COST

	FALL	FALL EXTENSION	SPRING/SUMMER
Effective Date	8/1/16	8/1/16	1/1/17
Termination Date	12/31/16	2/28/17	7/31/17
Student only	$1,126.36	$1,576.90	$1,576.90
NOTE: Costs below are in addition to the student premium			
Spouse only	$1,126.30	$1,576.83	$1,576.83
Child(ren) only	$935.71	$1,309.99	$1,309.99

Rates include premium payable to Kaiser Permanente, as well as administrative fees payable to Wells Fargo Student Insurance. Rates also include Medical Evacuation and Repatriation and Worldwide Emergency Travel Assistance benefits/services provided through On Call International and its contracted underwriting companies.

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 approved online waiver application by **August 19, 2016**.

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 Student 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 Student 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-2, J-2, or M-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 Student 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 coverage for which the Insured Student enrolls. Dependent coverage expires concurrently with that of the Insured Student, and Dependents must re-enroll when coverage terminates to maintain coverage.*

PREMIUM REFUND/CANCELLATION

Refund requests should be directed to Wells Fargo Student 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 premium.
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 Student Insurance 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.

INSURANCE PAYMENTS WITH 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 Student 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.

You can view the standard Summary of Benefits & Coverage (SBC) which is required by Health Care Reform. It summarizes your coverage in a format that all insurance companies now use. To view your plan SBC, go to: ***studentinsurance.wellsfargo.com*** or call ***800-853-5899*** to request a paper copy free of charge.

WELLS FARGO INSURANCE PRIVACY INFORMATION

We know that your privacy is important to you and we strive to protect the confidentiality of your personal information. We do not disclose any personal information about our plan participants, except as permitted or required by law (e.g., information you provide to us may be shared with your school to process your insurance transaction). To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. You may obtain a detailed copy of our privacy policy through your school or by calling us at ***(800) 853-5899*** or by visiting us at ***studentinsurance.wellsfargo.com***.

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 Student Insurance
(800) 853-5899
Mon-Fri, 8am-5pm PST
Fax (877) 612-7966
Email: studentinsurance@wellsfargo.com
studentinsurance.wellsfargo.com

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 Student Insurance at (***800) 853-5899***. You will be able to obtain a copy of the full Master Policy as soon as it is available. If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will govern and control the payment of benefits.

Domestic & International

2016-2017 Student Health Insurance

Thomas Jefferson School of Law

studentinsurance.wellsfargo.com

Underwritten by:
Kaiser Permanente
Contract #230423

Plan Brokered by:
Wells Fargo Insurance Services USA, Inc.
CA License No. 0D08408

SCHEDULE OF MEDICAL BENEFITS

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 directed by 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 co-pays are due at time of visit.

BENEFIT SUMMARY	STUDENT/SUBSCRIBER PAYS
Medical calendar-year deductible	$500
Annual out-of-pocket maximum[1] **Individual/Family**	$3,000/$6,000
OUTPATIENT CARE	**STUDENT/SUBSCRIBER PAYS**
Office visits	$40 copay (Deductible waived)
Preventive exams	No charge (Deductible waived)
Maternity/Prenatal care[2]	No charge (Deductible waived)
Well-child preventive care visits[3]	No charge (Deductible waived)
Vaccines (immunizations)	No charge (Deductible waived)
Allergy injections	$5 copay (After deductible)
Occupational, physical, and speech therapy	$40 copay (After deductible)
Most labs and imaging	$10 copay (After deductible)
MRI, CT, and PET scans	$50 copay (After deductible)
Outpatient Surgery	20% Coinsurance (After deductible)
EMERGENCY SERVICES	**STUDENT/SUBSCRIBER PAYS**
Emergency Department visits, (waived if admitted directly to hospital)	20% Coinsurance (After deductible)
Ambulance services	$150 copay (After deductible)
PRESCRIPTIONS[4]	**STUDENT/SUBSCRIBER PAYS**
Generic (Up to a 30-day supply)	$10 copay [4] (Deductible waived)
Brand-name (Up to a 30-day supply)	$30 copay [4] (Deductible waived)
Generic mail order incentive (MOI) (Up to a 100-day supply)	$20 copay (Deductible waived)
Brand-name mail order incentive (MOI) (Up to a 100-day supply)	$60 copay (Deductible waived)
HOSPITAL CARE	**STUDENT/SUBSCRIBER PAYS**
Physician services, room and board, tests, medications, supplies, and therapies	20% Coinsurance (After deductible)
Skilled nursing facility care (up to 100 days)	20% Coinsurance (After deductible)
MENTAL HEALTH SERVICES	**STUDENT/SUBSCRIBER PAYS**
Outpatient visits	$40 copay (for individual therapy, deductible waived) $20 copay (for group therapy, deductible waived)
Inpatient psychiatric hospitalization and intensive psychiatric treatment programs	20% Coinsurance (After deductible)
CHEMICAL DEPENDENCY SERVICES	**STUDENT/SUBSCRIBER PAYS**
Outpatient visits	$40 copay (for individual therapy, deductible waived) $5 copay (for group therapy, deductible waived)
Inpatient detoxification	20% Coinsurance (After deductible)
OTHER	**STUDENT/SUBSCRIBER PAYS**
Certain durable medical equipment (DME)[5]	20% coinsurance (Deductible waived)
Optical (eyewear)	Not covered[6]
Vision exam	No charge (Deductible waived)
Home health care (up to 100 two-hour visits per calendar year)	No Charge (Deductible waived)
Hospice care	No Charge (Deductible waived)

[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] Most 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 discounts will not apply to any sale, promotional, or packaged eye wear program, for any contact lens extended purchase agreement, or to low-vision aids or devices. Visit kp.org/2020 for Kaiser Permanente optical locations.

EXCLUSIONS & LIMITATIONS

The following are the principal exclusions from coverage. See your Evidence of Coverage for the complete list, including details and any exceptions to the exclusions. Also, additional exclusions 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
4. Cosmetic Services, except for Services covered under "Reconstructive Surgery" and "Prosthetic and Orthotic Devices" in the Evidence of Coverage
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. Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Acetype 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 orthokeratologic 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 orders, 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
19. Travel and lodging expenses, except for travel and lodging expenses provided under "Bariatric Surgery" in the Evidence of Coverage
20. Treatment of hair loss or growth

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 that section. Additional limitations that apply only to a particular benefit are listed in the description of that benefit in your Evidence of Coverage.

You may obtain a copy of your Evidence of Coverage (EOC), by calling Wells Fargo Student Insurance at ***800-853-5899***.

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***.

HOW TO FILE A CLAIM

For claims filing requirements or status inquiries, you may contact Kaiser Permanente by calling ***1-800-390-3510***.