2022-2023

San Diego State University - Graduate Plan

Student Health Insurance Plan

www.anthem.com/studentadvantageca

Anthem Student Advantage

Keeping you at your personal best

A00325CAMENABC 07/22

Anthem | STUDENT ADVANTAGE

Important notice

This is a brief description of your student health plan underwritten by Anthem Blue Cross. If you would like more details about your coverage and costs, you can find the complete terms in the policy or plan document online at www.anthem.com/ca.

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Welcome to Anthem Student Advantage

As your new school year begins, it's important to understand your health care benefits and how they work. Your Anthem Student Advantage plan will help guide you through that process with information about who is eligible, what is covered, how much it costs, and the best ways to access care.

What you need to know about Anthem Student Advantage

Who is eligible for the Plan?

All SDSU students enrolled in graduate or post-baccalaureate programs at SDSU and SDSU Imperial Valley, excluding those covered by the existing SDSU International Student requirement, are automatically enrolled in this insurance plan, unless a wavier on the basis of other current health insurance coverage is submitted.

Students must actively attend classes on campus for the first 31 consecutive days after the effective date, except for university-authorized breaks.

Remote courses such as home study, correspondence and online courses do not fulfill this requirement.

A once-per-lifetime medical withdrawal exception may be granted to students on school approved medical leave during the first 31 days of coverage.

All refund requests must be sent to the University who will confirm non-student status with JCB, and submit the refund request on behalf of the student. Only refunds submitted by the University before the refund deadline will be considered. Credit card refunds must be requested and processed within 120 days of the date of purchase and before the refund deadline. No refunds will be considered after the refund deadline. All refunds will be processed back to the original form of payment only, no exceptions. All refunds will be assessed a $35 processing fee. Please allow 30 business days for us to receive and process the refund request, then an additional 3-5 business days to receive your refund from your financial institution. Pro-rated/partial refunds are not allowed. NOTE: You can check to see if your refund has been processed by logging in to your JCB account.

Coverage for dependents (spouse/children) is not available under this plan.

Coverage periods

Coverage will become effective at 12:01 a.m., and will end at 11:59 p.m. on the dates shown below.

Dates of coverage (San Diego State Graduate Plan)

Session
Fall 8/15/2022 - 1/15/2023
Spring/Summer 1/16/2023 - 8/14/2023

*Coverage for dependents (spouse/children) is not available under this plan.
*The above rates include premiums for the plan and commissions and administrative fees.
*Rates are pending approval with the state and subject to change.

Keep in touch with your benefits information

Eligibility and Enrollment questions

https://jcbins.com/
1-619-415-0233

Student Health Center

San Diego State University
Student Health Services
Calpulli Center, 5700 Hardy Avenue, San Diego, CA 92115
1-619-594-4325
https://sa.sdsu.edu/student-health-services

Claims and coverage

1-800-888-2108
Anthem Blue Cross Life and Health Insurance Company
P.O. Box 60007
Los Angeles, CA 90060-0007

Easy access to care

Access the care you need, when you need it, and in the way that works best for you.

Sydney Health app

With the Sydney Health[1] app through Anthem Student Advantage, you have instant access to:

- Your member ID card.
- The Find Care tool.
- More information about your plan benefits.
- Health tips that are tailored to you.
- LiveHealth Online and 24/7 NurseLine.
- Student support specialists (through click-to-chat or by phone).

Access the Sydney Health app
Go to the App Store℠ or Google Play™ and search for the Sydney Health app to download it today.

Anthem Student Advantage SDSU website

Use www.anthem.com/studentadvantageca to see your health plan information, including providers, benefits, claims, covered drugs and more.

ID Cards

To download your ID card, please access the Sydney app. You can also log onto anthem.com/ca to register and view your ID card.

24/7 NurseLine

Call **1-844-545-1429** to speak to a registered nurse who can help you with health issues like fever, allergy relief, cold and flu symptoms and where to go for care. Nurses can also help you enroll in health management programs if you have specific health conditions, and remind you about scheduling important screenings and exams, and more.

Provider finder

Use www.anthem.com/find-doctor/ to find the right doctor or facility close to where you are.

LiveHealth Online

From your mobile device or computer with a webcam, you can use LiveHealth Online to visit with a board-certified doctor, psychiatrist or licensed therapist through live video.[2] To use, go to your Sydney Health app or www.livehealthonline.com. You can also download the free LiveHealth Online app to sign up.

