Berkeley SHIP
student health insurance plan

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2019/2020

DESIGNED EXCLUSIVELY FOR THE DOMESTIC AND INTERNATIONAL STUDENTS OF:

UNIVERSITY OF CALIFORNIA, BERKELEY
Berkeley, CA
("the Policyholder")

Policy Number: CCIC1920CASHIP81
Group Number: W01
Effective: 8/1/2019 – 7/31/2020

UNDERWRITTEN BY:
Commercial Casualty Insurance Company
Fort Wayne, IN
("the Company")

ADMINISTERED BY:
HealthComp
Fresno, CA

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Welcome Students…

We are pleased to provide you with this summary of the 2019–2020 Berkeley Student Health Insurance Plan ("Plan"), which is fully compliant with the Affordable Care Act. "Benefits at a Glance" includes effective dates and costs of coverage, as well as other helpful information. For additional details about the Plan, please consult the Plan Certificate and other materials at http://berkeley.wellfleetinsurance.com/ship For questions about medical benefits or claims, please call Member Services at (833) 302-9785.

This is not the Certificate. Rather, it is a brief description of the benefits and other provisions of the Certificate. The Certificate is governed by the laws and regulations of the state in which it is issued and is subject to any necessary state approvals. Any provisions of the Certificate, as described in this brochure, that may be in conflict with the laws of the state where the school is located will be administered to conform with the requirements of that state's laws, including those relating to mandated benefits.

Where to Find Help

IMPORTANT CONTACTS		
Appointments – Tang Center	**University Health Services** uhs.berkeley.edu /get-health-care Telephone: (510) 642-2000	
Benefits, Referrals and General Questions	**Berkeley SHIP Office** **ship@berkeley.edu** Telephone: (510) 642-5700 M-F 8:00 a.m.- 4:45 p.m. PST, except Wednesdays 9:30 a.m.- 4:45 p.m. PST www.uhs.berkeley.edu/insurance	*A referral from the Berkeley SHIP Office is required for most services outside University Health Services. UHS (aka Tang Center) is your primary care provider (PCP). Your PCP coordinates your care and facilitates your referrals*
Benefits and Claims Questions	**Wellfleet Member Services** Telephone: (833) 302-9785 M-F 6:00 a.m.- 5:00 p.m. PST http://berkeley.wellfleetinsurance.com/ship	
Eligibility and Enrollment	**Academic HealthPlans (AHP)** Telephone: (855) 854-3254 M-F 8:00 a.m.- 5:00 p.m. PST Fax: (855) 858-1964	**Plan Brokered By** Academic HealthPlans (AHP) CA License No 0H64806
Pharmacy Benefits Manager	**Wellfleet Rx** Telephone: (888) 265-7884 Customer Service hours: 24/7 Pre-authorization hours: M-F 5:00 a.m.- 2:00 p.m. PST	
Find a Preferred Provider	**Wellfleet Providers** (833) 302-9785 http://berkeley.wellfleetinsurance.com/providers M-F 6:00 a.m.- 5:00 p.m. PST	
24-Hour SHIP Nurse Line **24-Hour Teladoc** **24-Hour Travel Assistance**	Telephone: (800) 681-4065 Telephone: (800) 835-2362 Travel Guard: Toll-free: (877) 283-1226 Collect: (715) 342-2431	24/7 Advice Nurse 24/7 Appointments with an MD 24/7 Travel helpline when out of the Bay area

When Coverage Begins

Insurance takes effect on the effective date at 12:00 a.m. local time at the Policyholder's address.
Your coverage under the Plan will become effective at 12:00 a.m. on the later of:

- The Policy effective date;
- The beginning date of the term of coverage for which premium has been paid.

IMPORTANT NOTICE - Premiums will not be pro-rated if you enroll past the waiver/enrollment deadline date for the term of coverage for which you are applying.

When Coverage Ends

Insurance terminates at 11:59 p.m. local time at the Policyholder's address. Your insurance will terminate at 11:59 p.m. on the earliest of:

- Date the Policy terminates; or
- End of the period of coverage for which premium has been paid; or

- The date the Insured Person ceases to be eligible for the insurance; or
- Date the Insured Person enters military service.

Your dependent may become eligible for coverage under the Plan only when you become eligible; or within 60 days of a qualifying life event. Dependent coverage will not be effective prior to that of the insured student or extend beyond that of the insured student.

Extension of Benefits

Coverage under the Plan ceases on the Termination Date of your insurance coverage. However, the Company will extend coverage for you as follows:
If you are Hospital Confined for a Covered Injury or Covered Sickness and under a Physician's care on the date your insurance coverage terminates, we will continue to pay benefits until the earliest of: (1) the date the Hospital Confinement ends; or (2) the end of the 30 day period following the date your coverage terminated.

Dependents that are newly acquired during your Extension of Benefits period are not eligible for benefits under this provision.

Premium Refund/Cancellation

Refund requests should be directed to Academic HealthPlans (AHP) at (**855) 854-3254** or via email at **berkeley@myahpcare.com**. A refund of premium will be considered for the reasons listed below only. No other refunds will be granted.

If an insured student or the insured student's dependent enters the Armed Forces of any country, the insured student or the insured student's dependent will not be covered under the Plan as of the date of such entry. If the insured student enters the Armed Forces of any country, coverage for the student and the insured student's dependent(s) will be terminated as of the date of entry into the service. If the insured student's dependent enters the armed forces of any country, coverage for the dependent will terminate as of the date of such entry. A pro rata refund of premium will be made for such person upon written request received by AHP within **45 days** of entry into service.

How Do I Waive?

