Otis College of Art & Design

2019-2020 Student Health Plan

Important notice

This is a brief description of your Student Health Plan underwritten by Anthem Blue Cross (Anthem). If you'd like more details about your coverage and costs, you can get the complete terms in the policy or plan document online at anthem.com/ca. You'll be able to get a copy of the full Master Policy as soon as it's available.

Note: Subjected to change based on state approval.

Anthem | STUDENT ADVANTAGE

OTIS COLLEGE OF ART AND DESIGN

anthem.com/ca

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Who is eligible for the plan

All Otis College students are required to have health insurance and are automatically enrolled on the student health insurance plan. Students with health insurance coverage that meets the College's requirements may waive out of the plan by completing an online waiver.

Students will submit a waiver for the academic school year annually. If you submit an Annual waiver, you do not have to submit another waiver until the next academic school year.

Please visit **https://otis.myahpcare.com** for more information

Refunds

Once eligibility requirements have been met for the first 30 days of coverage, coverage will remain in force during the period for which premium has been paid, even if the student leaves school or obtains other coverage or has a change in status. Refunds will ONLY be considered during the first 30 days of coverage and ONLY for students who enter full time active duty military service. Approval is subject to verification that no medical claims were filed or paid during the coverage period. No other refunds will be granted.

Withdrawal from school

If you leave school for reason of a covered accident or sickness, you will be eligible for continued coverage under this Plan for only the first term immediately following your leave, provided you have approval by your school and any applicable regulatory authority, and you were enrolled in this Plan for the term previous to your leave.

Enrollment must be initiated by the student and is not automatic. All applicable enrollment deadline dates apply. You must pay the applicable insurance premium.

Plan costs

2019-2020 Premium Rates — MFA Graphic Design

Medical	Annual 6/10/2019 through 8/31/2020	Summer 1 6/10/2019 through 8/31/2019	Fall 9/1/2019 through 1/6/2020	Spring 1/7/2020 through 6/8/2020	Summer 2 6/9/2020 through 8/31/2020
Student	$2,850.00	$570.00	$760.00	$950.00	$570.00
Spouse	$2,850.00	$570.00	$760.00	$950.00	$570.00
Each Child	$2,850.00	$570.00	$760.00	$950.00	$570.00

2019-2020 Premium Rates – BFA/MFA

Medical	Annual 8/17/2019 through 8/14/2020	Fall 8/17/2019 through 1/6/2020	Spring 1/7/2020 through 8/14/2020
Student	$2,280.00	$950.00	$ 1,330.00
Spouse	$2,280.00	$950.00	$ 1,330.00
Each Child	$2,280.00	$950.00	$ 1,330.00

Emergency travel assistance

GeoBlue medical evacuation services

GeoBlue's 24/7 assistance center is here to support members experiencing medical emergencies. GeoBlue coordinates emergency services with a worldwide network of Physician Advisors. Members in need of life-saving medical intervention are treated at the nearest appropriate medical facility.

What should I do in the event of a medical emergency?

Go immediately to the nearest physician or hospital and then contact us. Call collect: **1-833-511-4763**.

The GeoBlue Global Health & Safety Team will contact your treating physician and closely monitor your case to determine if a medical evacuation is necessary.

GeoBlue Global Health & Safety contact details can be found on the back of your ID card.

When you call Global Health and Safety, please be prepared to provide the following information:

- The insured person's name
- The ID number located on the front of your ID card
- The name of the program: Anthem Student Advantage
- Detailed information regarding the nature of the emergency
- If applicable, the name and contact details for the treating physician and/or hospital
- The insured person's specific location in the country. Utilize a GPS if available.

Global assistance services and benefits

Medical assistance	Limits are per member, per event
Emergency medical evacuation	Maximum benefit up to $250,000 per coverage year
Repatriation of remains	Maximum benefit up to $50,000 per coverage year
Emergency family travel arrangements	Maximum benefit up to $5,000 per coverage year
Political emergency and natural disaster evacuation	Covered 100% up to $100,000 per person subject to a combined $5,000,000 aggregate limit per any one covered event for all persons covered under the plan
Accidental death and dismemberment	Maximum benefit up to $10,000 per coverage year

For more information visit www.geobluestudents.com.