1 Sydney Health is a service mark of CareMarket, Inc.
2 Appointments subject to availability of a therapist. Psychologists or therapists using LiveHealth Online cannot prescribe medications. Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 1-800-784-2433 (National Suicide Prevention Lifeline) or 911 and ask for help. If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.
LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

Your summary of benefits

Anthem Blue Cross

Student health insurance plan:
San Diego State University
(Graduate Plan)

Your network:
Prudent Buyer PPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail. Plan benefits are pending approval with the state and subject to change.

Medical

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible		
See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.	$500 student	Not applicable
Out-of-Pocket Limit		
When you meet your out-of-pocket limit, you will no longer have to pay cost- shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.	$8,700 student	Not applicable
Preventive care/screening/immunization		
In-network preventive care is not subject to deductible, if your plan has a deductible.	No charge	Not covered
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	$20 copay per visit deductible does not apply	Not covered
Specialist care visit	$20 copay per visit deductible does not apply	Not covered
Prenatal Care and Post-natal Care	No charge	Not covered
Other practitioner visits:		
Retail Health Clinic Visit	$20 copay per visit deductible does not apply	Not covered
On-line Visit *Live Health Online is the preferred telehealth solutions (www.livehealthonline.com)*	$20 copay per visit deductible does not apply	Not covered
Chiropractic/Manipulation Therapy *Coverage is unlimited. Applies to In-Network. Visit limits are combined across both outpatient and other professional visits.*	$20 copay per visit deductible does not apply	Not covered
Acupuncture	$20 copay per visit deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other services in an Office:		
Allergy Testing	$20 copay per visit after deductible is met	Not covered
Chemo/Radiation Therapy	10% coinsurance after deductible is met	Not covered
Hemodialysis	10% coinsurance after deductible is met	Not covered
Drugs Administered in the Office *For the drugs itself dispensed in the office through infusion/injection.*	10% coinsurance after deductible is met	Not covered
Diagnostic Services		
Lab:		
Office	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
X-Ray:		
Office	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Emergency and Urgent Care		
Urgent Care	$20 copay per visit deductible does not apply	Not covered
Emergency Room Facility Services *Copay waived if admitted.*	$150 copay per visit plus 10% coinsurance, deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	10% coinsurance after deductible is met	Covered as In-Network
Emergency Ambulance Transportation	10% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit and Online Visit	$20 copay per visit deductible does not apply	Not covered
Facility visit:		
Facility fees	10% coinsurance after deductible is met	Not covered
Doctor Services	10% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility fees:		
Hospital	$150 copay per visit plus 10% coinsurance after deductible is met	Not covered
Freestanding Surgical Center	$150 copay per visit plus 10% coinsurance after deductible is met	Not covered
Doctor and Other Services		
Hospital	10% coinsurance after deductible is met	Not covered
Freestanding Surgical Center	10% coinsurance after deductible is met	Not covered
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 100 days combined per benefit period.*	$150 copay per visit plus 10% coinsurance after deductible is met	Not covered
Doctor and other services	10% coinsurance after deductible is met	Not covered
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per year combined with home health services.*	10% coinsurance after deductible is met	Not covered
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Habilitation services (for example, physical/speech/occupational therapy):		
Office	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Cardiac rehabilitation		
Office	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Skilled Nursing Care (in a facility) *Coverage is limited to 100 days combined per benefit period.*	$250 copay per visit; then no additional charge	Not covered
Hospice	10% coinsurance after deductible is met	Not covered
Durable Medical Equipment	10% coinsurance after deductible is met	Not covered

Pharmacy

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	None	Not applicable
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Not covered
Prescription Drug Coverage *This Plan uses a Traditional Drug List. Drugs not on this list are not covered.* *This product has a 90-day Retail Pharmacy Network available. A 90-day supply is available at most retail pharmacies.*		
Tier 1 - Typically Generic *CCovers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$20 copay per prescription (retail); $40 copay per prescription (home delivery)	Not covered
Tier 2 - Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$30 copay per prescription (retail); $60 copay per prescription (home delivery)	Not covered
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$50 copay per prescription (retail); $100 copay per prescription (home delivery)	Not covered