All eligible registered full time domestic and international students will be automatically enrolled in the Berkeley Student Health Insurance Plan (SHIP) unless an online waiver has been submitted and approved, by the specified waiver deadline dates listed on page 6 of the "Benefits at a Glance." Registered eligible students may provide evidence of health coverage through another plan and request a waiver of Berkeley SHIP. The coverage must meet the criteria established by University of California, Berkeley. To complete an online waiver, please visit:
https://uhs.berkeley.edu/insurance/waiving-ship

Waiver applications are completed during the fall semester waiver period. The fall semester waiver will be valid for the full academic year. A student who waives Berkeley SHIP in the fall will not be required to complete another waiver for the spring semester. However, a spring waiver is available for students registering for the first time in the spring, or who did not waive enrollment in a prior term but wants to waive for the spring term. A spring semester waiver is valid for the remainder of the academic year. A new waiver must be completed and approved during the fall waiver period prior to each academic year that the eligible student is registered. UC Berkeley will audit waiver submissions and has sole discretion on determining whether a plan meets the waiver criteria at any given time.

ID Cards

You will receive a copy of your ID Card in conjunction with your SHIP Welcome kit which will arrive shortly after enrollment. You will also have access to an electronic version of your ID card at My SHIP Online. By accessing your digital ID card, you don't have to keep the plastic version in your wallet anymore. If your ID card is lost/stolen, simply pull it up on your computer or mobile device at: http://berkeley.wellfleetinsurance.com/ship.

To register for My SHIP Online simply click the "Sign Up" in the top right-hand corner of the screen and you will be guided through the Sign-Up process. In My SHIP Online you will be able to:

- View your ID card
- Print out a copy of your ID card
- Email your card to yourself and/or a provider
- View and submit claims
- Find an in-network provider

If you happen to misplace your physical ID Card and still require assistance, please call Member Services at (833) 302-9785 and a replacement card will be sent to you.

University Health Services

University Health Services, AKA the Tang Center, is a comprehensive outpatient health center that provides on campus medical, behavioral health, and preventive care. The Tang Center is staffed by board-certified physicians, nurse practitioners, physician assistants, and nurses, who are experts in student health needs. Tang Center clinicians provide primary care for Berkeley SHIP students and coordinate any needed additional care. All registered students may use the services of Tang Center, regardless of their medical insurance. Many services are offered at a reduced price to students.

Visit the Tang Center website at **www.uhs.berkeley.edu** or call (510) 642-2000 for more information on hours of operation, available services and fees. Counseling and Psychological Services can be reached at (510) 642-9494.

- In the event of an emergency, go to the nearest hospital emergency department or call 911 (on-campus or off-campus) if an ambulance is needed. The closest hospital emergency room to campus is Alta Bates Hospital, 2450 Ashby Avenue (east of Telegraph Avenue).
- When Tang Center is open: Visit Urgent Care at Tang Center.
- When Tang Center is closed: Call the 24/7 NurseLine at (800) 681-4065 or use Teladoc services at (800) 835-2362 or visit www.teladoc.com.

Where Do I Go For Services?

University Health Services or UHS (AKA the Tang Center) is your primary care provider (PCP). Your PCP coordinates your care, facilitates referrals, and acts as your health care advocate. **All care with the exception of medical emergencies and some other specific services (see below for exception details) must be coordinated through UHS.**

You can access care at the Tang Center through in person appointments, advice nurse, appointment office, or Urgent Care center to coordinate your care.

Exceptions to referral requirement:

1. Emergency Medical Condition or Urgent Care.
2. Services outside the country.
3. Certain women's health services including pregnancy and maternity care.
4. Certain preventive and well visit services.

With the exception of the above services, a referral from Tang Center is required for all non-emergency services performed outside of the Tang Center prior to receiving treatment outside of the Tang Center. If a referral is not obtained prior to treatment, benefits are not payable.

The Preferred Provider Organization (PPO) network allows Insured Persons easy access to a wide range of medical providers. Insured Persons have the option to receive care from a provider who is not participating in the PPO network. The trade-off is higher out-of-pocket expenses. Participating providers (PPO Providers) agree to provide services to Insured Persons at discounted rates as payment in full. This is the incentive for Insured Persons to use PPO providers and protects them from being balance-billed (except for coinsurance, copayments and deductible amounts). Providers working within a PPO facility (example: a hospital) may not always be PPO providers. **You should request all of your provider services be performed by a PPO Provider when you use a PPO facility.** When Non-PPO providers are used, you may be subject to higher out-of-pocket expenses.

Additionally, PPO physicians agree to admit their patients to network hospitals, guaranteeing discounted charges and utilization management savings will occur.
With no claim forms to file, Insured Persons can focus on their health, not paperwork.

Insured Persons can find a PPO physician in their area by calling Member Services at (833) 302-9785 or by accessing the "Find a Doctor" link on http://berkeley.wellfleetinsurance.com/ship/providers**.**

How much does it cost?

Rates include premium payable to the Company, MetLife, and VSP, as well as administrative fees payable to UC Berkeley and AHP.

REGISTERED UNDERGRADUATES		
	FALL 8/1/19 - 12/31/19	**SPRING/SUMMER 1/1/20 - 7/31/20**
Waiver Start Date	5/1/19	12/2/19
Waiver Deadline Without Fee	7/15/19	1/1/20
Final Waiver Deadline	8/15/19	1/15/20
Student only	$1,643.00	$1,643.00
NOTE: Costs below are in addition to the student premium. Dependent enrollment in this plan is voluntary.		
Dependent Enrollment Start Date	7/15/19	12/2/19
Dependent Enrollment End Date	9/15/19	2/1/20
Spouse only	$1,643.00	$1,643.00
One Child Age 0-25 only	$1,643.00	$1,643.00
Two or More Children Age 0-25 only	$3,181.00	$3,181.00

VOLUNTARY UNDERGRADUATES (CONCURRENT ENROLLMENT)		
	FALL 8/1/19 - 12/31/19	**SPRING/SUMMER 1/1/20 - 7/31/20**
Enrollment Start Date	7/15/19	12/2/19
Enrollment End Date	9/15/19	2/1/20
Student only	$1,643.00	$1,643.00
NOTE: Costs below are in addition to the student premium. Dependent enrollment in this plan is voluntary.		
Spouse only	$1,643.00	$1,643.00
One Child Age 0-25 only	$1,643.00	$1,643.00
Two or More Children Age 0-25 only	$3,181.00	$3,181.00

For more information on the cost to add dependents, please contact AHP Customer Care by phone (**855) 854-3254** or by email **berkeley@myahpcare.com**.

