this prescription drug plan covers the cost of formulary generic prescription drugs only. You are responsible for the full cost of all other prescription drugs. See page 9 for Prescription Drug Benefit details.</i> Generic drugs and medication, including oral contraceptives & insulin, when dispensed by a physician or licensed pharmacist (<i>30 day supply</i>) Generic self-administered injectable prescription drugs	\$15 co-pay 30%	\$15 co-pay plus 50% 30% plus 50% of remaining covered expense
Preventive Care Services Routine physical exams, screenings, tests, education and immunizations, administered with the intent of preventing future disease, illness or injury	No charge (<i>deductible waived</i>)	50%
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services (<i>limited to 12 visits/benefit year; additional visits may be authorized</i>)	20%	50% (<i>limited to \$25/visit</i>)
Speech Therapy Outpatient speech therapy following injury or organic disease	20%	50%
Acupuncture Services for the treatment of disease, illness or injury (<i>limited to \$30/visit & 12 visits/benefit year</i>)	20% ⁵	50% ⁵
Temporomandibular Joint Disorders Splint therapy & surgical treatment	20%	50%
Pregnancy & Maternity Care Physician office visits Prescription drug for elective abortion (<i>mifepristone</i>) Normal delivery, cesarean section, complications of pregnancy & abortion Inpatient physician services Hospital & ancillary services	\$35/visit ³ (<i>deductible waived</i>) 20% 20% 20%	50% 50% 50% 50%
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 (<i>deductible waived</i>)	
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 (<i>deductible waived</i>)	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 members with diabetes	20%	50%
Durable Medical Equipment (DME) Rental or purchase of DME including hearing aids, dialysis equipment & supplies	20%	50%

Covered Services	PPO: Per Insured Person Co-pay	Non-PPO: Per Insured Person Co-pay ¹
Skilled Nursing Facility (preauthorization required) Semi-private room, services & supplies (medical conditions & severe mental disorders limited to 100 days/benefit year; care in a residential treatment center for treatment of substance abuse limited to 30 days/benefit year and is charged against Skilled Nursing Facility maximum)	20%	50%
Home Health Care (preauthorization required) 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)	20%	50%
Home Infusion Therapy (preauthorization required) Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	50% (limited to \$600/day)

¹ The percentage co-pay for non-emergency services from non-PPO providers is based on the lesser of billed charges or Customary and Reasonable amount.

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 & LIMITATIONS

Unless specifically provided for elsewhere under the Plan, the Plan does not cover loss caused by or resulting from, nor is any premium charged for the following:

- Not Medically Necessary.** Services or supplies that are not medically necessary, as defined.
- Experimental or Investigative.** Any experimental or investigative procedure or medication. But, if you are denied benefits because it is determined that the requested treatment is experimental or investigative, you may request an independent medical review.
- Crime or Nuclear Energy.** Conditions that result from: (1) your commission of or attempt to commit a felony as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.
- Uninsured.** Services received before your effective date or after your coverage ends, except as specifically stated under CONTINUATION OF BENEFITS AFTER TERMINATION.
- Excess Amounts.** Any amounts in excess of the maximum allowed amount 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, even if you do not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits will be provided subject to the right of recovery and reimbursement under California Labor Code Section 4903, and as described in REIMBURSEMENT FOR ACTS OF THIRD PARTIES.
- 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 who lives in your home or who is related to you by blood or marriage.
- Voluntary Payment.** Services for which you are not legally obligated to pay. Services for which you are not charged. Services for which no charge is made in the absence of insurance coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

- It must be internationally known as being devoted mainly to medresearch;
- 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.

- Not Specifically Listed.** Services not specifically listed in this 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 the 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. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specifically stated.
- Nicotine Use.** Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs.
- Orthodontia.** Braces and other orthodontic appliances or services.
- Dental Services or Supplies.** For dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:

- ◆ Extraction, restoration, and replacement of teeth;
- ◆ Services to improve dental clinical outcomes.