Emergency travel assistance

Medical/travel benefit exclusions

No payment will be made for charges for:

1. Services rendered without the authorization or intervention of Us or Our designee;
2. Expenses incurred if the original or ancillary purpose of Your trip is to obtain medical treatment;
3. Services provided for which no charge is normally made;
4. Hospital or medical expenses of any kind or nature.
5. More than one Emergency Medical Evacuation and/or repatriation for any single medical condition of a Covered Person during the term of the Program.
6. Initial transportation to local facilities, including ground, water or air ambulance fees, unless otherwise specified in this Plan.
7. Any expense for medical evacuation or repatriation if the Covered Person is not suffering from a Serious Medical Condition, and/or in the opinion of the Our physician, the Covered Person can be adequately treated locally, or treatment can be reasonably delayed until the Covered Person returns to his/ her Home Country or Country of Assignment.
8. Any expense for Emergency Evacuation where the Covered Person, in the opinion of Our physician, can travel as an ordinary passenger without a medical escort.
9. A Covered Person who is medically discharged from the hospital, or leaves against medical advice and is physically able to travel on his or her own, is not eligible for medical transport services.
10. Medical Evacuation from a marine vessel, ship or watercraft of any kind.
11. Any treatment or expense related to childbirth, miscarriage or pregnancy. This exception shall not apply to any abnormal pregnancy or vital complication of pregnancy which endangers the life of the mother and/or unborn child during the first twenty- four (24) weeks of pregnancy.
12. Any expense related to the Covered Person engaging in the commission of, or the attempt to commit, an unlawful act.
13. Any expense incurred as a result of the Covered Person engaging in active service in the armed forces or police of any nation; active participation in war (whether declared or not), invasion, act of foreign enemy, hostilities, civil war, rebellion, riot, revolution or insurrection.
14. Medical transport services will not be provided to a Covered Person who has a diagnosis of, or is suspected of having, a Biosafety Class Level 3 (and above) pathogen as classified by either the Centers for Disease Control and Prevention (CDC) or the National Institutes of Health (NIH).
15. Services not otherwise shown as covered.
16. To the extent that such payments would be prohibited by law.

Emergency travel assistance

Exclusions and limitations for accidental death and dismemberment coverage

Special limitations/expenses not covered:

Benefits will not be provided for the following:

1. For loss of life or dismemberment due to a Sickness, disease or infection.
2. For any loss of life or dismemberment before the effective date of coverage.
3. For any loss of life or dismemberment after coverage ends.
4. While riding or driving in any kind of competition
5. Injury sustained while the Covered Person is riding as a pilot, student pilot, operator or crew member, in or on, boarding or alighting from, any type of aircraft;
6. For loss of life or dismemberment caused by or contributed by (a) an act of war; (b) a Covered Person participating in the military service of any country; (c) a Covered Person participating in an insurrection, rebellion, or riot; (d) services received for any condition caused by a Covered Person's commission of, or attempt to commit a felony or to which a contributing cause was the Covered Person being engaged in an illegal occupation.

Important contact information

Insurance Company

Anthem Blue Cross Life and Health Insurance Company

Claims & Coverage Questions

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 60007
Los Angeles, CA 90060
1-800-888-2108
www.anthem.com/ca

Find a Doctor or Preferred Care Provider

PPO Prudent Buyer Plan
1-800-888-2108
www.anthem.com/ca

Enroll and Waive

1-855-422-3834
https://otis.myahpcare.com/cost

Getting started

StudentHealth App

With the StudentHealth app through Anthem Student Advantage, you have instant access to:

- Your member ID card
- Find a Doctor
- More information about your plan benefits
- Health tips that are tailored to you
- LiveHealth Online and 24/7 Nurseline
- Student support specialists; just click to call or chat
- And more!

From your mobile device or tablet go to The App Store℠ or Google Play™ and search for the StudentHealth app to download it today.

LiveHealth Online

Using LiveHealth Online, you can visit with a board-certified doctor, psychiatrist or licensed therapist through live video on your smartphone, tablet or computer with a webcam. It's an easy and convenient way to get the care you need. Go to your StudentHeath app, livehealthonline.com or download the free LiveHealth Online app to sign up on your smartphone or tablet.

