requirements have been met. The term which coverage is purchased, except in the case of school-approved
Insured students must actively attend classes until the add/drop deadline for
application by August 25, 2015. Students may waive coverage under this plan by submitting an online waiver
All registered law students who are actively attending classes will
concurrently with that of the Insured Student, and Dependents must re-enroll
for which the Insured Student enrolls. Dependent coverage expires
any additional premium.
Coverage may be continued for that child when Wells Fargo Insurance is
after the birth (including the date of birth).
Sickness from birth for
(F-2, J-2, or M-2). A “Newborn” will automatically be covered for Injury or
or visiting faculty member must possess a valid passport and a proper visa
with the Insured Student. Dependents of an Eligible International student
child under twenty-six years of age who are not self-supporting and reside
partner who resides with the Insured Student and the student’s, the spouse’s,
including one of the following qualified events: marriage, birth, adoption.

WELLS FARGO INSURANCE PRIVACY INFORMATION
Who Is Eligible To Enroll?
WHO IS ELIGIBLE TO ENROLL?
All registered law students who are actively attending classes will automatically be enrolled in the plan unless proof of coverage is furnished. Students may waive coverage under this plan by submitting an online waiver application by August 25, 2015. Insured students must actively attend classes until the add/drop deadline for the term which coverage is purchased, except in the case of school-approved medical withdrawal. Kaiser Permanente maintains its right to investigate student status and attendance records to verify that the contract eligibility requirements have been met. Eligible students who involuntarily lose coverage under another group health plan are also eligible to purchase the Student Health Plan within 30 days of loss of coverage. These students must provide Wells Fargo Insurance with proof that they have lost coverage through another group (certificate and letter of ineligibility) within 30 days of the qualifying event. The effective date would be the later of: a) term effective date, or b) the day after prior coverage ends if enrollment request is received by Wells Fargo Insurance within 30 days from loss of prior coverage. DEPENDENT COVERAGE - Eligible Insured Students may also purchase Dependent coverage at the time of student’s enrollment in the plan; or within 31 days of one of the following qualified events: marriage, birth, adoption. Eligible Dependents are the spouse or legally registered and valid domestic partner who resides with the Insured Student and the student’s, the spouse’s, or the domestic partner’s unmarried natural child, stepchild or legally adopted child under twenty-six years of age who are not self-supporting and reside with the Insured Student. Dependents of an Eligible International student or visiting faculty member must possess a valid passport and a proper visa (F-1, J-2, or H-2). A “Newborn” will automatically be covered for Injury or Sickness from birth for 31 days after the birth (including the date of birth). Coverage may be continued for that child when Wells Fargo Insurance is notified in writing within 31 days from the date of birth and by payment of any additional premium. Dependents must be enrolled for the same term of

PREMIUM REFUND/CANCELLATION
Refund requests should be directed to Wells Fargo Insurance at (800) 853-5899 or via email at studentinsurance@wellsfargo.com. A refund of premium will be granted for the reasons listed below only. No other refunds will be granted.
1. If you withdraw from school within the first 45 days of the coverage period, you and your insured dependents will receive a full refund of the insurance premium provided that you and your insured dependents did not file a medical claim during this period. Written proof of withdrawal from the school must be provided. If you withdraw after 45 days of the coverage period, your and your insured dependents’ coverage will remain in effect until the end of the term for which you have paid the
2. If you or your insured dependents enter the armed forces of any country you and your insured dependents will not be covered under the Master Policy as of the date of such entry. If you enter the armed forces the policy will be cancelled. If your dependent enters the armed forces, a pro-rata refund of premium will be made for such person, upon written request received by Wells Fargo Insurance Services within 45 days of entry into service.
3. Refunds will be granted for insured dependents in case of a qualifying event such as legal separation, divorce or death within 31 days of the occurred event, provided that your insured dependents did not file a medical claim during the insured period. Written proof of such qualifying event must be submitted. Refunds will not be prorated.

INFORMATION PURCHASED PERSONAL CHECK
(Note: personal checks are not always a payment option. Please check your school’s enrollment form for available payment options.) If you make your or your dependents’ insurance payment via personal check payable to Wells Fargo Insurance and we are unable to process the check (due to insufficient funds, closure of account, etc.), your and your dependents insurance coverage will be terminated retroactive to the effective date of the enrolled term.

IMPORTANT NOTICE
This is just a brief description of your benefits. For information regarding the full Master Policy (which includes plan benefits, exclusions and limitations, and information about refund requests, how to file a claim, mandated benefits and other important information) please call Wells Fargo Insurance at (800) 853-5899. You will be able to obtain a copy of the full Master Policy as soon as it is available.

