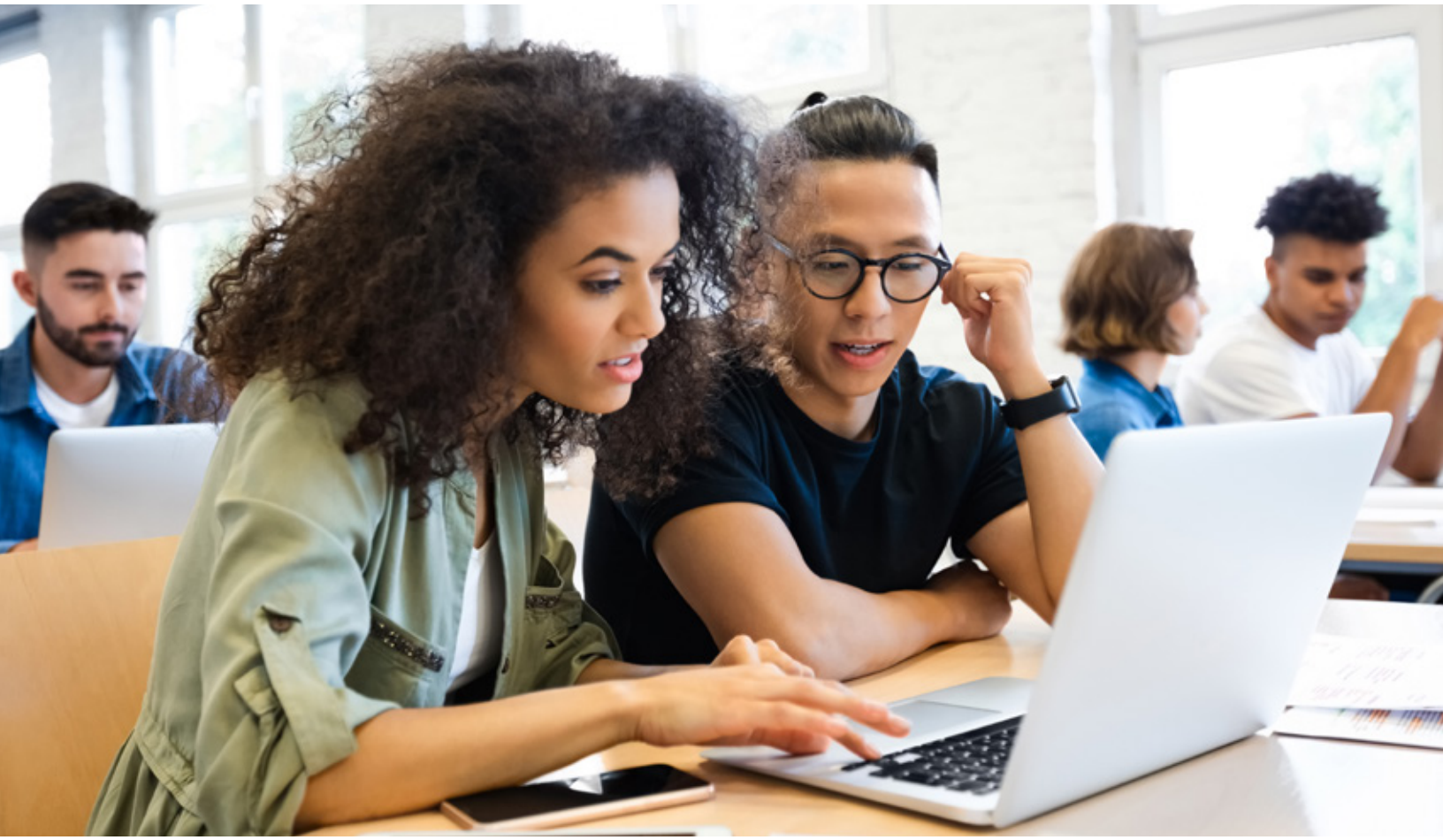
2023-2024

Anthem Student Advantage

Helping keep you at your personal best



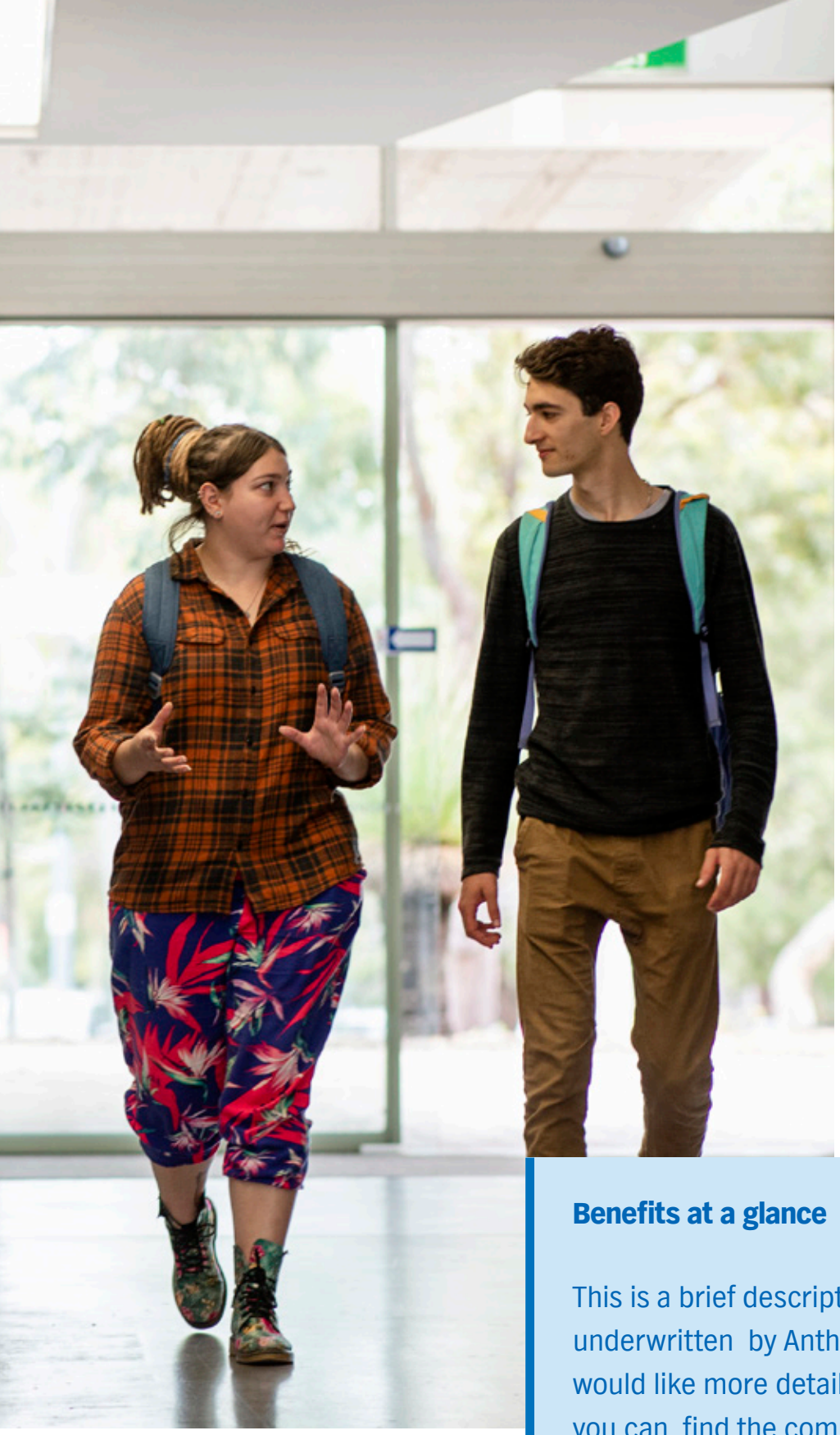
University of the Pacific

Student Health Insurance Plan

www.anthem.com/studentadvantageca

A0032OCAMENABC 06/23