REGISTERED GRADUATES		
	FALL 8/1/19 - 12/31/19	**SPRING/SUMMER 1/1/20 - 7/31/20**
Waiver Start Date	5/1/19	12/2/19
Waiver Deadline Without Fee	7/15/19	1/1/20
Final Waiver Deadline	8/15/19	1/15/20
Student only	$2,620.00	$2,620.00
NOTE: Costs below are in addition to the student premium. Dependent enrollment in this plan is voluntary.		
Dependent Enrollment Start Date	7/15/19	12/2/19
Dependent Enrollment End Date	9/15/19	2/1/20
Spouse only	$2,620.00	$2,620.00
One Child Age 0-25 only	$2,620.00	$2,620.00
Two or More Children Age 0-25 only	$5,106.00	$5,106.00

VOLUNTARY GRADUATES (FILING FEE)		
	FALL 8/1/19 - 12/31/19	**SPRING/SUMMER 1/1/20- 7/31/20**
Enrollment Start Date	7/15/19	12/2/19
Enrollment End Date	9/15/19	2/1/20
Student only	$2,620.00	$2,620.00
NOTE: Costs below are in addition to the student premium. Dependent enrollment in this plan is voluntary.		
Spouse only	$2,620.00	$2,620.00
One Child Age 0-25 only	$2,620.00	$2,620.00
Two or More Children Age 0-25 only	$5,106.00	$5,106.00

For more information on the cost to add dependents, please contact AHP Customer Care by phone (**855) 854-3254** or by email ***berkeley@myahpcare.com***.

**Please note waiver periods may be different for undergraduate and graduate programs on special insurance cycles. For more information on these programs and their waiver dates, please contact the Berkeley SHIP Office at (510) 642-5700 or ship@berkeley.edu*

Eligibility

Hard Waiver Mandatory Enrollments
The following eligible students will automatically be enrolled in this Plan unless an approved online Waiver Form has been received by the University by the specified waiver deadline dates listed in the "How Much Does It Cost" section of the "Benefits at a Glance."

- All eligible registered domestic and international undergraduate and graduate students of the University of California Berkeley including eligible students who are registered-in-absentia. Note: An eligible student may waive enrollment in the Plan during the specified waiver period by meeting the University's waiver policies and providing proof of other coverage. A waiver is effective for one academic year and must be completed and approved again during the waiver period at the start of each fall term of the academic year. Waiver requests for each academic term within a year are also available. Information about waiving enrollment in the Plan may be obtained from the Student Health Insurance Plan Office at: **www.uhs.berkeley.edu/insurance**.

Voluntary Enrollments
The following classes of eligible students may enroll in the UC Berkeley SHIP on a voluntary basis directly with Academic HealthPlans (AHP) by the specified enrollment deadline dates listed in the "How Much Does It Cost" section of the "Benefits at a Glance." For voluntary enrollment, visit: https://uhs.berkeley.edu/insurance/ship-non-registered-students.

- All non-registered "Filing Fee" status graduate students of the University of California Berkeley who are completing work under the auspices of the University of California Berkeley but are not attending classes. Students on Filing Fee status may purchase Plan coverage for a maximum of one semester by calling SHIP at (510) 642-5700. An eligible student must have been covered by SHIP in the term immediately preceding the term the student wants to purchase.
- All non-registered Concurrent Enrollment status undergraduate students of the University of California Berkeley may purchase Plan coverage for a maximum of one semester by calling SHIP at (510) 642-5700. An eligible student must have been covered by SHIP in the term immediately preceding the term the student wants to purchase.

To be an Insured Person under the Plan, the student must have paid the required premium and his/her name, student number and date of birth must have been included in the declaration made by UC Berkeley or AHP to the Company.

Hard Waiver Mandatory and Voluntary Enrollments
Except in the case of medical withdrawal from school due to sickness or injury, any student who cancels enrollment or withdraws from UC Berkeley prior to attending at least the first day of classes for the period for which he or she is enrolled shall not be covered under the insurance plan. A student who graduates or withdraws after attending the first day of classes for the period for which he or she is enrolled will remain covered under the Plan for the term purchased and no refund will be allowed. For additional information, please contact AHP at (855) 854-3254.

The Company and AHP maintain the right to investigate student eligibility status and attendance records to verify that the Plan's eligibility requirements have been met. If and whenever the Company and/or AHP discover the eligibility requirements have not been met, the Company's only obligation is a refund of premium less any claims paid.

Eligible students who involuntarily lose coverage under another health insurance plan are also eligible to purchase the Student Health Insurance Plan. These students must provide UC Berkeley with proof they have lost insurance through another health insurance plan (certificate and letter of ineligibility) within **60 days** of the qualifying event **The effective date of your coverage will be the later of the following dates: (1) the Policy effective date; (2) the day after the date for which you lose your coverage providing premium for your coverage has been paid; (3) the date UC Berkeley's term of coverage begins; or (4) the date you become a member of an eligible class of persons.** Premium will not be prorated.

Medical Leave of Absence
A student withdrawing due to a University approved medical leave due to a Sickness or Injury may be eligible to continue coverage under the Plan for himself/herself and his or her previously insured dependents for one semester with the payment of any required premium. To be eligible, the student must have been enrolled in the UC Berkeley SHIP the semester immediately preceding the semester for which he or she is withdrawing due to a Sickness or Injury. The student must submit documentation or certification of the medical withdrawal and payment of any required premium must be made to AHP at least 30 days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable, or 30 days after the date of the medical leave from school.

Please contact the Berkeley SHIP Office at (510) 642-5700 or ship@berkeley.edu for more details.