Adult Vision

Blue View Vision plan benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Routine Eye Exam		
A comprehensive eye examination once every plan year	$10 copay	Up to $42 reimbursement
Eyeglass Frames		
One pair of eyeglass frames once every two plan years	$130 allowance, then 20% off any balance	Up to $45 reimbursement
Eyeglass Lenses *(instead of contact lenses)*		
One pair of standard plastic prescription lenses:		
Single vision lenses once every plan year	$10 copay	Up to $40 reimbursement
Bifocal lenses once every plan year	$10 copay	Up to $60 reimbursement
Trifocal lenses once every plan year	$10 copay	Up to $80 reimbursement
Eyeglass Lens Enhancements[1]		
Transitions Lenses (for a child under age 19) same as covered eyeglass lenses	$0 copay	No allowance when obtained out-of-network
Standard polycarbonate (for a child under age 19) same as covered eyeglass lenses	$0 copay	No allowance when obtained out-of-network
Factory scratch coating same as covered eyeglass lenses	$0 copay	No allowance when obtained out-of-network
Contact Lenses[2] *(instead of eyeglass lenses)*		
Elective conventional (non-disposable); OR once every plan year	$130 allowance, then 15% off any balance	Up to $105 reimbursement
Elective disposable; OR once every plan year	$130 allowance *(no additional discount)*	Up to $105 reimbursement
Non-elective (medically necessary) Once every plan year	Covered in full	Up to $210 reimbursement

1 When obtaining covered eyewear from a Blue View Vision provider, members may choose to add any of the listed lens enhancements at no extra cost.
2 Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.

Additional savings available from in-network providers

Description	Member cost
When obtaining covered eyewear from a Blue View Vision provider, members may choose to upgrade their new eyeglass lenses at a discounted cost. Costs shown are after any applicable eyeglass lens copayment.	
Progressive Lenses	
Standard	$55
Premium Tier 1	$85
Premium Tier 2	$95
Premium Tier 3	$110
Premium Tier 4	$175
Anti-Reflective Coating	
Standard	$45
Premium Tier 1	$57
Premium Tier 2	$68
Premium Tier 3	$85
Transitions lenses (Adults)	$75
Standard Polycarbonate lenses (Adults)	$40
UV Coating	$15
Tint (Solid and Gradient)	$15
Other lens upgrades and add-ons	20% off retail price
Retinal Imaging (obtained at same time as covered eye exam)	Up to $39
Standard contact lens fitting and follow-up after comprehensive eye exam	Up to $55
Premium contact lens fitting and follow-up after comprehensive eye exam	10% off retail price
Additional supplies of conventional contact lenses after benefits have been used	15% off retail price
Additional complete pairs of eyeglasses	40% off retail price
Eyeglass materials purchased separately	20% off retail price
Other items including most non-prescription sunglasses, eyewear accessories such as lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price

Other discount offers on LASIK surgery and much more are available through our SpecialOffers program.

Adult Dental

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Annual Benefit Maximum Plan Year		
Per insured person	$1,000	$1,000
Annual Deductible Plan Year		
Per insured person/Family maximum	$50 Individual	$50 Individual
Deductible Waived for Diagnostic/Preventive Services	Yes	Yes
Diagnostic and Preventive Services		
Periodic oral exam 2 per 12 months	0% Coinsurance	0% Coinsurance
Teeth cleaning (prophylaxis) 2 per 12 months; w/periodontal maintenance	0% Coinsurance	0% Coinsurance
Bitewing X-rays: 1 set per 12 months	0% Coinsurance	0% Coinsurance
Full-mouth or Panoramic X-rays: 1 per 60 months	0% Coinsurance	0% Coinsurance
Fluoride application: 1 per 12 months through age 18	0% Coinsurance	0% Coinsurance
Sealants 1 per 60 months; through age 18	0% Coinsurance	0% Coinsurance
Basic Services		
Consultation (second opinion) 1 per 12 months	20% Coinsurance	20% Coinsurance
Amalgam (silver-colored) Filling 1 per tooth per 24 months	20% Coinsurance	20% Coinsurance
Composite (tooth-colored) Filling posterior (back) fillings covered as composites 1 per tooth per 24 months	20% Coinsurance	20% Coinsurance
Brush Biopsy (cancer test) Covered, 1 per 12 months; all ages	20% Coinsurance	20% Coinsurance
Space Maintainers 1 per lifetime through age 18; posterior teeth	20% Coinsurance	20% Coinsurance
Endodontics (Non-Surgical)		
Root Canal and retreatments 1 per tooth per lifetime	Not Covered	Not Covered
Endodontics (Surgical)		
Apicoectomy and apexification 1 per tooth per lifetime	Not Covered	Not Covered
Periodontics (Non-Surgical)		
Periodontal Maintenance 2 per 12 months; w/teeth cleaning	20% Coinsurance	20% Coinsurance
Scaling and root planing 1 per quadrant per 24 months	20% Coinsurance	20% Coinsurance