Anthem | STUDENT ADVANTAGE



Benefits at a glance

This is a brief description of your student health plan underwritten by Anthem Blue Cross (Anthem). 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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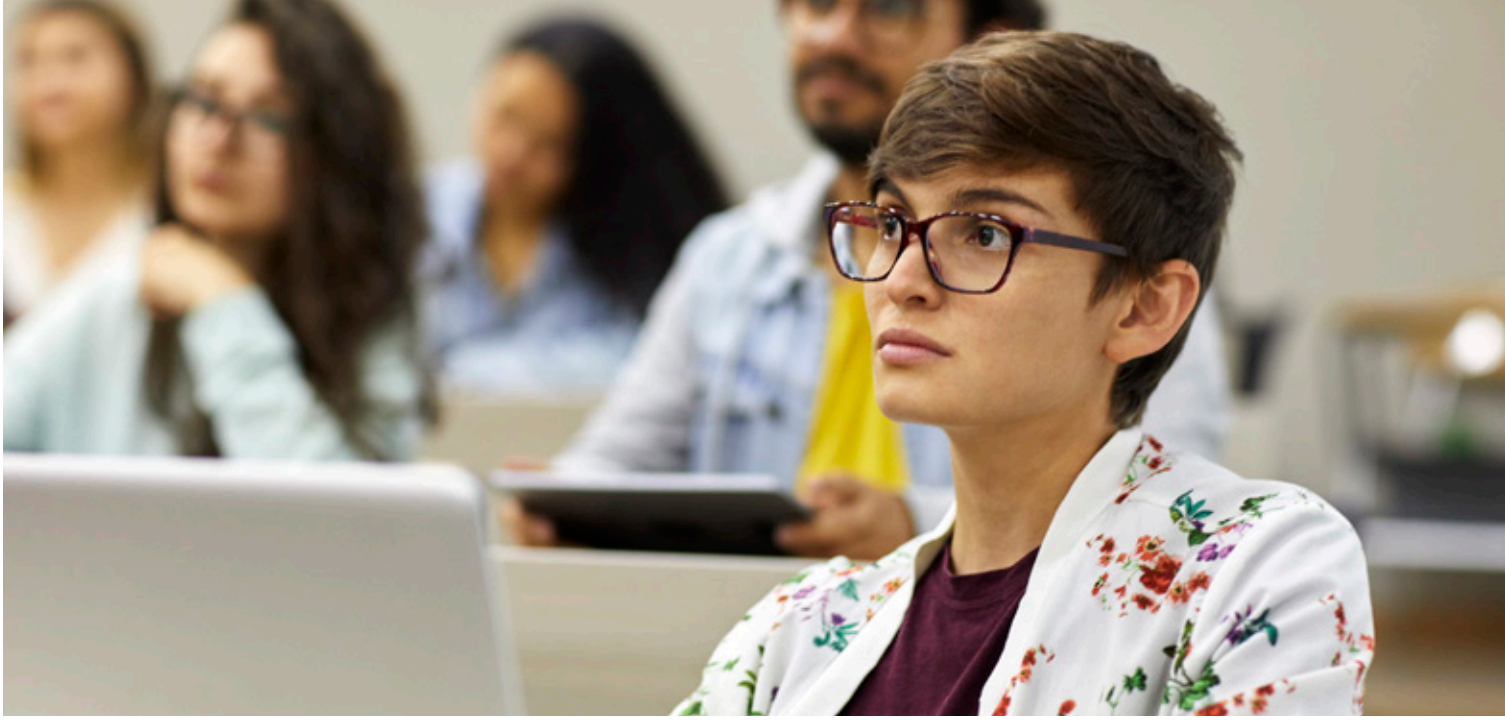


