



PRUDENT BUYER PLAN AMENDMENT

issued by

**ANTHEM BLUE CROSS LIFE AND HEALTH
INSURANCE COMPANY**

to

SAMUEL MERRITT UNIVERSITY

Anthem Blue Cross Life and Health Insurance Company (“Anthem Blue Cross Life and Health”) agrees to modify your certificate by this amendment. All other provisions of certificate which are not inconsistent with this amendment remain in effect. Officers of Anthem Blue Cross Life and Health have approved this amendment to become effective August 1, 2009.

The name of the *group*, wherever it appears in your Certificate-Booklet and any amendments issued thereunder, is changed from **SAMUEL MERRITT COLLEGE** to **SAMUEL MERRITT UNIVERSITY**.

The following changes are made to **MEDICAL BENEFIT MAXIMUMS** in the **SUMMARY OF BENEFITS: MEDICAL BENEFITS** section:

The **Mental or Nervous Disorders** provision is deleted and replaced by:

Mental or Nervous Disorders

- For covered *facility-based care***30 days**
per *benefit year*
- For *physician* visits during a covered
inpatient stay.....**30 visits**
per *benefit year*
- For covered outpatient *physician* visits**20 visits**
per *benefit year*

The *benefit year* maximum *plan* payment amount applicable to the **Physical Exam (Insured Persons Age 7 and Over)** benefit is deleted and of no further effect.

Benefit Year Maximum

- Domestic *Student* or
• *Family Member* of a Domestic *Student***\$1,000,000**
during an *insured person's* lifetime

- International *Student* or
• *Family Member* of an International *Student***\$1,000,000**
per illness or injury

The following is added to **PRESCRIPTION DRUG CO-PAYMENTS** in the **SUMMARY OF BENEFITS: PRESCRIPTION DRUG BENEFITS** section:

Specialty Pharmacy Drug Prescriptions: The following co-payments apply for a 30-day supply of medication obtained from the specialty pharmacy program.

- *Generic Drugs* **\$10**
- *Brand Name Drugs* **\$20**

The following changes are made to **MEDICAL CARE THAT IS COVERED** in the section **YOUR MEDICAL BENEFITS**:

The **Mental or Nervous Disorders** provision is deleted and replaced by:

Mental or Nervous Disorders. Covered services shown below for the treatment of *mental or nervous disorders*, provided such services offer a reasonable expectation of improvement, and are the lowest level of care consistent with safe medical practice.

1. Inpatient *hospital* services as stated in the "Hospital" provision of this section, services from a *residential treatment center*, and visits to a *day treatment center*. The combined maximum for inpatient *hospital* and *residential treatment center* services and visits to a *day treatment center* will be 30 days during a *year*.
2. *Physician* visits during a covered inpatient *stay* for the treatment *mental or nervous disorders*, up to 30 visits per *year*.

3. *Physician* visits for outpatient psychotherapy or psychological testing or outpatient rehabilitative care (such as physical therapy, occupational therapy, or speech therapy) for the treatment of *mental or nervous disorders*. The combined maximum for all outpatient *physician* visits will be 20 visits during a *year*.

If we apply *covered expense* toward the Benefit Year Deductible and do not provide payment, that day or visit is not included in the maximum for that *year*. However, if we pay any portion of your *covered expense* for a day or visit, it will be counted in the maximum.

Covered services for the treatment of *severe mental disorders* will not be subject to any limitations applicable to *mental or nervous disorders* as shown in the SUMMARY OF BENEFITS and under these "Mental or Nervous Disorders" provisions. Such services will be subject to all other terms, conditions, limitations and exclusions, including applicable Medical Benefit Maximums. Please refer to the DEFINITIONS section for a description of "severe mental disorders".

The **Physical Exam (Insured Persons Age 7 and Over)** provision is deleted and replaced by:

Physical Exam (Insured Persons Age 7 and Over). In addition to any services specified elsewhere in the certificate, we will pay, after any applicable co-payment, for the following services when provided for *insured persons* age 7 and over by *participating providers*. The Benefit Year Deductible will not apply to these services.

1. A *physician's* services for routine physical examinations. You must pay a **\$10** co-payment for each examination.
2. Immunizations given as standard medical practice.
3. Radiology and laboratory services and tests that are ordered by the examining *physician* in connection with a routine physical examination excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the provision "Diagnostic Services".

Services under the Physical Exam benefit are covered only if provided by a *participating provider*. Prostate cancer screenings, cervical cancer screenings including human papillomavirus (HPV) screening, breast cancer screenings, colorectal cancer screenings, and other cancer screenings are not covered under this "Physical Exam" benefit but are covered under the medical care provisions of

this *plan* as described under "Adult Preventive Services", "Breast Cancer" and "Other Cancer Screening Tests", subject to the terms and conditions of this *plan* that apply to those benefits.

The **Adult Preventive Services** provision is deleted and replaced by:

Adult Preventive Services. FDA-approved cancer screenings for cervical cancer, including human papillomavirus (HPV) screening, mammography testing and appropriate screening for breast cancer, prostate cancer screenings, colorectal cancer screenings, and the office visit related to those services. The Benefit Year Deductible will not apply to these services.