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Periodontics (Surgical)		
Periodontal Surgery (osseous, gingivectomy, graft procedures) 1 per quadrant per 36 months	50% Coinsurance	50% Coinsurance
Oral Surgery (Simple)		
Simple Extractions 1 per tooth per lifetime	50% Coinsurance	50% Coinsurance
Oral Surgery (Complex)		
Surgical Extractions 1 per tooth per lifetime	50% Coinsurance	50% Coinsurance
Major (Restorative) Services		
Crowns, onlays, veneers 1 per tooth per 84 months	Not Covered	Not Covered
Prosthodontics		
Dentures and bridges 1 per tooth per 84 months	50% Coinsurance	50% Coinsurance
Dental Implants Covered, 1 per tooth per 84 month	50% Coinsurance	50% Coinsurance
Prosthodontic Repairs/Adjustments		
Crown, denture, bridge repairs 1 per 12 months; 6 months after placement	Not Covered	Not Covered
Denture and bridge adjustments: 2 per 12 months; 6 months after placement	Not Covered	Not Covered
Orthodontic Services		
None	Not Covered	Not Covered

Additional Limitations & Exclusions. Below is a partial listing of non-covered services under your dental plan. Please see your policy for a full list.

Services provided before or after the term of this coverage - Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate
Orthodontics (unless included as part of your dental plan benefits) including orthodontic braces, appliances and all related services
Cosmetic dentistry (unless included as part of your dental plan benefits) provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist
Drugs and medications including intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care
Analgesia, analgesic agents, and anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.
Waiting periods for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan.
There is a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

Pediatric Vision *Limited to covered persons under the age of 19*.

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for student's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's vision services count towards your out of pocket limit.		
Pediatric Vision Essential Health Benefits (up to age 19)		
Pediatric Vision Deductible	$0	$0
Routine Eye Exam *A comprehensive eye examination once per benefit period.*	$0 Copay	$0 Copay up to Maximum Allowed Amount
Eyeglass Frames *One pair of eyeglass frames per benefit period.*	$0 copay, formulary	$0 Copay up to Maximum Allowed Amount
Eyeglass Lenses (instead of contact lenses) *One pair of standard glass or plastic prescription lenses per benefit period.*		
Single vision lenses *Bifocal lenses* *Trifocal lenses* *Lenticular lenses* *Progressive lenses (standard, premium, select, ultra)*	$0 copay $0 copay $0 copay $0 copay $0 copay	$0 Copay up to Maximum Allowed Amount
Eyeglass Lens Enhancements (instead of contact lenses) *When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost*		
Transitions lenses (for a child under age 19) *Standard polycarbonate (for a child under age 19)* *Factory Scratch Coating*	$0 copay $0 copay $0 copay	$0 Copay up to Maximum Allowed Amount
Contact Lenses (one year supply of contacts instead of eyeglass lenses) *Contact lens allowance will only be applies toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.*		
Elective conventional (non-disposable) *OR* *Elective disposable* *OR* *Non-elective (medically necessary)*	$0 copay, formulary $0 copay, formulary $0 copay	$0 Copay up to Maximum Allowed Amount
Adult Vision (age 19 and older)		
Adult Vision Coverage *Limited to certain vision screenings required by Federal law and covered under the "Preventive Care" benefit.*	See "Preventive Care" benefit	See "Preventive Care" benefit

Pediatric Dental *Limited to covered persons under the age of 19*.