Welcome to Anthem Student Advantage

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

Law School Students (Sacramento):

All degree seeking Law School students on the Sacramento campus enrolled in 6 or more units are required to have health insurance. You will be automatically enrolled in and billed for the Student Health Insurance Plan unless proof of comparable coverage is received by the published deadline.

Undergraduate & Pharmacy D Students (Sacramento, San Francisco, Stockton):

Undergraduate & Pharmacy D students on all campuses enrolled in 9 or more units are required to have health insurance. You will be automatically enrolled in and billed for the Student Health Insurance Plan unless proof of comparable coverage is received by the published deadline.

Continues

What you need to know about Anthem Student Advantage continued

Graduate/Professional Students (Sacramento, San Francisco, Stockton):

All Graduate/Professional Students on all campuses enrolled in 1 unit or more are required to have health insurance. You will be automatically enrolled in and billed for the Student Health Insurance Plan unless proof of comparable coverage is received by the published deadline.

Dental Students (not including Dental Hygiene):

All Dental School students on the San Francisco campus enrolled in 1 unit or more are required to have health insurance. You will be automatically enrolled in and billed for the Student Health Insurance Plan unless proof of comparable coverage is received by the published deadline.

Advanced Education in General Dentistry (AEGD) Residents:

All AEGD Residents based out of the San Francisco campus and/or practicing in Union City are required to have health insurance. You will be automatically enrolled in and billed for the Student Health Insurance Plan unless proof of comparable coverage is received by the published deadline.

International Students:

All International students taking 1 or more units, regardless of class level and program on all campuses are required to have health insurance. You will be automatically enrolled in and billed for the Student Health Insurance Plan unless proof of comparable coverage is received by the published deadline.

Students in fully online and external partnership programs are not eligible in the Student Health Insurance Plan.

All Campuses:

Students must actively attend classes for at least the first 45 days after the effective date of the period for which coverage is purchased. Students on an approved Leave of Absence

(LOA) who were enrolled in at least one semester immediately preceding their LOA can enroll in a max of one semester at the regular semester rate (non-continuation term). Students may NOT purchase coverage for the following semester unless they meet University of the Pacific's eligibility requirements.

Only students who graduate, withdraw, or drop out AFTER the first 45 days from the start of the term, can purchase continuation coverage. Students should visit **www.gallagherstudent.com/UOP** and click on 'Forms & Applications' to enroll.

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

Coverage periods and rates

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

Costs and dates of coverage, Medical, Dental and Vision Plan

Undergraduate & International Students

	Annual 8/1/2023 -7/31/2024	Fall 8/1/2023–1/31/2024	Spring 2/1/2024–7/31/2024
Enrollment/ Waiver Deadline	9/8/2023	9/8/23	1/31/ 24 (newly eligible students only)
Student	$2,608.00	$1,304.00	$1,304.00

Graduate/Professional/Law Students

	Annual 8/1/2023-7/31/2024	Fall 8/1/2023–1/31/2024	Spring 2/1/2024–7/31/2024
Enrollment/ Waiver Deadline	9/8/2023	9/8/23	1/31/ 24 (newly eligible students only)
Student	$3,296.00	$1,648.00	$1,648.00

Dental Students (not including Dental Hygiene)

	Annual 07/1/2023-6/30/2024	Fall 7/1/2023-12/31/2023	Spring 1/1/2024-6/30/2024
Enrollment/ Waiver Deadline	7/31/23	7/31/23	N/A
Student	$3,296.00	$1,648.00	$1,648.00

*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

Student Health Center

STOCKTON
Location
1041 Brookside Road
(across the footbridge
from the main campus