Dependent Coverage
Note: Dependent enrollment in this plan is voluntary. Eligible students, including those who enroll in the Plan on a voluntary basis, may also enroll their eligible dependents. Dependents may only be enrolled at the time of the student's enrollment in the Plan; or within **60 days** of qualifying life event.

Eligible dependents are the insured student's lawful spouse, or domestic partner who resides with the insured student, and the insured student's, the spouse's, or the domestic partner's dependent biological or adopted child or stepchild under 26 years of age. To enroll your domestic partner, a Declaration of Domestic Partnership issued by the State of California; or proof of a same sex legal union other than marriage formed in another jurisdiction; or a completed Declaration of Domestic Partnership form issued by University Health Services is necessary. A "Newborn" will automatically be covered from the moment of birth. Such newborn child will be covered for medically necessary health care services for an initial period of **31 days** OR until the insured student's coverage terminates, if earlier. Coverage of a newborn may be continued beyond this initial 31 day period by notifying AHP 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 is enrolled. Dependent coverage expires concurrently with that of the insured student and dependents must re-enroll when coverage terminates to maintain coverage.

Dependents must be re-enrolled each term. It is the student's responsibility to contact AHP prior to the enrollment deadline date listed in the "Benefits at a Glance." To enroll your eligible dependent(s), you must call AHP Customer Care Unit at (855) 854-3254 or go to: https://uhs.berkeley.edu/insurance/insurance-dependents.

Prescription Drug Benefits

To fill a prescription, take your prescription to a participating pharmacy and present your member ID card. The amount you pay for a covered prescription – your copayment – will be determined by the tier of the drug under the formulary. Higher tiers are associated with higher copays. Generic drug means a drug that is the same as its brand name drug equivalent in dosage, strength, effect, how it is taken, quality, safety, and intended use. Brand name drugs are marketed under a proprietary, trademark-protected name. Tier 1 drugs are preferred generic drugs. Tier 2 drugs are preferred brand name drugs and high cost generics. Tier 3 drugs are non-preferred drugs. Some formulary drugs have coverage requirements and limits, such as prior authorization, quantity limits, and step therapy. Drugs identified as specialty drugs have a higher copay associated with them. The formulary is available online at https://uhs.berkeley.edu/insurance/ship-benefits/prescriptions**.** You or your provider may also contact Member Services at (833) 302-9785.

A general description of what is covered under your Prescription Drug Benefit is listed below. Coverage is subject to the requirements and limits indicated in the formulary.

- Outpatient prescription drugs and medications which the law restricts to sale by prescription.
- Formulas prescribed by a physician for the treatment of phenylketonuria.
- Insulin, insulin syringes, and diabetic supplies, such as blood glucose test strips, lancets, and glucometers.
- Prescription contraceptives; including oral contraceptives, diaphragms, and patches. Contraceptives may be covered as preventive care services at no copay and are noted as $0 under the drug tier in the formulary.
- Self-administered injectable drugs as labeled by the Food and Drug Administration (FDA).
- Certain compound drugs that contain at least one covered prescription ingredient.
- Prescription drugs for treatment of impotence and/or sexual dysfunction.
- Inhaler spacers and peak flow meters.

Prescription drug copayments apply toward the Policy Year Out-of-Pocket Maximums.

Covered Services (outpatient prescriptions only)	**Per Member Copay** for Each Prescription or Refill		
Tang Pharmacy or Retail Participating Pharmacy Preventive immunizations administered by a participating retail pharmacy and certain prescription contraceptives are covered at no charge. The Deductible does not apply to outpatient prescription drugs.	**Tang Center** Tier 1: no Copay Tier 2[1]: $25 Copay Tier 3: $40 Copay Specialty drugs: $75 Copay	**Participating Retail** Tier 1: $10 Copay Tier 2: $35 Copay Tier 3: $50 Copay Specialty drugs: 20% up to $250 Copay	**Non-Participating Retail** Tier 1: $10 Copay; then 50% up to $250 Copay plus all charges in excess of the participating pharmacy's negotiated charge Tier 2: $35 Copay; then 50% up to $250 Copay plus all charges in excess of the participating pharmacy's negotiated charge Tier 3: $50 Copay; then 50% up to $250 Copay plus all charges in excess of the participating pharmacy's negotiated charge Specialty drugs: 50% up to $250 Copay plus all charges in excess of the participating pharmacy's negotiated charge
Supply Limits - Retail Pharmacy	Prescription drugs are limited to a 30-day supply, except where provided for by federal or CA state law or regulation		

[1] Dispense as Written: If a prescriber prescribes a covered brand name drug where a generic drug equivalent is available and specifies: "Dispense as Written" (DAW), You will pay the copayment for the brand name drug. If a prescriber does not specify DAW and you request a covered brand name drug where a generic drug equivalent is available, you will be responsible for the cost difference between the brand name drug and the generic drug equivalent, and the copayment that applies to brand name drugs.

How the Student Health Insurance Plan Works

In addition to coinsurance and copayments, insured persons are responsible for deductibles, as described in the Schedule of Benefits below. Please review the deductible information to know if a deductible applies to a specific covered service. Insured persons who elects to use an Out-of-Network Provider are also responsible for all costs over the usual and customary charge.

Certain covered services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your deductible has been met.

Benefits are subject to all terms, conditions, limitations, and exclusions of the Plan.

Referral Requirements

University Health Services or UHS (AKA the Tang Center) is your primary care provider (PCP). Your PCP coordinates your care, facilitates referrals, and acts as your health care advocate.

All care with the exception of medical emergencies and some other specific services (see below for exception details) must be coordinated through UHS. You can access care at Tang through in person appointments, Tang advice nurse, Tang appointment office, or Tang Urgent Care center to coordinate your care. Exceptions:

- Emergency Room or Urgent Care
- Services outside the country
- Certain women's health services including pregnancy and maternity care
- Certain preventative and well visit services

A referral is required even when University Health Services is closed, when the student is away from campus or during school holidays and breaks.

Preferred Provider Organization

If you use an In-Network Provider, you will pay the coinsurance percentage of the negotiated charge for covered medical expenses shown in the Schedule of Benefits below for covered medical expenses.

