WHO IS ELIGIBLE TO ENROLL?

All full time undergraduate students taking 12 units or more will be automatically insured by the plan and will be billed for the annual premium unless proof of coverage is furnished. Students may waive coverage under this plan by completing the online waiver form by August 31,2012.

Insured students must actively attend classes until the add/drop deadline for the term which coverage is purchased, except in the case of 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 Services 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 Services 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 inpatient and outpatient services, even when the newborn is not enrolled in the Plan for 31 days from birth. Coverage may be continued for that child when Wells Fargo Insurance Services 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.***

COST

	ANNUAL	SPRING/SUMMER
Effective Date	8/1/12	1/1/13
Termination Date	7/31/13	7/31/13
Students	$1,650	$ 957
Spouse	$3,539	$2,059
Child(ren)	$2,572	$1,495

IMPORTANT!

This is only a brief overview of the student health plan available to you at your University. For a full description of covered benefits, please visit: ***https://wfis.wellsfargo.com/concordia*** or call the student health insurance broker, Wells Fargo Insurance Services, at ***(800) 853-5899***, Monday-Friday 8:30am to 5:00pm (PST).

NOTE: Prior to enrolling in the health plan, you must have read and understood the full Kaiser Permanente Disclosure Document available online at https://wfis.wellsfargo.com/concordia.

WELLS FARGO INSURANCE SERVICES USA, INC.
PRIVACY POLICY

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. 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 ***https://wfis.wellsfargo.com/concordia***.

PLAN UNDERWRITTEN BY:

Eligibility and Coverage Questions

Kaiser Permanente
(800) 464-4000
www.kp.org

EMERGENCY TRAVEL ASSISTANCE:

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

THE POLICY ADMINISTERED BY:

General Questions

Wells Fargo Insurance Services USA, Inc.
Student Insurance Division
CA License No. 0D08408
(800) 853-5899
https://wfis.wellsfargo.com/concordia

Irvine Medical Center
6640 Alton Parkway
Irvine, CA 92618
(949) 932-5000
Emergency Room Hours of Operation:
24 hours a day, 7 days a week

Barranca Medical Offices
6 Willard
Irvine, CA 92604
(888) 988-2800
Monday & Tuesday, 8:30am - 7:00pm
Wednesday - Friday, 8:30am - 5:00pm

Mission Viejo Medical Offices and Urgent Care
23781 Maquina Avenue
Mission Viejo, CA 92623
(888) 988-2800
Open daily 9:00am - 9:00pm

IMPORTANT NOTICE

This information is a brief description of the important features of the health plan. It is not a contract of coverage. The terms and conditions of coverage are set forth in the contract issued in the state in which the contract was delivered. Complete details may be found in the contract on file at your school's office. The contract is subject to the laws of the state in which it was issued. Please keep this information as a reference.

Student Health Insurance

Concordia University

Domestic & International

2012-2013

wfis.wellsfargo.com/Concordia

Underwritten by:
Kaiser Permanente
Contract # 230629

Brokered by:
Wells Fargo Insurance Services USA, Inc.
Student Insurance Division

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

2012- 2013 BENEFIT SUMMARY	STUDENT/SUBSCRIBER PAYS
Medical calendar-year deductible	$500 Per Insured
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. Transgender surgery
20. Travel and lodging expenses, except for travel and lodging expenses provided under "Bariatric Surgery" in the Evidence of Coverage
21. 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.

This is only a summary of Plan features. Consult the Evidence of Coverage for a more detailed description of Plan features, including benefits, exclusions, and limitations.