Hours*
Monday – Friday
7:00 am – 5:00 pm

SACRAMENTO
Location
Halbert Hall
3257 5th Avenue
Sacramento, CA 95817

Hours: 8:00am to 5:00pm
Mondays, Wednesdays, Thursdays
& Fridays (closed Tuesdays)

SAN FRANCISCO
Location
155 Fifth Street, 5th Floor, Suite 513

Hours*
Monday 7:30 am - 4:30 pm
Tuesday 8:30 am - 5:30 pm
Wednesday 11:30 am - 6:00 pm
Thursday 7:30 am - 4:30 pm
Closed on Fridays

* (Hours subject to change. Visit Visit www.pacific.edu/healthservices for more information)

Claims and coverage

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

General information on Benefits, Eligibility & Enrollment, ID Cards or Service Issues

Gallagher Student Health
& Special Risk
1-833-233-0764
www.gallagherstudent.com/uop
University of the Pacific

Convenient 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] mobile app through Anthem Student Advantage, you have instant access to:

- Your member ID card.
- The Find a Doctor 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.

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.

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

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

Anthem Student Advantage University of the Pacific website

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

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 plan details

Anthem Blue Cross and Blue Shield

Student Health Insurance Plan:
University of the Pacific

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 an Out-of-Network Provider
Overall Deductible	$300 student	$300 student
Overall Out-of-Pocket Limit	$5,600 student	$5,600 student
All medical and prescription drugs deductibles, copayments and coinsurance apply towards the out-of-pocket maximum. In-network and out-of-network out-of-pocket maximum amounts are seperate and do not accumulate towards each other.		
Virtual Visits from online provider LiveHealth Online for urgent/acute medical and mental health and substance use disorder care vis www.livehealthonline.com are covered No charge.		
Primary Care (PCP) virtual and office	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Mental Health and Substance Use Disorder Care virtual and office	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist Care virtual and office	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) In-Network routine prenatal office visits and other preventive prenatal care and screening are covered at 100%.	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Retail Health Clinic for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Chiropractic Services	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Acupuncture	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Other services in an office		
Allergy Testing	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prescription Drugs - Dispensed in the office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Surgery	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after medical deductible is met
Preventive care for Chronic Conditions per IRS guidelines	No charge	40% coinsurance after medical deductible is met
Diagnostic Services		
Lab		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Lab	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
X-Ray		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Radiology Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Advanced Diagnostic Imaging		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Radiology Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Emergency and urgent care		
Urgent Care	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Emergency Room Facility Services Copay waived if addmited.	$150 copay per visit and 20% coinsurance after medical deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Emergency Room Doctor and Other Service	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Emergency Ambulance	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Mental Health and Substance Use Disorder Care at a Facility		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor Services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Ambulatory Surgical Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor and Other Services Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Ambulatory Surgical Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse)		
Facility fees Coverage for Inpatient Rehabilitation is limited to 100 days per benefit period.	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Human Organ and Tissue Transplants Coverage includes acquisition and transplant procedures, collection and storage.	20% coinsurance after medical deductible is met	Not covered
Doctor and other services		
Recovery & Rehabilitation		
Home Health Care Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Rehabilitation service		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Habilitation service		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