If an Out-of-Network Provider is used, you will pay the percentage of the usual and customary charge for covered medical expenses shown in the Schedule of Benefits below. The difference between the provider fee and the coinsurance amount paid by the Company will be your responsibility.

Note, however, that the Company will pay at the In-Network level for treatment by an Out-of-Network Provider and will calculate your cost sharing amount at the In-Network Provider level if:

1. There is no In-Network Provider within a 25-mile radius of the service area available to treat you for a specific covered injury or covered sickness; or
2. There is an emergency medical condition and you cannot reasonably reach an In-Network Provider; or
3. You receive non-emergency covered services at an In-Network Provider facility (hospital, an ambulatory surgery or other outpatient facility, laboratory, radiology or imaging center) at which, or as a result of which, you also receive covered services provided by an Out-of-Network Provider (surgeon, anesthesiologist, x-ray technician, etc.) Unless you consent in writing to receive services from the Out-of-Network Provider at least 24 hours in advance of the covered services, the Out-of-Network Provider is prohibited from billing or collecting any amount beyond what you would have owed had the provider been In-Network. Additionally, the Out-of-Network Provider must give you a written estimate of total Out-of-Pocket costs for the covered service at the time consent is provided.

Please note, the Preferred Provider Organization for Berkeley SHIP is Blue Shield of California within the State of California and Cigna outside of California.

Medical Benefit Payments for In-Network Providers and Out-of-Network Providers

The Plan provides benefits based on the type of health care provider you and your covered dependent selects. The Plan provides access to both In-Network Providers and Out-of-Network Providers. Different benefits may be payable for covered medical expenses rendered by In-Network Providers versus Out-of-Network Providers, as shown in the Schedule of Benefits below.

Schedule of Benefits

Policy Year Deductible (other than Pediatric Dental Care): $300 Individual/$900Family
Pediatric Dental Care Deductible: $60 Individual/$180 Family

The Deductible is waived if covered medical expenses are incurred at the Tang Center.

Hospital Inpatient Facility Copayment:
In-Network Provider: $250 per hospital admission
Out-of-Network Provider: $500 per hospital admission
Emergency Services Copayment: $250 per visit (waived if admitted)

Policy Year Out-of-Pocket Maximum:
For other than Pediatric Dental Care:
In-Network Provider/Tang Center combined: $3,200 Individual/$6,400 Family
Out-of-Network Provider (not combined): $6,500 Individual/$13,000 Family

For Pediatric Dental Care – In-Network and Out-of-Network combined: $1,000 Individual/$2,000 Family

The Out-of-Pocket Maximum is the amount of covered medical expenses you have to incur before covered medical expense will be paid at 100% for the reminder of the Policy Year subject to any benefit maximums or limits that may apply. Any applicable coinsurance amounts, deductibles and copayments will apply toward the Out-of-Pocket Maximum. Services that are not covered medical expenses, certain non-essential benefits, balance-billed charges and premium do not count toward meeting the Out-of-Pocket Maximum.

The combined Out of Pocket Maximums for all covered medical expenses you incur will never exceed the maximum amount permitted by law.

Policy Year Maximum: Unlimited

The Covered Medical Expense Below Will Be:

1. **Determined by whether the service or treatment is provided by an IN-NETWORK or OUT-OF-NETWORK provider;**
2. **Unless otherwise specified, the Policy Year Deductible will always apply; and**
3. **Unless otherwise specified, any day or visit limits will be applied to IN-NETWORK and OUT-OF-NETWORK combined.**

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING
Hospital Care		
Inpatient hospital room & board expenses, subject to semi-private room rate unless intensive care unit is required, and miscellaneous services and supplies *Pre-Certification Required*	$250 Copayment per admission then 10% of the Negotiated Charge	$500 Copayment per admission then 50% of Usual and Customary Charge
Outpatient surgery facility and miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma *Pre-Certification Required*	10% of the Negotiated Charge	50% of Usual and Customary Charge

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING
Physician's Visits		
While confined in a hospital or skilled nursing facility	10% of the Negotiated Charge	50% of Usual and Customary Charge
Physician's Office or Home Visits *Referral Required*	$15 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Telemedicine or Telehealth Services	$15 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Specialist/Consultant Physician Services *Referral Required*	$25 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Retail Health Clinics *Referral Required*	$15 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Allergy Testing and Treatment *Referral Required*	10% of the Negotiated Charge	50% of Usual and Customary Charge
Inpatient or Outpatient Surgery *Pre-Certification and Referral Required*		
Surgeon Services	10% of the Negotiated Charge	50% of Usual and Customary Charge
Anesthetist	10% of the Negotiated Charge	50% of Usual and Customary Charge
Assistant Surgeon	10% of the Negotiated Charge	50% of Usual and Customary Charge
Skilled Nursing Facility Benefit		
Limited to 100 days per benefit period. (This limitation does not apply to Mental Health Disorder or Substance Use Disorder Benefits) *Pre-Certification Required*	$250 Copayment per admission then 10% of the Negotiated Charge	$500 Copayment per admission then 50% of Usual and Customary Charge