EMERGENCY TRAVEL ASSISTANCE SERVICES:
On Call International
One Delaware Drive
Salem, NH 03079
(877) 318-6901 (Toll-free within the U.S.)
(603) 328-1909 (Outside the U.S.)
www.oncallinternational.com

ELIGIBILITY, ENROLLMENT, AND GENERAL QUESTIONS:
Wells Fargo Insurance - Student Insurance
CA License No. 0D08408
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Email: studentinsurance@wellsfargo.com
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Email: studentinsurance@wellsfargo.com
studentinsurance.wellsfargo.com

You will be able to obtain a copy of the full Master Policy as soon as it is available.
STUDENT/SUBSCRIBER PAYS

No charge (Deductible waived)

20% Coinsurance

$3,000/$6,000

STUDENT/SUBSCRIBER PAYS

20% Coinsurance (After deductible)

$40 copay (Deductible waived)

$40 copay (for individual therapy, deductible waived)

$150 copay

$20 copay (for group therapy, deductible waived)

$5 copay (After deductible)

No charge

STUDENT/SUBSCRIBER PAYS

No Charge

STUDENT/SUBSCRIBER PAYS

No Charge

STUDENT/SUBSCRIBER PAYS

No Charge

STUDENT/SUBSCRIBER PAYS

No Charge

The Services described below are covered only if all the following conditions are satisfied: The Services are Medically Necessary; The Services are provided, prescribed, authorized, or rendered at a Plan Physician and you receive the Services from Plan Providers inside Kaiser Permanente’s Southern California Region Service Area (your Home Region), except where specifically noted to the contrary in the Evidence of Coverage (EOC) for authorized referrals, hospice care, Emergency Care, Post-Stabilization Care, Out-Of-Area Urgent Care, and emergency ambulance Services. For more information about your plan physicians or plan providers, visit www.kp.org.

All copays are due at time of visit.

SCHEDULE OF MEDICAL BENEFITS

<table>
<thead>
<tr>
<th>BENEFIT SUMMARY</th>
<th>STUDENT/SUBSCRIBER PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical calendar-year deductible</td>
<td>$500</td>
</tr>
<tr>
<td>Annual out-of-pocket maximum1</td>
<td>Individual/Family $3,000/$6,000</td>
</tr>
</tbody>
</table>

OUTPATIENT CARE

<table>
<thead>
<tr>
<th>STUDENT/SUBSCRIBER PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits</td>
</tr>
<tr>
<td>Preventive exams</td>
</tr>
<tr>
<td>Maternity/Prenatal care2</td>
</tr>
<tr>
<td>Well-child preventive care visits3</td>
</tr>
<tr>
<td>Vaccines (immunizations)</td>
</tr>
<tr>
<td>Allergy injections</td>
</tr>
<tr>
<td>Occupational, physical, and speech therapy</td>
</tr>
<tr>
<td>Podiatry (foot and imaging)</td>
</tr>
<tr>
<td>MRI, CT, and PET scans</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
</tr>
</tbody>
</table>

EMERGENCY SERVICES

<table>
<thead>
<tr>
<th>STUDENT/SUBSCRIBER PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department visits, (waived if admitted directly to hospital)</td>
</tr>
<tr>
<td>Ambulance services</td>
</tr>
</tbody>
</table>

PRESCRIPTIONS4

<table>
<thead>
<tr>
<th>STUDENT/SUBSCRIBER PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic (Up to a 30-day supply)</td>
</tr>
<tr>
<td>Brand-name (Up to a 30-day supply)</td>
</tr>
<tr>
<td>Generic mail order incentive (MOI) (Up to a 100-day supply)</td>
</tr>
<tr>
<td>Brand-name mail order incentive (MOI) (Up to a 100-day supply)</td>
</tr>
<tr>
<td>HOSPITAL CARE</td>
</tr>
<tr>
<td>GERIATRIC &amp; CHRONIC CARE</td>
</tr>
<tr>
<td>Physical services, room and board, tests, medications, supplies, and therapies</td>
</tr>
<tr>
<td>Skilled nursing facility care (up to 100 days)</td>
</tr>
</tbody>
</table>

MENTAL HEALTH SERVICES

<table>
<thead>
<tr>
<th>STUDENT/SUBSCRIBER PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient visits</td>
</tr>
<tr>
<td>Inpatient psychiatric hospitalization and intensive psychiatric treatment programs</td>
</tr>
</tbody>
</table>