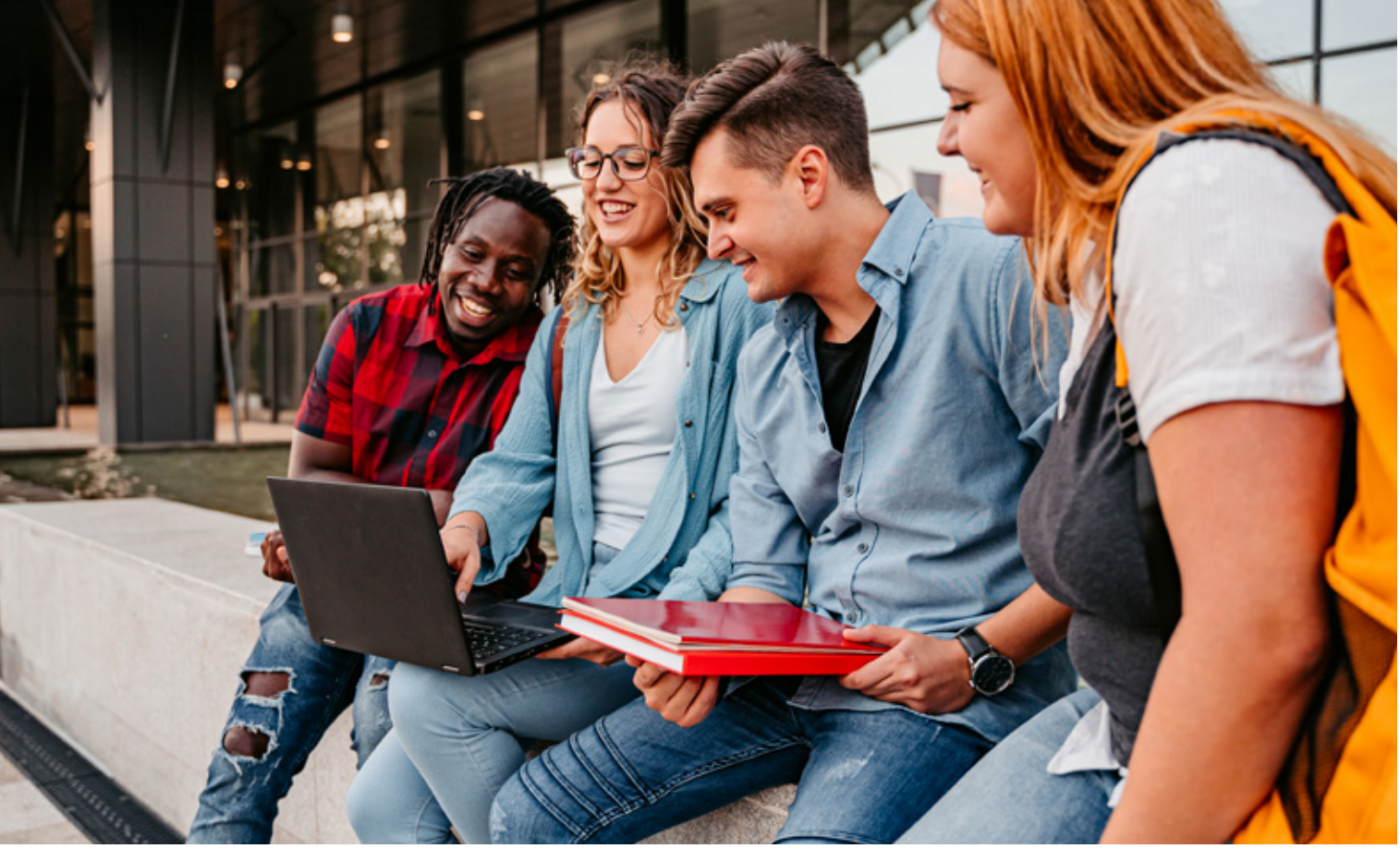
Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Habilitation services		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) Coverage is limited to 100 days per benefit period.	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospice	20% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Pharmacy

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket Limit	Combined with medical out-of-pocket limit	Combined with medical out-of-pocket limit
Prescription Drug Coverage **Network: Base Network** **Drug List: Traditional Open**		
Day Supply Limits: **Retail Pharmacy** 30 day supply (cost shares noted below) **Retail 90 Pharmacy** 90 day supply (cost shares noted below) **Home Delivery Pharmacy** 90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail. **Specialty Pharmacy** 30 day supply (cost shares noted below for retail and home delivery apply).We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.		
Tier 1 - Typically Generic Each 90 day supply script filled at Retail 90 pharmacies is subject fo 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.	$15 copay per prescription (retail) and $30 copay per prescription (home delivery)	$15 copay plus 50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand Each 90 day supply script filled at Retail 90 pharmacies is subject fo 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.	$30 copay per prescription (retail) and $60 copay per prescription (home delivery)	$30 copay plus 50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brands Each 90 day supply script filled at Retail 90 pharmacies is subject fo 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.	$50 copay per prescription (retail) and $100 copay per prescription (home delivery)	$50 copay plus 50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance up to $250 per prescription(retail) and 20% coinsurance up to $750 per prescription (home delivery)	Not covered (retail and home delivery)

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. To receive the In-Network benefit, you must use a Blue View Vision Provider.		
Children's Vision Essential Health Benefits (up to age 19)		
Vision exam Limited to 1 exam per benefit period.	No charge	Reimbursed Up to $30
Frames Limited to 1 unit per benefit period.	No charge	Reimbursed Up to $45
Lenses Limited to 1 unit per benefit period combined with OON Coverage. OON Reimbursement: Single Reimbursed Up to $25, Bifocal Reimbursed Up to $40, Trifocal Reimbursed Up to $55.	No charge	Receives Reimbursement
Elective Contact Lenses Limited to 1 unit per benefit period.	No charge	Reimbursed Up to $60
Non-Elective Contact Lenses Limited to 1 unit per benefit period.	No charge	Reimbursed Up to $210

Covered Dental 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 dental coverage. Only children's dental services count towards your out of pocket limit.		
Children's Dental Essential Health Benefits (up to age 19)		
Children's Dental Essential Health Benefits **Diagnostic and preventive** Limited to 1 visit per 6 months.	No charge	No charge
Basic services	20% coinsurance dental deductible does not apply	20% coinsurance dental deductible does not apply
Major services	50% coinsurance dental deductible does not apply	50% coinsurance dental deductible does not apply
Medically Necessary Orthodontia services	50% coinsurance dental deductible does not apply	50% coinsurance dental deductible does not apply
Cosmetic Orthodontia services	Not covered	Not covered
Adult Dental	Not covered	Not covered



Dental Plan

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	$1000	$1000
Annual Deductible Plan Year		
Per insured person	$25	$50
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 month	0% Coinsurance	0% Coinsurance
Intraoral X-rays	0% Coinsurance	0% Coinsurance