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING
Preventive Services mandated by the Patient Protection and Affordable Care Act including, but not limited to, physical exams, preventive screenings, (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision), immunizations, health education, intervention services and HIV testing. This is not an exhaustive list. *Referral Required for most services*	0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Inpatient Rehabilitation Facility Expense Benefit *Pre-Certification Required*	$250 Copayment per admission then 10% of the Negotiated Charge	$500 Copayment per admission then the plan pays 50% of Usual and Customary Charge
Autologous Blood Banking (self-donated blood collection, testing, processing & storage for planned surgery)	10% of the Negotiated Charge	10% of Usual and Customary Charge
Rehabilitation Therapy and Habilitative Services including, Physical Therapy, Occupational Therapy and Speech Therapy; Cardiac Rehabilitation and Pulmonary Rehabilitation *Pre-Certification required after the 12th visit and Referral Required*	$15 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Emergency Services & supplies rendered in a Hospital Emergency Room	$250 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived) Copayment waived if admitted	Paid the same as IN-NETWORK Provider subject to Usual and Customary Charge
Urgent Care Centers	$50 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived) If Urgent Care at Tang Center, $35 Copayment per visit (Deductible Waived)	50% of Usual and Customary Charge
Laboratory Procedures (Outpatient)	10% of the Negotiated Charge	50% of Usual and Customary Charge
Diagnostic Imaging Services, CT Scan, MRI and/or PET Scans (Outpatient) *Pre-Certification required for certain services.*	10% of the Negotiated Charge	50% of Usual and Customary Charge
Chemotherapy and Radiation Therapy *Referral Required*	10% of the Negotiated Charge	50% of Usual and Customary Charge

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING
Infusion Therapy Includes medication, ancillary services and supplies, caregiver training, durable medical equipment, and laboratory services. *Pre-Certification and Referral Required*	10% of the Negotiated Charge	50% of Usual and Customary Charge
Home Health Care Expenses Limited to 100 visits per Policy Year. (This limitation applies separately to Rehabilitation Services and Habilitative Services.) A visit of 4 hours or less by a home health aide shall be considered as one home health care visit. *Pre-Certification and Referral Required*	10% of the Negotiated Charge	50% of Usual and Customary Charge
Hospice Care Coverage Inpatient or Outpatient care during the final stages of a terminal illness and during the bereavement	0% of the Negotiated Charge	0% of Usual and Customary Charge
Treatment for Mental Health Disorder, Substance Use Disorder including Gender Dysphoria and Behavioral Health Treatment for Pervasive Developmental Disorder or Autism: **Inpatient Benefits** *Pre-Certification Required*		
Hospital Expenses including Inpatient Psychiatric Hospitals and Residential Treatment Centers	$250 Copayment per admission then 10% of the Negotiated Charge	$500 Copayment per admission then 50% of Usual and Customary Charge
Physician's Visits while Confined	10% of the Negotiated Charge	50% of Usual and Customary Charge

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING
Treatment for Mental Health Disorder, Substance Use Disorder including Gender Dysphoria and Behavioral Health Treatment for Pervasive Developmental Disorder or Autism: **Outpatient Benefits**		
Physician's Office Visits (including but not limited to: physician visits, individual and group therapy, hormone therapy, medication management) *Referral Required.*	$15 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
All other outpatient services including but not limited to: Intensive Outpatient Programs; Partial Hospitalization, Electronic Convulsive Therapy, Repetitive Transcranial Magnetic Stimulation (rTMS); Psychiatric and Neuro Psychiatric testing The Deductible is waived for Psycho-educational Testing. *Referral Required.*	10% of the Negotiated Charge	50% of Usual and Customary Charge
Ambulance Services		
Ambulance Service ground and/or air, water transportation	10% of the Actual Charge (Deductible Waived)	
Bariatric Surgery		
Bariatric Surgery *Pre-Certification and Referral Required*	10% of the Negotiated Charge when performed at a hospital or ambulatory surgical facility that is designated as a Bariatric Surgery Center of Excellence.	When performed at a facility in one of the 9 designated Southern California Counties that is not designated as a Bariatric Surgery Center of Excellence, not covered When performed at a facility located outside the 9 designated Southern California Counties, 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses **Designated Southern California counties**: Imperial, Kern, Los Angeles, Orange Riverside, San Bernardino, San Diego, Santa Barbara, Ventura
Bariatric Surgery Travel Expenses (recipient and companion transportation) provided in connection with a covered bariatric surgical procedure when your home is 50 miles or more from the nearest facility designated as a Bariatric Surgery Center of Excellence. All travel expenses must be authorized in advance.	0% of Actual Charge up to $3,000 maximum per surgery (Deductible Waived)	Not covered

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING
Diabetic services and supplies (including equipment and training)		
Self-management training and education Referral Required Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	$15 Copayment per Visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Other diabetic services, supplies and equipment Referral Required Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	10% of the Negotiated Charge	50% of Usual and Customary Charge
Maternity Benefit: **Inpatient Benefits**		
Hospital Expenses	$250 Copayment per admission then 10% of the Negotiated Charge	$500 Copayment per admission then 50% of Usual and Customary Charge
Physician's Visits while Confined	10% of the Negotiated Charge	50% of Usual and Customary Charge
Maternity Benefit: **Outpatient Benefits**		
Physician's Office Visits *Referral Required*	$15 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Prenatal services and first postnatal visit covered; breastfeeding support, supplies, and counseling, including breast pumps. Coverage of breast pumps is limited to one breast pump per pregnancy or as required by law. *Referral Required*	0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
All other outpatient services *Referral Required*	10% of the Negotiated Charge	50% of Usual and Customary Charge
Non-emergency Care While Traveling Outside of the United States: **Inpatient Benefits:**		
Hospital Expenses	$250 Copayment per admission then 10% of Actual Charge	
Physician's Visits while Confined	10% of Actual Charge	

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING
Non-emergency Care While Traveling Outside of the United States: **Outpatient Benefits:**		
Physician's Office Visits	$15 Copayment per visit then 0% of the Actual Charge (Deductible Waived)	
Specialist/Consultant Physician Services	$25 Copayment per visit then 0% of the Actual Charge (Deductible Waived)	
All other outpatient services	10% of the Actual Charge	
Durable Medical Equipment, Prosthetics & Orthotic Devices		
Durable Medical Equipment and Prosthetic and Orthotic Devices Including, but not limited to, breast protheses, prosthetic devices to restore a method of speaking, internally implanted devices, artificial limbs or eyes, therapeutic shoes and inserts for insured persons with diabetes; hearing aids (limited to 1 hearing aid per ear every 3 years), rental or purchase of dialysis equipment & supplies,) *Pre-Certification and Referral Required*	10% of the Negotiated Charge	50% of Usual and Customary Charge
Pediatric Dental & Vision Care		
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19). See the Pediatric Dental Care Benefit description in the Certificate for further information.		
Diagnostic and Preventive Dental Care	0% of Usual and Customary Charge (Deductible Waived)	
Basic Restorative Care	30% of Usual and Customary Charge after satisfaction of the Pediatric Dental Care Deductible.	
Major Restorative Care	30% of Usual and Customary Charge after satisfaction of the Pediatric Dental Care Deductible.	
Orthodontic Services (Medically Necessary)	30% of Usual and Customary Charge after satisfaction of the Pediatric Dental Care Deductible.	
Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19) Routine Eye Exam and one pair of glasses or contact lenses (in lieu of eyeglasses) per Policy Year	0% of Usual and Customary Charge (Deductible Waived) See the Pediatric Vision Care Benefit description in the Certificate for further information.	