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's dental services count towards your out of pocket limit.		
Children's Dental Essential Health Benefits (up to age 19)		
Diagnostic and preventive *Includes cleanings, exams, x-rays, sealants, fluoride.*	No charge	No charge
Basic services *Includes filing and simple extractions*	20% coinsurance	20% coinsurance
Major services/Prosthodontic	50% coinsurance	50% coinsurance
Endodontic, Periodontics, Oral Surgery	50% coinsurance	50% coinsurance
Medically Necessary Orthodontia	50% coinsurance	50% coinsurance
Deductible	Not applicable	Not applicable
Adult Dental	Not covered	Not covered

Benefits that go with you

You can count on medical coverage anywhere worldwide with GeoBlue.[1] Easily access international doctors by phone or video and use our 24/7 help center for emergency health questions. Anthem Student Advantage and GeoBlue provides the right support and services when you need them the most.

Visit https://www.geobluestudents.com to learn more.

GeoBlue benefits for the 2022-2023 school year

Use of benefits must be coordinated and approved by GeoBlue.

International telemedicine services[2]	
Global TeleMD™	Confidential access to international doctors by telephone or video call.
Coverage outside the U.S., excluding student's home country.	
Medical Expenses	Maximum benefit up to $250,000 per coverage year, no deductibles or copays. Consult coverage certificate for benefit limitations and exclusions.[3]
Coverage worldwide except within 100 miles of primary residence for U.S. students. Coverage worldwide, excluding home country for international students.	
Emergency medical evacuation	Unlimited
Repatriation of remains	Unlimited
Emergency family travel arrangements	Maximum benefit up to $5,000 per coverage year
Political emergency and natural disaster evacuation (Available only when traveling outside the United States)[4]	Covered 100% up to $100,000 per person. Subject to a combined $5,000,000 limit per any one covered event for all people covered under the plan.
Accidental death and dismemberment	Maximum benefit up to $10,000 per coverage year