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Basic Services		
Amalgam (silver-colored) Filling	20% Coinsurance	20% Coinsurance
Front Composite (tooth-colored) Filling	20% Coinsurance	20% Coinsurance
Back Composite Filling	20% Coinsurance	20% Coinsurance
Simple Extractions	20% Coinsurance	20% Coinsurance
Endodontics		
Root Canal	20% Coinsurance	20% Coinsurance
Periodontics		
Scaling and root planing	20% Coinsurance	20% Coinsurance
Oral Surgery		
Simple Extractions 1 per tooth per lifetime	20% Coinsurance	20% Coinsurance
Oral Surgery (Complex)		
Surgical Extractions	20% Coinsurance	20% Coinsurance
Major (Restorative) Services		
Crowns	50% Coinsurance	50% Coinsurance
Prosthodontics		
Dentures and bridges	50% Coinsurance	50% Coinsurance
Dental Implants	50% Coinsurance	50% Coinsurance
Prosthodontic Repairs/Adjustments		
Crown, denture, bridge repairs	50% Coinsurance	50% Coinsurance
Denture and bridge adjustments	50% Coinsurance	50% Coinsurance
Orthodontic Services		
None	Not Covered	Not Covered

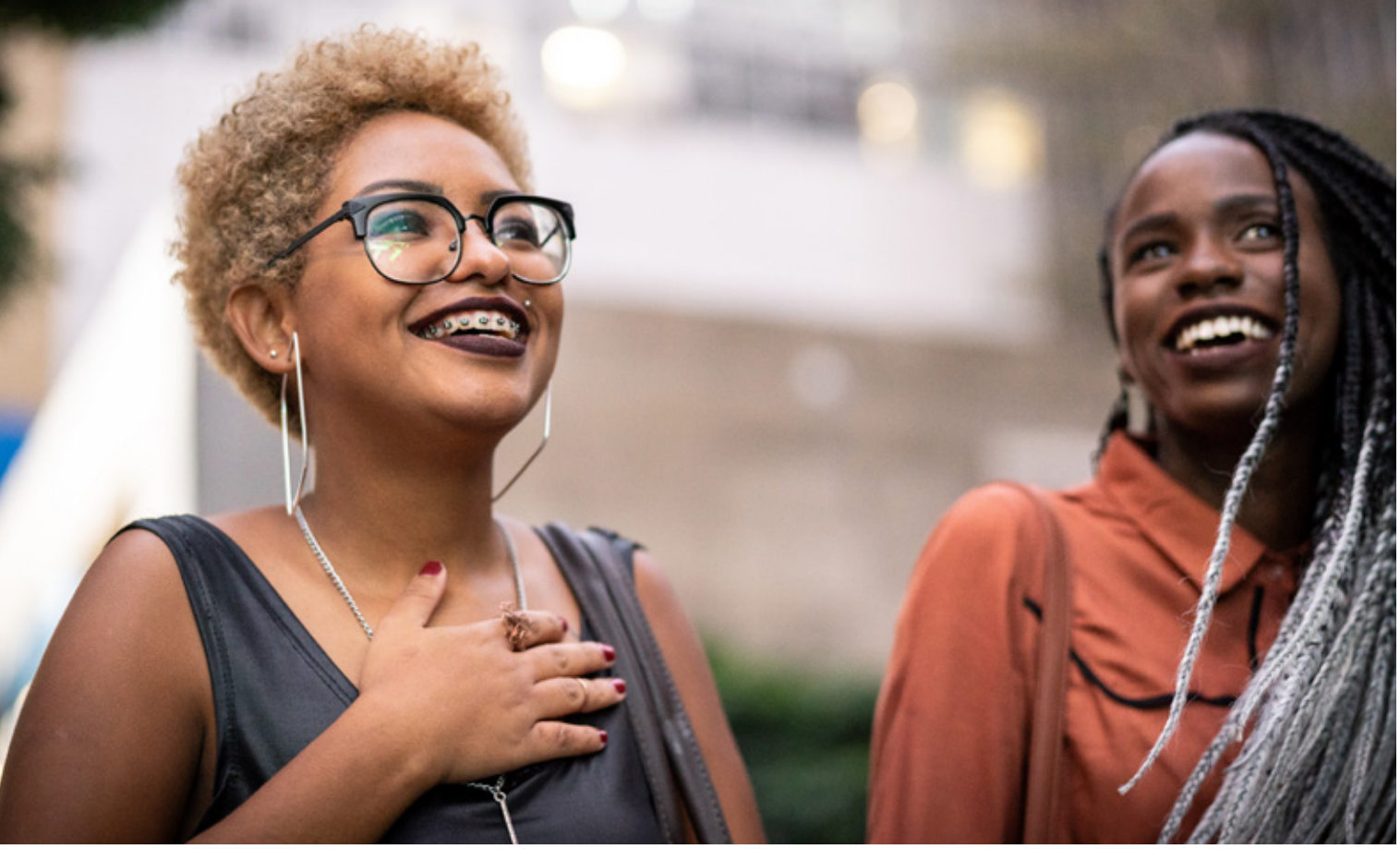
Additional Limitations & Exclusions. Below is a partial listing of non-covered services under your dental plan. Please see your policy for a full list.