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING
Abortion Expense: **Inpatient Benefits**		
Hospital Expenses	0% of the Negotiated Charge (Deductible Waived)	$500 Copayment per admission, then 50% of Usual and Customary Charge
Physician's Visits while Confined	0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Abortion Expense: **Outpatient Benefits**		
Physician's Office Visits *Referral Required*	0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
All other outpatient services *Referral Required*	0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Acupuncture		
Acupuncture Expense Benefit (Medically Necessary Treatment only) *Pre-Certification required after the 12th visit and Referral Required*	$25 Copayment per visit then 0% of Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Chiropractic Care		
Chiropractic Care Benefit *Pre-Certification required after the 12th visit and Referral Required*	$25 Copayment per visit then 0% of Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Transgender Services: **Inpatient Benefits** *Referral Required and/or Pre-Certification Required*		
Transgender Services Benefits Coverage includes, but is not limited to, medically necessary services related to gender transition such as gender reassignment surgery, hormone therapy, vocal training, electrolysis, and laser hair removal.		
Hospital Expenses *Referral Required and/or Pre-Certification Required*	$250 Copayment per admission then 10% of the Negotiated Charge	$500 Copayment per admission then 50% of Usual and Customary Charge
Physician's Visits while Confined	10% of the Negotiated Charge	50% of Usual and Customary Charge
Transgender Services: **Outpatient Benefits**		
Outpatient Surgery	10% of the Negotiated Charge	50% of Usual and Customary Charge
Specialist/Consultant Physician Services	$25 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
All other outpatient services	10% of the Negotiated Charge	50% of Usual and Customary Charge
Transgender Services Benefit Travel Expenses (Must be authorized in advance.)	0% of Actual Charge up to $10,000 maximum per surgery or series of surgical stages (Deductible Waived)	

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING
Fertility Preservation		
Fertility Preservation Expense (When medically necessary due to a need for medical treatment that may directly or indirectly cause infertility. Includes annual storage costs while insured on Plan) Benefits, other than outpatient prescription drugs, are limited to a maximum of $20,000 per lifetime. This benefit does not provide any coverage for the testing or treatment of infertility.		
Consultation *Pre-Certification Required*	$25 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Treatment *Pre-Certification Required*	$250 Copayment per round of treatment then 10% of the Negotiated Charge	$250 Copayment per round of treatment then 50% of Usual and Customary Charge
Organ and Tissue Transplant Surgery: **Inpatient Benefits** *Pre-Certification Required*		
Hospital Expenses	$250 Copayment per admission then 10% of the Negotiated Charge	$500 Copayment per admission then 50% of Usual and Customary Charge
Physician's Visits while Confined	10% of the Negotiated Charge	50% of Usual and Customary Charge
Organ and Tissue Transplant Surgery: **Outpatient Benefits** *Pre-Certification Required*		
Physician's Office Visits	$15 Copayment per visit the 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Specialist/Consultant Physician Services	$25 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
All other outpatient services	10% of the Negotiated Charge	50% of Usual and Customary Charge
An unrelated donor search is limited to $30,000 per transplant (inpatient and/or outpatient).		
Organ Transplant Travel Expenses (recipient and companion transportation) All travel expenses must be authorized in advance.	0% of Actual Charge up to $10,000 maximum per transplant (Deductible Waived)	
Treatment for Temporomandibular Joint (TMJ) Disorders Referral Required	10% of the Negotiated Charge	50% of Usual and Customary Charge

BENEFITS FOR COVERED INJURY/SICKNESS	INSURED'S RESPONSIBILITY FOR COST SHARING
For the following benefits to be payable, all arrangements and expenses must be authorized by Travel Guard in advance. For assistance, please call Member Services at (833) 302-9785.	
Bedside Visits (All covered Students and their Dependents) Up to 5 days per Policy Year Expenses do not apply towards the In-Network or Out-of-Network Out-of-Pocket Maximums. See the Bedside Visits Benefit description in the Certificate for further information.	0% of Actual Charge (Deductible Waived) Subject to $5,000 maximum per Policy Year
Return of Dependent Child(ren) (All covered Students and their Dependents) Expenses do not apply towards the In-Network or Out-of-Network Out-of-Pocket Maximums. See the Return of Dependent Child(ren) Benefit description in the Certificate for further information.	0% of Actual Charge (Deductible Waived) Subject to $5,000 maximum per Dependent Child per Policy Year
Emergency Return Home Benefit (All covered Students and their Dependents) Expenses do not apply towards the In-Network or Out-of-Network Out-of-Pocket Maximums. See the Emergency Return Home Benefit description in the Certificate for further information.	0% of Actual Charge (Deductible Waived) Subject to $2,500 maximum per Policy Year
Bereavement Reunion Benefit (All covered Students and their Dependents) Expenses do not apply towards the In-Network or Out-of-Network Out-of-Pocket Maximums. See the Bereavement Reunion Benefit description in the Certificate for further information.	0% of Actual Charge (Deductible Waived) Subject to $2,500 maximum per Policy Year
Medical Evacuation Expense (All covered Students and their Dependents) In the event of a medical evacuation, the return of personal belongings is limited to $1,000 Expenses do not apply towards the In-Network or Out-of-Network Out-of-Pocket Maximums. See the Medical Evacuation Expense Benefit description in the Certificate for further information.	0% of Actual Charge (Deductible Waived)
Repatriation Expense (All covered Students and their Dependents) In the event of a repatriation of remains, the return of personal belongings is limited to $1,000 Expenses do not apply towards the In-Network or Out-of-Network Out-of-Pocket Maximums. See the Repatriation Expense Benefit description in the Certificate for further information.	0% of Actual Charge (Deductible Waived)
Security Evacuation Expense: For temporary lodging, if needed, and for transportation/related costs within 5 days of the security evacuation back to the host country or to the Insured 's home country or place of primary residence, benefits will be limited a maximum of $5,000. Expenses do not apply towards the In-Network or Out-of-Network Out-of-Pocket Maximums. See the Security Evacuation Expense Benefit description in the Certificate for further information.	0% of Actual Charge (Deductible Waived)