24/7 Nurseline

With 24/7 Nurseline , you can call registered nurses to help you with needs such as your fever, allergy relief tips and where to go for care. They can also help you enroll in in valuable health management programs for certain health conditions, remind you about scheduling important screenings and exams, and more. Just call 844-545-1429 to speak to a registered nurse today.

Your summary of benefits

Anthem Blue Cross

Your Plan: Anthem Student Advantage PPO 250/20/20 (Traditional Formulary $15/$30/$70)

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 Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Student Health Center Benefits: $0 copay for services rendered at the Student Health Center.

Covered Medical Benefits	In-network Provider	Non-network Provider
Overall Deductible *See notes section to understand how your deductible works.*	$250 single / $500 family	$750 single / $1,500 family
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.*	$5,900 single / $11,800 family	$12,700 single / $25,400 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	50% coinsurance
Doctor Home and Office Services		
Primary care visit to treat an injury or illness *Deductible does not apply to In-Network providers. $0 copay for services rendered at the Student Health Center.*	$20 copay per visit	50% coinsurance
Specialist care visit *Deductible does not apply to In-Network providers.*	$20 copay per visit	50% coinsurance
Prenatal and Post-natal Care *Deductible does not apply to In-Network providers.*	$20 copay per visit	50% coinsurance
Other practitioner visits:		
Retail health clinic *Deductible does not apply to In-Network providers.*	$20 copay per visit	50% coinsurance
On-line Visit *Deductible does not apply to In-Network providers.*	$20 copay per visit	50% coinsurance
Chiropractor services	20% coinsurance	50% coinsurance
Acupuncture	20% coinsurance	50% coinsurance

Your summary of benefits

Covered Medical Benefits	In-network Provider	Non-network Provider
Other services in an office:		
Allergy testing	$0 copay per visit	$20 copay per visit + 50% coinsurance
Chemo/radiation therapy	20% coinsurance	50% coinsurance
Hemodialysis	20% coinsurance	50% coinsurance
Prescription drugs For the drugs itself dispensed in the office thru infusion/injection	20% coinsurance	50% coinsurance
Diagnostic Services		
Lab:		
Office	20% coinsurance	50% coinsurance
Freestanding Lab	20% coinsurance	50% coinsurance
Outpatient Hospital	20% coinsurance	50% coinsurance
X-ray:		
Office *(Deductible waived with referral for In-Network providers)*	20% coinsurance	50% coinsurance
Freestanding Radiology Center	20% coinsurance	50% coinsurance
Outpatient Hospital	20% coinsurance	50% coinsurance
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office *(Deductible waived with referral for In-Network providers)*	20% coinsurance	50% coinsurance
Freestanding Radiology Center	20% coinsurance	50% coinsurance
Outpatient Hospital	20% coinsurance	50% coinsurance

Your summary of benefits

Covered Medical Benefits	In-network Provider	Non-network Provider
Emergency and Urgent Care		
Emergency room facility services *Copay waived if admitted. This is for the hospital/facility charge only. The ER physician charge may be separate. Copay waived if admitted.*	$150 copay per admission and then 20% coinsurance	Covered as In-Network
Emergency room doctor and other services	20% coinsurance	Covered as In-Network
Ambulance (air and ground)	20% coinsurance	Covered as In-Network
Urgent Care (office setting) *Deductible does not apply to In-Network providers.*	$20 copay per visit	50% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse:		
Doctor office visit *Deductible does not apply to In-Network providers.*	No charge for first 15 visits and then $20 copay per visit	50% coinsurance
Facility visit: Facility fees	20% coinsurance	50% coinsurance
Outpatient Surgery		
Facility fees:		
Hospital	20% coinsurance	50% coinsurance
Freestanding Surgical Center	20% coinsurance	50% coinsurance
Doctor and other services	20% coinsurance	50% coinsurance
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board)	20% coinsurance	50% coinsurance
Doctor and other services	20% coinsurance	50% coinsurance
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 visit limit per benefit period.*	20% coinsurance	50% coinsurance