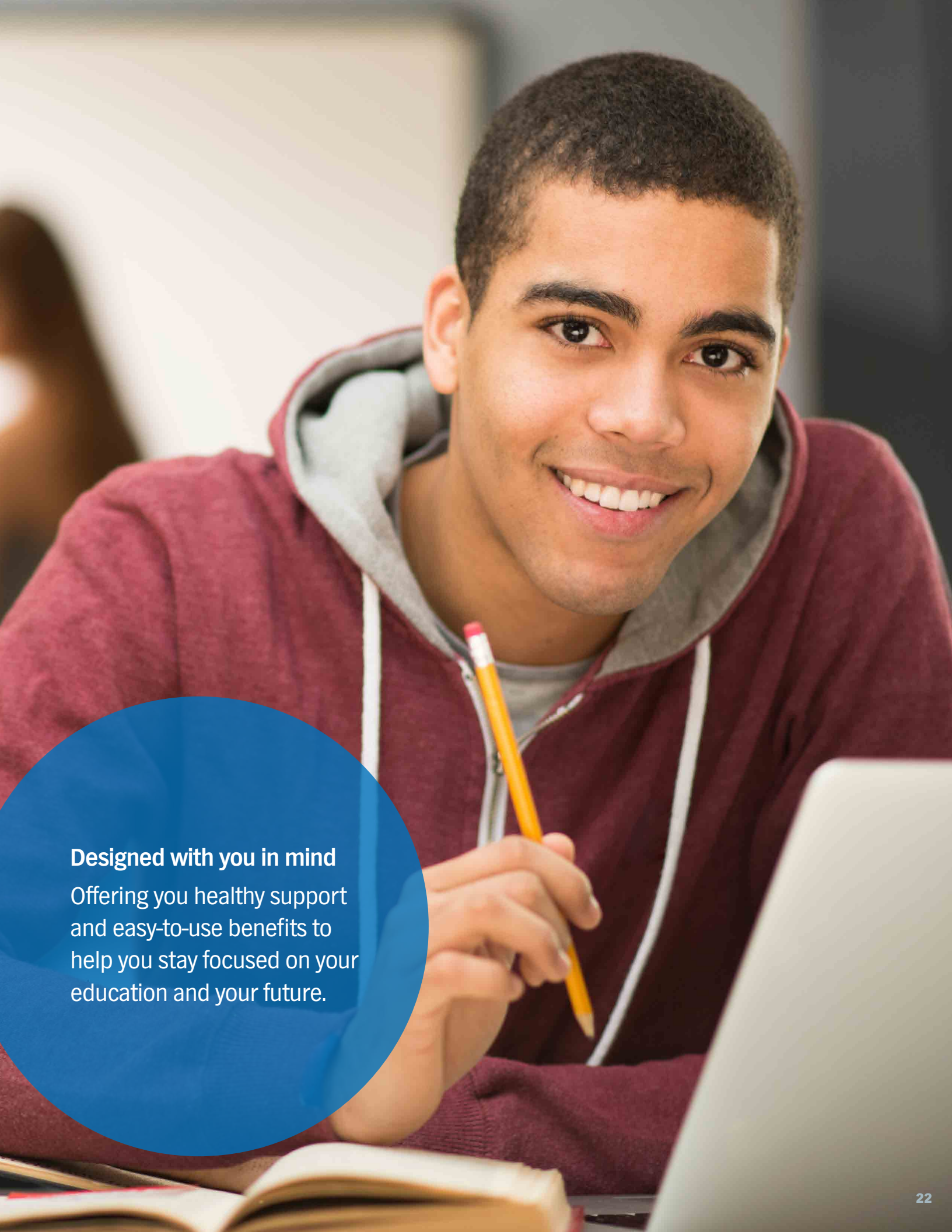
GeoBlue

1 GeoBlue is the trade name of Worldwide Insurance Services, LLC (Worldwide Services Insurance Agency, LLC in California and New York), an independent licensee of the Blue Cross and Blue Shield Association. GeoBlue is the administrator of coverage provided under insurance policies issued by 4 Ever Life International Limited, Bermuda, an independent licensee of the Blue Cross Blue Shield Association. Coverage is not available in all states. Some restrictions apply.

2 Telemedicine services are provided by Teladoc Health, directly to members. GeoBlue assumes no liability and accepts no responsibility for information provided by Teladoc Health and the performance of the services by Teladoc Health. Support and information provided through this service does not confirm that any related treatment or additional support is covered under a member's health plan.

3 These medical expenses are limited and are subject to limitations and exclusions. See full certificate of insurance for a full description of services and coverage of what is and isn't covered.

4 The Political, Military and Natural Disaster Evacuation Services (PEND) are provided through Crisis24, an independent third party, non-affiliated service provider. Crisis24 does not supply Blue Cross or Blue Shield products or other benefits, and is therefore solely responsible for PEND and other collateral services it provides. GeoBlue makes no warranty, express or implied, and accepts no responsibility resulting from the provision or use of Crisis24 PEND or other Crisis24 services.



Designed with you in mind

Offering you healthy support and easy-to-use benefits to help you stay focused on your education and your future.

Notes

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help themember know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum(excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- Network Deductibles Preferred and In-Network commingle towards each other.
- All network covered services cost share for both Preferred and In-Network apply to the In-Network OOP.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsuranceup to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible forany balance due after the plan payment.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance andout-of-pocket maximum amounts are separate and do not accumulate toward each other.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CA_SH_PPO.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summarydoes not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details,important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a differencebetween this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Access help in your language

If you have any questions about this document, you have the right to help and information in your language at no cost. To talk to an interpreter, call **1-855-330-1098**.

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card. (TTY/TDD: 711)

Arabic

ىلع دوجوملا ءاضعلأا تامدخ مقرب لصتا .اًناجم كتغلب ةدعاسملاو تامولعملا هذه ىلع لوصحلا كل قحي
ةدعاسملا كب ةصاخلا فيرعتلا ةقاطب.(TTY/TDD: 711)

Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi

تروصه ب ار اهکمک و تاعلاطا نیا هک دیراد ار قح نیا امش
هب کمک تفایرد یارب .دینک تفایرد ناتدوخ نابز هب ناگیار
جرد ناتییاسانش تراک یور رب هک ءاضعا تامدخ زکرم هرامش
دیریگب سامت ،تسا (TTY/TDD: 711). هدش

French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Navajo

Bee ná ahóót'i' t'áá ni nizaad k'ehjí níká a'doowoł t'áá jíík'e. Naaltsoos bee atah nílínígíí bee néého' dólzingo nanitinígíí béésh bee hane' í bikáá' áajį' hodíílnih. (TTY/TDD: 711)

Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵੱਿਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵੱਿਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Tagalog

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

It is important we treat you fairly

That is why we follow federal civil rights laws in our health programs and activities. We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language is not English, we offer free language assistance services through interpreters and other written languages. If you are interested in these services, call the Customer Service number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you have questions, call 1-800-888-2108 or visit us at www.anthem.com/studentadvantageca.

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