The **Other Cancer Screening Tests** provision is deleted and replaced by:

Other Cancer Screening Tests. Services and supplies provided in connection with all generally medically accepted cancer screening tests. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions.

The following provision is added:

HIV Testing. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions.

The following applies to the prior authorization of *prescription drugs* in the section **YOUR PRESCRIPTION DRUG BENEFITS**:

Revoking or modifying a prior authorization. A prior authorization of benefits for *prescription drugs* may be revoked or modified prior to your receiving the *drugs* for reasons including but not limited to the following:

- Your coverage under this *plan* ends;
- The *policy* with the *group* terminates;
- You reach a benefit maximum that applies to *prescription drugs*, if the *plan* includes such a maximum;
- Your *prescription drug* benefits under the *plan* change so that *prescription drugs* are no longer covered or are covered in a different way.

A revocation or modification of a prior authorization of benefits for *prescription drugs* applies only to unfilled portions or remaining refills of the *prescription*, if any, and not to *drugs* you have already received.

The following applies to **THE MEDICAL NECESSITY REVIEW PROCESS** provision in the section **UTILIZATION REVIEW PROGRAM**:

Revoking or modifying an authorization. An authorization for services or care may be revoked or modified prior to the services being rendered for reasons including but not limited to the following:

- Your coverage under this *plan* ends;
- The *policy* with the *group* terminates;
- You reach a benefit maximum that applies to the services in question;
- Your benefits under the *plan* change so that the services in question are no longer covered or are covered in a different way.

The following changes are made to the section **HOW COVERAGE BEGINS AND ENDS**:

Paragraphs (b) and (c) of the definition of “child” under the **Definition of Family Member** are deleted and replaced by the following:

- b. The unmarried child is under 19 years of age, or if age 19 or over, that child is eligible until his or her 25th birthday, provided he or she is enrolled as a full-time student (for 12 or more units or credits) in a properly accredited secondary or post-secondary educational or vocational institution (a college, university, or trade or technical school). Any break in the school calendar will not disqualify a child from coverage under this provision. An unmarried child 19 years of age, but, less than 25 years of age who enters or returns to an eligible status will become eligible for coverage on the first day of the month following the date an enrollment application is filed on their behalf.
- c. The unmarried child is 19 years of age, or more and: (i) was covered under the *prior plan*, or has six or more months of *creditable coverage*, (ii) is chiefly dependent on the *student, spouse or domestic partner* for support and maintenance, and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the

child is incapable of self-sustaining employment due to a physical or mental condition. We must receive the certification, at no expense to us, within 60-days of the date the *student* receives our request. We may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent on the *student, spouse* or *domestic partner* for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

The **Handicapped Children** exception to the provision **HOW COVERAGE ENDS** is deleted and replaced by the following:

- b. **Handicapped Children.** If a *child* reaches the age limits shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *family member* if he or she is (i) covered under this *plan*, (ii) still chiefly dependent on the *insured student, spouse* or *domestic partner* for support and maintenance, and (iii) incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the *child* has a physical or mental condition that makes the *child* incapable of obtaining self-sustaining employment. We will notify the *insured student* that the *child's* coverage will end when the *child* reaches the *plan's* upper age limit at least 90-days prior to the date the *child* reaches that age. The *insured student* must send proof of the *child's* physical or mental condition within 60-days of the date the *insured student* receives our request. If we do not complete our determination of the *child's* continuing eligibility by the date the *child* reaches the *plan's* upper age limit, the *child* will remain covered pending our determination. When a period of two years has passed, we may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the *child* is no longer chiefly dependent on the *insured student, spouse* or *domestic partner* for support and maintenance or a physical or mental condition no longer exists. A *child* is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

The following is added as an additional exception to the provision
HOW COVERAGE ENDS:

- c. **Full time students taking a medical leave of absence from school:** If a *child* who is 19 years of age or more, enrolled as a full-time student (for 12 or more units or credits) in a properly accredited secondary or post-secondary educational or vocational institution (a college, university, or trade or technical school), and covered under this *plan* in accordance with the "Eligible Status" provision of this section, the *child* may remain covered under this *plan* for a period not to exceed 12 months or until the date the *child's* coverage would normally end in accordance with the terms and conditions of this *plan*, whichever comes first, during a medical leave of absence from school. This provision applies if the nature of the *child's* health condition does not meet the requirements of the "Handicapped Children" provision, above. The period of coverage during this medical leave of absence will begin on the first day of the leave or on the date a *physician* determines the *child's* illness, injury, or condition prevented the *child* from attending school, whichever comes first. Any break in the school calendar will not disqualify the *child* from maintaining coverage under this provision. A *physician* must certify in writing that the leave of absence from school is medically necessary. This certification must be submitted to us at least 30 days prior to the date the leave begins if the medical reason for the leave and the leave itself are foreseeable. If the medical reason for the leave and the leave itself are not foreseeable, the certification must be submitted to us within 30 days after the date the leave begins.

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