This exclusion does not apply to the following:

- ◆ Services which we are required by law to cover;
- ◆ Services specified as covered in this booklet;

EXCLUSIONS & LIMITATIONS (CONTINUED)

- ♦ Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.
- 17. **Hearing Aids or Tests.** Hearing aids, except as specifically stated.
- 18. **Optometric Services or Supplies.** Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except as specifically stated. Eyeglasses or contact lenses, except as specifically stated.
- 19. **Outpatient Occupational Therapy.** Outpatient occupational therapy, except by a home health agency, hospice or home infusion therapy provider as specifically stated.
- 20. **Outpatient Speech Therapy.** Outpatient speech therapy except as stated.
- 21. **Cosmetic Surgery.** Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.
- 22. **Scalp hair prostheses.** Including wigs or any form of hair replacement.
- 23. **Commercial Weight Loss Programs.** Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is not covered.
- 24. **Sex Transformation.** Procedures or treatments to change characteristics of the body to those of the opposite sex.
- 25. **Reversal of sterilization.**
- 26. **Infertility Treatment.** Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.
- 27. **Orthopedic Supplies.** Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated.
- 28. **Air Conditioners.** Air purifiers, air conditioners, or humidifiers.
- 29. **Custodial Care or Rest Cures.** Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Custodial care or rest cures, except as specifically stated. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility, except as specifically stated.
- 30. **Chronic Pain.** Treatment of chronic pain, except as specifically stated.
- 31. **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.
- 32. **Personal Items.** Any supplies for comfort, hygiene or beautification.
- 33. **Education or Counseling.** Educational services, or nutritional counseling, or any services that are educational, vocational, except as specifically stated.
- 34. **Telephone and Facsimile Machine Consultations.** Consultations provided by telephone or facsimile machine.
- 35. **Routine Exams or Tests.** Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated.
- 36. **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.
- 37. **Physical Therapy or Physical Medicine.** Services of a physician for physical therapy or physical medicine, except as stated.
- 38. **Outpatient Prescription Drugs and Medications.** Outpatient prescription drugs or medications and insulin, except as specifically stated. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.
- 39. **Contraceptive Devices.** Contraceptive devices prescribed for birth control except as specifically stated.
- 40. **Private Duty Nursing.** *Private duty nursing services.*
- 41. **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 the insurer.
- 42. **Clinical Trials.** Services and supplies in connection with clinical trials, except as specifically stated.
- 43. **Injury sustained by reason of a motor vehicle accident** to the extent that benefits are paid or payable by any other valid and collectible insurance, except for automobile medical payments insurance.
- 44. **Services provided normally without charge** by the Recognized Student Health Center or services covered or provided by the student health fee, except as specifically provide in this Certificate.
- 45. **Organ or tissue transplant,** except as specifically stated.
- 46. **Diagnosis and treatment of acne and sebaceous cyst.**
- 47. **Loss due to war,** declared or undeclared; service in the armed forces of any country or international authority; riot; civil commotion; or acts of terrorism.
- 48. **Riding in any aircraft,** except as a passenger on a regularly scheduled airline or charter flight.
- 49. **Loss** arising from participation in interscholastic, intercollegiate, club and professional sports, scuba diving, hang gliding, parachuting or bungee jumping, except as specifically provided.
- 50. **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).
- 51. **Non-Licensed Providers.** Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed physician, except as specifically provided or arranged by the insurer.
- 52. **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.
- 53. **Varicose Vein Treatment.** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

PRESCRIPTION DRUG BENEFITS Generic Only Rx

Note: This plan covers generic prescription drugs only. Insured persons are responsible for the full cost of all other prescription drugs.

To get a generic prescription filled, you need only take your prescription to a participating pharmacy and present your ID card.

A generic drug contains the same effective ingredients, meets the same standards of purity as its brand-name counterpart and typically costs less. Please be aware that this prescription drug plan covers the cost of formulary generic prescription drugs only. You are responsible for the full cost of all other prescription drugs.

The formulary is a list of approximately 700 recommended generic medications. These medications have undergone extensive review for therapeutic value for a particular medical condition, safety and cost. Copies of the Anthem Blue Cross Life and Health formulary 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 (or TTY/TDD [800]-905-9821). Your co-pay amount for a generic drug at a participating pharmacy is \$15.00.

Finding and Using a Participating Pharmacy

You can find a participating pharmacy by calling Customer Service at (800) 700-2541 (or TTY/TDD [800] 905-9821) or 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 participating pharmacies. Provided you have identified yourself as an insured person, a participating pharmacy will only charge your co-payment.

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.

Non-Participating Pharmacies are reimbursed according to the prescription drug covered expense determined by the pharmacy benefits manager. You are responsible for paying any difference.