Your summary of benefits

Covered Medical Benefits	In-network Provider	Non-network Provider
Rehabilitation and Habilitation services (for example, physical/speech/occupational therapy): Office *Deductible does not apply to In-Network providers. Costs may vary by site of service.* Outpatient hospital *Deductible does not apply to In-Network providers.*	$20 copay per visit then 20% coinsurance $20 copay per visit then 20% coinsurance	$20 copay per visit + 50% coinsurance $20 copay per visit + 50% coinsurance
Cardiac rehabilitation Office *Deductible does not apply to In-Network providers.* Outpatient hospital *Deductible does not apply to In-Network providers.*	$20 copay per visit then 20% coinsurance $20 copay per visit then 20% coinsurance	$20 copay per visit + 50% coinsurance $20 copay per visit + 50% coinsurance
Skilled nursing care (in a facility) *Precertification is required. Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 day limit per benefit period.*	20% coinsurance	50% coinsurance
Hospice *Precertification is required.*	20% coinsurance	50% coinsurance
Durable Medical Equipment	20% coinsurance	20% coinsurance
Prosthetic Devices	20% coinsurance	50% coinsurance
Medical Evacuation *Expenses for transporting insured person back to home country for medical care and treatment limited to $250,000; see certificate for specific details. Charges do not apply toward out of pocket maximum.*	No charge	No charge
Repatriation of Remains *In the event of insured person's death, expenses for preparing & transporting the insured person's bodily remains back to home country limited to $50,000. Valid for students traveling abroad or international students attending classes in the U.S. See Certificate for specific details.*	No charge	No charge

Your summary of benefits

Covered Vision Benefits	In-Network Provider	Non-Network Provider
Children's Vision Essential Health Benefits *Limited to covered persons under the age of 19.*		
Vision exam *Includes one exam/fitting per year*	No charge	$0 copay plus all charges in excess of the maximum allowed amount
Frames *Includes one per year*	No charge	$0 copay plus all charges in excess of the maximum allowed amount
Lenses *Includes one per year*	No charge	$0 copay plus all charges in excess of the maximum allowed amount
Elective contact lenses *Includes one per year*	No charge	$0 copay plus all charges in excess of the maximum allowed amount
Covered Dental Benefits	**In-network Provider**	**Non-network Provider**
Children's Dental Essential Health Benefits *Limited to covered persons under the age of 19:*		
Diagnostic and Preventive services	0% coinsurance	0% coinsurance
Annual Deductible for pediatric dental	$60/member; $180/family	$60/member; $180/family
Annual Out of Pocket Limit for pediatric dental	$1,000/member; $2,000/family	No maximum for Non-Network Provider
Basic services	50% coinsurance	50% coinsurance
Major services	50% coinsurance	50% coinsurance

Your summary of benefits

Covered Prescription Benefits	In-network Provider	Non-network Provider
Pharmacy Deductible	$0	$0
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage *This plan uses a Traditional Drug List. Drugs not on the list are not covered. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days.*		
Tier1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy) . Covers up to a 90 day supply (home delivery program).*	$15 copay per prescription (retail) and $45 copay per prescription (home delivery).	N/A.
Tier2 - Typically Preferred / Brand *Covers up to a 30 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).*	$30 copay per prescription (retail) and $90 copay per prescription (home delivery).	N/A.
Tier3 - Typically Non-Preferred / Specialty Drugs *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	$70 copay per prescription (retail only) and $210 copay per prescription (home delivery).	3 N/A.
Tier4 - Typically Specialty Drugs *Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program. Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	$200 copay per prescription (retail) and $600 copay per prescription (home delivery).	N/A.

Your summary of benefits

Notes:

- 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 Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual Out-of-Pocket Maximums includes deductible, copays, coinsurance and prescription drug.
- In network and out of network out of pocket maximum are exclusive of each other.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration. This is not an inclusive list of services. Please refer to your evidence of coverage.
- For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- If your plan includes out of network benefits and you use a non-network provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.

Your summary of benefits

- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.
- Bariatric Surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 consecutive days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense
- Supply limits for certain drugs may be different, go to Anthem website or call customer service.
- Certain drugs require pre-authorization approval to obtain coverage.
- 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_LG_PPO.
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.

Questions: 1-800-888-2108 or visit us at www.anthem.com/ca

CA/L/F/PPO/LP2037/LR2067/01-19