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

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.



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
Contact Lenses[1] (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 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
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
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

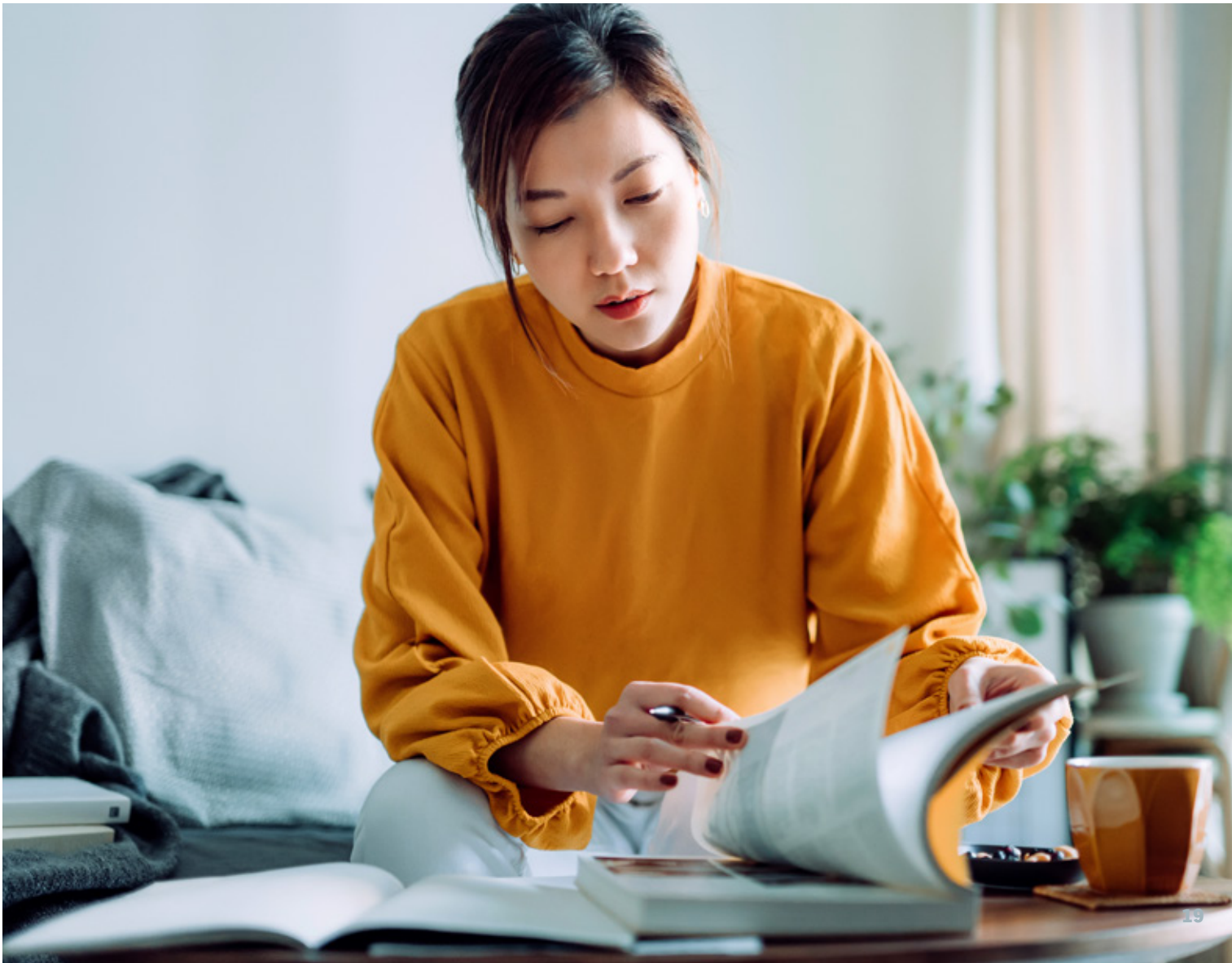
Other discount offers on LASIK surgery and much more are available through our SpecialOffers program.

Notes:

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- When using a non-network pharmacy, members are responsible for the stated copay & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdi?x=CA SH PP0276470MG01.

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.

Questions: (800) 888-2108 or visit us at https://student.anthem.com
CA/SH/CUSTOM STUDENT HEALTH PLAN WITHOUT STUDENT HEALTH CENTER/0GT7/07-01-2023



Benefits that go with you

Emergency travel assistance
As a participant in the student health plan, you have access to emergency travel services and benefits when you are traveling over 100 miles from home or outside your home country.

To ensure you have immediate access to assistance if you experience a travel-related crisis, Academic HealthPlans has included Academic Emergency Services (AES) in your Student Health Insurance Plan coverage. AES offers a wide range of services and benefits to provide everything you need to prepare for your international experience, as well as get the help or information you need in a crisis.

Academic Emergency Services phone numbers

- To contact Academic Emergency Services from the U.S or Canada, call **855-873-3555**.
- To contact Academic Emergency Services from outside the U.S. or Canada, dial the country access code followed by the collect number: **1-610-263-4660**.