You may obtain a prescription drug claim form by calling the Customer Service toll-free at (800) 700-2541 (or TTY/TDD [800]-905-9821) 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 TTY/TDD [800]-905-9821), 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 generic prescription drugs and medications which the law restricts to sale by prescription. Formulas prescribed by a physician for the treatment of phenylketonuria.
- ♦ Inhalers spacers and peak flow meters for the treatment of pediatric asthma.
- ♦ Prescription drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
- ♦ Insulin. Syringes when dispensed for use with insulin and other self-injectable drugs or medications.

- ♦ Generic prescription oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms 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.
- ♦ All compound prescription drugs that contain at least one covered prescription ingredient.
- ♦ Diabetic supplies (i.e., test strips and lancets).

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
Pharmacy- Generic drugs Mail Service- Generic drugs Generic self-administered injectable drugs, except insulin	\$15 \$30 30% of prescription drug covered expense
Non-participating Pharmacies	Insured person pays the co-pay above plus 50% of the remaining prescription drug covered expense & costs in excess of the maximum amount allowed
Supply Limits: Retail Pharmacy Mail Service	30-day supply 90-day supply

*Supply limits for certain drugs may be different. Limits apply to participating & non-participating pharmacies. Please refer to the Certificate of Insurance for complete information.

Additional Features That are Part of your Plan

Prior authorization of benefit coverage, as the term implies, is similar to prior authorization for medical services. Prior authorization of benefit applies to a select pool of medications that are often a second line of therapy. To require prior authorization, a drug must meet specific criteria. This criteria is based, among other things, on FDA approved drug indications, targeted populations and the current availability of effective drug therapies. Prior authorization of benefit drugs are not covered unless you receive an approval from Anthem Blue Cross Life and Health.

Anthem Blue Cross Life and Health distributes instructions on how to obtain prior authorization of benefit to physicians and pharmacies so that you may obtain prior authorization of benefit for required medications. You may call Anthem Blue Cross Life and Health Pharmacy Customer Service, toll-free at (800) 700-2541 (or TTY/TDD [800]-905-9821), to receive a prior authorization of benefit form and/or list of medications requiring prior authorization of benefit coverage.

PRESCRIPTION DRUG BENEFIT EXCLUSIONS & LIMITATIONS Generic Only Rx

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, but not limited to, outpatient hospital facilities and physicians' offices.
5. Professional charges in connection with administering, injecting or dispensing of drugs.
6. Drugs & medications that may be obtained without a physician's written prescription, except insulin or niacin for cholesterol lowering.

PRESCRIPTION Rx DRUG BENEFITS EXCLUSIONS & LIMITATIONS Generic Only Rx (Continued)

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. Any drugs or medications prescribed for experimental indications.
13. Any expense incurred for a drug or medication in excess of (a) the drug limited fee schedule for drugs dispensed by non-participating pharmacies; or (b) the prescription drug negotiated rate for drugs dispensed by participating pharmacies or through the mail service program.
14. Drugs which have not been approved for general use by the Food and Drug Administration. This does not apply to drugs that are medically necessary for a covered condition.
15. Over-the-counter smoking cessation drugs. This does not apply to medically necessary drugs that the insured person can only get with a prescription under state and federal law.
16. Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of drug for medically necessary treatment of a medical condition other than one that is cosmetic.
17. Drugs used primarily for the purpose of treating infertility, unless medically necessary for another covered condition.
18. Anorexiant and drugs used for weight loss.
19. Drugs obtained outside the United States unless they are furnished in connection with urgent care or an emergency.
20. Allergy desensitization products or allergy serum.
21. Infusion drugs, except drugs that are self-administered subcutaneously.
22. Herbal supplements, nutritional and dietary supplements. However, formulas prescribed by a physician for the treatment of phenylketonuria that are obtained from a pharmacy are covered as specified as covered in the Certificate.
23. Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was ineffective.

COMPLAINT NOTICE

Should you have any complaints or questions regarding your coverage, you should first contact Wells Fargo Insurance Services, 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**

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: **CSU** 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.

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 Company for further details on these benefits.

GUIDELINES FOR CANCER SCREENING TESTS

Anthem Blue Cross Life and Health Insurance Company 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.