CHEMICAL DEPENDENCY SERVICES

<table>
<thead>
<tr>
<th>STUDENT/SUBSCRIBER PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient visits</td>
</tr>
<tr>
<td>Inpatient detoxification</td>
</tr>
</tbody>
</table>

OTHER

<table>
<thead>
<tr>
<th>STUDENT/SUBSCRIBER PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certain durable medical equipment (DME)5</td>
</tr>
<tr>
<td>Optical (eyewear)</td>
</tr>
<tr>
<td>Vision exam</td>
</tr>
<tr>
<td>Home health care (up to 100 hour-bus visits per calendar year)</td>
</tr>
<tr>
<td>Hospice care</td>
</tr>
</tbody>
</table>

1 The annual out-of-pocket maximum is the limit to the total amount that an individual or family must pay for certain services in a calendar year (as discussed in the Evidence of Coverage).
2 Scheduled prenatal visits and the first postpartum visit.
3 For children 23 months or younger.
4 Prescription drugs are covered in accordance with our formulary when prescribed by a plan physician and obtained at Plan pharmacies. Some drugs have different copayments; please refer to the Evidence of Coverage for detailed information about prescription drug copayments.
5 Must DME for home use is not covered. Please refer to the Evidence of Coverage for a description of limited covered items.
6 Kaiser Permanente members are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be coordinated with any other health Plan vision benefit. The discount will not apply to free, promoted, or packaged eye wear program, for any contact lens extended partnership price, or to low-vision aids or devices. Visit kp.org/2020 for Kaiser Permanente optical locations.

EXCLUSIONS & LIMITATIONS

LIMITATIONS
Kaiser Permanente will do its best to provide or arrange for Kaiser Permanente Members’ health care needs in the event of unusual circumstances that delay or render impractical the provision of Services, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor disputes. Under these extreme circumstances, if you have an Emergency Medical Condition, go to the nearest hospital as described under “Emergency Care and Post-stabilization Care from Non–Plan Providers” in the “How to obtain care” section and Kaiser Permanente will provide coverage as described in this section. Additional limitations that apply only to a particular benefit are listed in the description of that benefit in your Evidence of Coverage.

1. Care in a licensed intermediate care facility, except for covered hospice care.
2. Chiropractic Services, unless otherwise stated in your Evidence of Coverage.
3. Artificial insemination, unless otherwise stated in your Evidence of Coverage, and conception by artificial means.
5. Custodial care, except for covered hospice care.
6. Dental and Orthodontic Services and X-rays, except for Services covered under “Dental and Orthodontic Services” in the Evidence of Coverage.
7. Disposables, supplies for home use, such as bandages, gauze, trauma antiseptics, dressings, Acetate bandages, and diapers, underpads, and other incontinence supplies.
8. Experimental or investigational Services, except as required by law for certain cancer clinical trials. You can request an independent medical review if you disagree with our decision to deny treatment because it is experimental or investigational (please refer to the Evidence of Coverage for details about independent medical review and other dispute resolution options).
9. Eyeglasses, contact lenses, and contact lens eye examinations, unless otherwise stated in your Evidence of Coverage.
10. Services related to eye surgery or ophthalmologic Services for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism.
11. Hearing aids, unless otherwise stated in your Evidence of Coverage.
12. Physical examinations related to employment, insurance, licensing, court order, parole, or probation, unless a Plan Physician determines that the Services are Medically Necessary.
13. Routine foot care Services that are not Medically Necessary.
14. Services arising from participation in any collegiate or intercollegiate sport activities when other medical coverage is either provided or required.
15. Services related to conception, pregnancy, or delivery in connection with a surrogacy arrangement, except for otherwise-covered Services provided to a Member who is a surrogate.
16. Services related to the diagnosis and treatment of infertility, unless otherwise stated in your Evidence of Coverage.
17. Services related to a noncovered Service, except for Services we would otherwise cover to treat complications of the noncovered Service.
18. Speech therapy Services to treat social, behavioral, or cognitive delays in speech or language development, unless Medically Necessary.
20. Treatment of hair loss or growth.

DEFINITIONS

Plan Physician: Any licensed physician who is a partner or employee of the Medical Group, or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

WHERE DO I GO FOR CARE?

You must receive all covered care from Plan Providers inside the Kaiser Service Area, except as described in the Evidence of Coverage. To find a Plan Provider, visit www.kp.org or call 1-800-853-5899.