You can count on medical coverage anywhere worldwide with GeoBlue.[1] Access international doctors by phone or video, and use our 24/7 help center for emergency health questions.

Visit geobluestudents.com to learn more.

Your GeoBlue benefits for the 2023-2024 school year

Use of benefits must be coordinated and approved by GeoBlue.

International telemedicine services[2]	
Global TeleMD™	Confidential access to international doctors by phone or video call.
Coverage outside of the U.S., excluding students home country.	
Medical expenses	Maximum benefit up to $250,000 each 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 each coverage year
Political emergency and natural disaster evacuation (Available only when traveling outside the United States)[4]	Covered 100% up to $100,000 each person. Subject to a combined $5,000,000 limit for each covered event for all people covered under the plan.
Accidental death and dismemberment	Maximum benefit up to $10,000 each 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 convenient benefits to help you stay focused on your education and your future.

Access help in your language

If you have 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

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف (TTY/TDD: 711) الخاصة بك للمساعدة

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)

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 n1 ahoot'i' t'11 ni nizaad k'ehj7 n7k1 a'doowo[t'11 j77k'e. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. (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 ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ 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

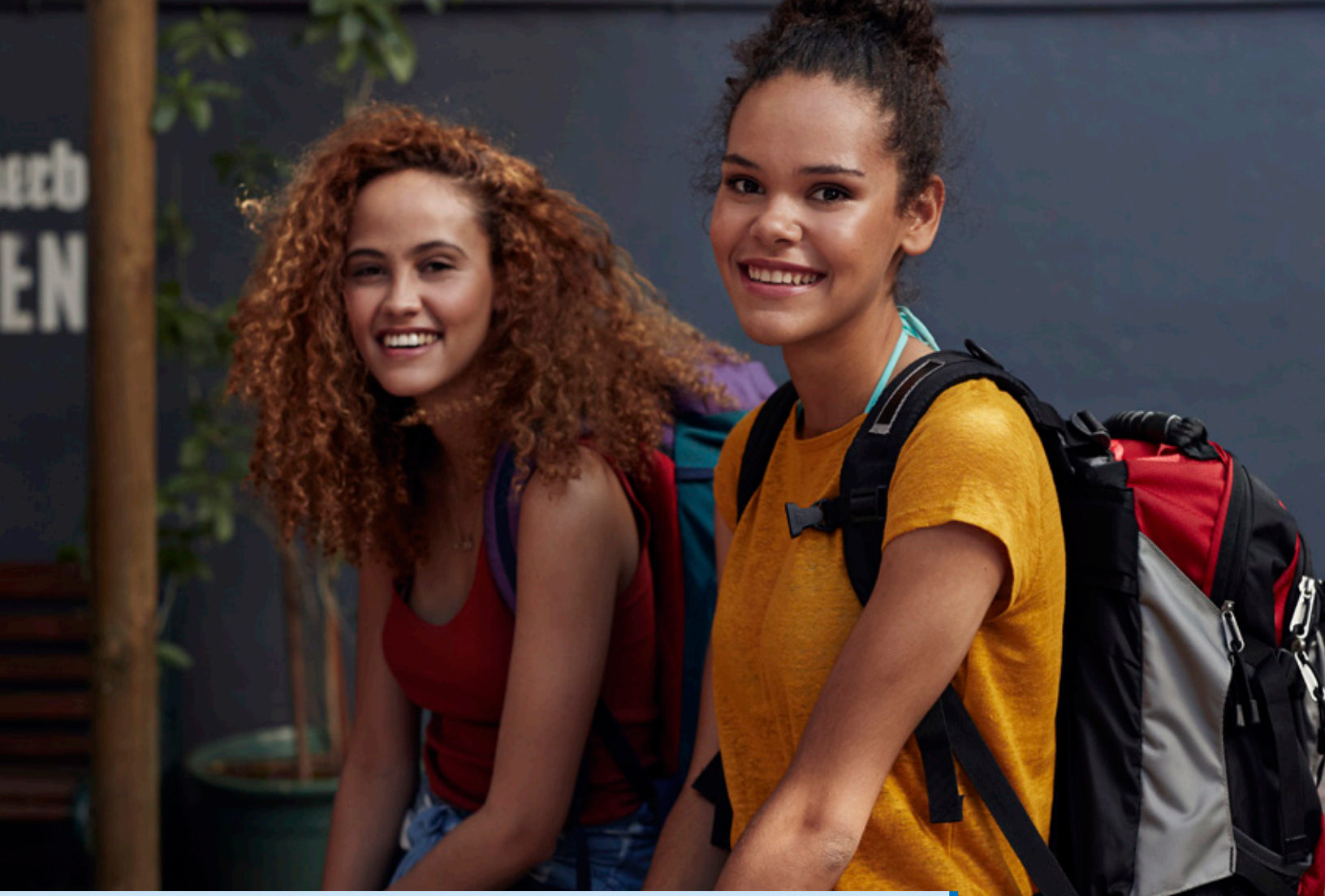
May karapatan kayong makakuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

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, we're here to help.

Call **1-800-888-2108** or visit us at **www.anthem.com/studentadvantage.**

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