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

ONLINE HEALTH CARE ADVISOR

Subimo™ is an innovative and interactive website 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 website through "Member Services" located on the home page at www.anthem.com/ca and logging in to the Secure Member Services site. First time users will need to register.

24-HOUR NURSE ADVICE LINE

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

HERE'S HOW EASY IT IS:

1. The insured student or insured dependent calls the 24-Hour 24/7 NurseLine.
2. A registered nurse asks questions and assesses the caller's condition.
3. If you speak a language other than English or Spanish, the registered nurse can utilize an interpreter, that will work with the nurse and the member.
4. The nurse provides information regarding care options to help the caller develop a proactive plan which could include: proceed to an urgent care or emergency facility, follow-up with your primary care provider, or develop a home care plan.
5. The nurse can provide information about your PPO network providers in the geographic area closest to your school.

One toll-free phone call is all it takes to access a wealth of useful health care information at **(800) 977-0027**.

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 30% off weight loss programs
- ♦ 5% off non-prescription items at drugstore.com and up to 15% off allergen avoidance products at natlallergy.com
- ♦ Up to 30% off 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! Discount 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.

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.

CONTINUOUS COVERAGE

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

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 Insurance Company agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The insured person and Anthem Blue Cross Life and Health Insurance Company agree to give up the right to participate in class arbitration against each other.

The arbitration findings will be final and binding except to the extent that California or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the insured person making written demand on Anthem Blue Cross Life and Health Insurance Company. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the insured person and Anthem Blue Cross Life and Health Insurance Company, or by order of the court, if the insured person and Anthem Blue Cross Life and Health Insurance Company cannot agree. The arbitration shall be held in the State of California.

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 # you can still seek medical treatment and submit a claim form for reimbursement.

HOW DO I FILE A CLAIM?

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

But sometimes a physician or an ambulance company may not bill Anthem Blue Cross Life and Health and may send the bill directly to you. **Also, your Student Health & Wellness Center and pharmacies will not bill Anthem Blue Cross Life and Health.** In these instances, Anthem Blue Cross Life and Health has no way of knowing about your claim. So, you must mail the bills or paid receipts to Anthem Blue Cross Life and Health within 90 days of treatment and include a claim form. Claim forms are available at www.csuhealthlink.com. 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
Attention: Student Health Customer Service Manager
21555 Oxnard Street; AC4G Woodland Hills, CA 91367**

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

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. The pre-existing condition exclusion does not apply to pregnancy nor to an insured person who is under age 19.

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, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. 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.

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	\$ 10,000
Covered Spouse	\$ 5,000
Covered Child	\$ 1,000

The principal sum is the largest amount payable under this benefit for all losses resulting from any one accident. This benefit is payable in addition to any other benefits payable under the Policy.

OES - ONLINE ENROLLEE SERVICES

Setting up your OES Account:

1. Go to www.csuhealthlink.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



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.

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

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.

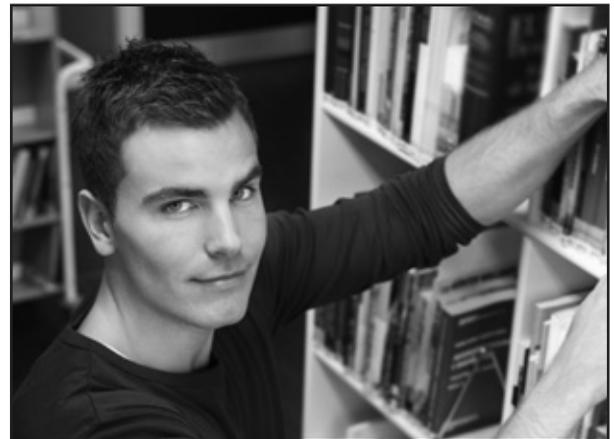
Copies and changes

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.



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



NOTES

WELLS FARGO INSURANCE SERVICES USA, 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 www.csuhealthlink.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/cam

PRESCRIPTIONS:

Prescription Drug Program

(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:

General Questions

Wells Fargo Insurance Services USA, Inc. Student Insurance Division

CA License No. 0D08408
10940 White Rock Road, 1st Floor
Rancho Cordova, CA 95670
(800) 853-5899
Fax: (877) 612-7966
studentinsurance.wellsfargo.com
www.csuhealthlink.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 175125 issued to CSURMA. 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.