Pre-Certification is not required for an emergency medical condition or urgent care or hospital confinement for the initial 48 hours following vaginal delivery/96 hours following a cesarean section of maternity care; or for services rendered at the University Health Services, AKA the Tang Center.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If, as the result of a covered accident, You sustain any of the following losses, the Company will pay the benefit shown below. The loss must occur within 90 days of the date of a covered accident.

Principal Sum $10,000

..... Percentage of Principal Sum
Loss of Life 100%
Loss of hand 50%
Loss of Foot 50%
Loss of either one hand, one foot or sight of one eye 50%
Loss of more than one of the above losses due to one Accident..... 100%

Loss of hand or foot means the complete severance through or above the wrist or ankle joint. Loss of eye means the total permanent loss of sight in the eye. The Principal Sum is the largest amount payable under this benefit for all losses resulting from any one Accident.

Only one benefit will be payable under this provision, that providing the largest benefit, when more than one (1) loss occurs as the result of any one Accident. This benefit is payable in addition to any other benefits payable under the Plan.

Exclusions and Limitations

Exclusion Disclaimer: Any exclusion in conflict with the Patient Protection and Affordable Care Act or any state-imposed requirements will be administered to comply with the requirements of the federal or state guideline, whichever is more favorable to You.

The Plan does not cover loss nor provide benefits for any of the following, except as otherwise provided by the benefits of the Plan and as shown in the Schedule of Benefits.

1. **International Students Only -** Eligible expenses incurred within your home country or country of origin or medical Treatment that is available under any governmental or national health plan except when a charge is made which You are required to pay.
2. Treatment, service or supply which is not medically necessary for the diagnosis, care or treatment of the sickness or injury involved. This applies even if they are prescribed, recommended or approved by the Student Health Center or by your attending physician or dentist.
3. Medical services rendered by a provider employed for or contracted with the Policyholder, including team physicians or trainers, except as specifically provided in the Schedule of Benefits or as part of the Student Health Center benefits provided by this Plan.
4. Professional services rendered by an immediate family member or anyone who lives with you.
5. Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be medically necessary because of injury, infection or disease.
6. Infertility treatment (male or female)-this includes but is not limited to:
   - Procreative counseling;
   - Premarital examinations;
   - Genetic counseling and genetic testing;
   - Impotence, organic or otherwise;
   - Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
   - In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
   - Costs for an ovum donor or donor sperm;
   - Ovulation induction and monitoring;
   - Artificial insemination;
   - Hysteroscopy;
   - Laparoscopy;

- Laparotomy;
- Ovulation predictor kits;
- Reversal of tubal ligations;
- Reversal of vasectomies;
- Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
- Cloning; or
- Medical and surgical procedures that are experimental or investigational, unless the Company's denial is overturned by an External Appeal Agent.

7. Expenses paid by any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medi-Cal, or outside of California, Medicaid.
8. Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services covered by Student Health Fees.
9. Any expenses in excess of usual and customary charges except where noted and as provided in the Certificate.
10. Treatment, services, supplies or facilities in a hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which you are required to pay.
11. Services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
12. Expenses payable under any prior policy which was in force for the person making the claim.
13. Expenses incurred after:
    - the date insurance terminates as to an insured person, except as specified in the extension of benefits provision; and
    - the end of the Policy Year specified in the Policy.
14. Elective surgery or elective treatment unless such coverage is otherwise specifically covered under the Plan.
15. Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
16. Weight management. Weight reduction. Nutrition programs. This does not apply to nutritional counseling or any screening or assessment specifically provided under the Preventive Services benefit, or otherwise specifically covered under the Plan.
17. Treatment for obesity except surgery for morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat.
18. Charges for hair growth or removal unless otherwise specifically covered under the Plan.
19. Expenses for radial keratotomy.
20. Adult vision care.
21. Charges for office visit exam for the fitting of prescription contact lenses, duplicate spare eyeglasses, lenses or frames, non-prescription lenses or contact lenses that are for cosmetic purposes unless otherwise covered under the Pediatric Vision Care Benefit.
22. Charges for hearing screening, hearing aids and the fitting or repair or replacement of hearing aids except as specifically provided in the Certificate.
23. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma, or otherwise covered under the Transgender Services Benefit.
24. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
25. Extraction of impacted wisdom teeth or dental abscesses.
26. You are:
    - committing or attempting to commit a felony, or
    - engaged in an illegal occupation.
27. Custodial Care service and supplies.

28. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
29. Services of private duty Nurse except as provided in the Certificate.
30. Expenses that are not recommended and approved by a physician as defined in the Certificate.
31. Physician's charges for diagnosis and treatment of structural imbalance, distorting or subluxation in vertebral column or elsewhere in body by manual, mechanical means, through muscular-skeletal adjustments, manipulations, and related modalities or except as specifically covered under the Plan.
32. Routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal or artificial organs or tissues unless such animal or artificial organs or tissues are approved and generally accepted for use.
33. Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under covered clinical trials or covered under clinical trials (routine patient costs). See the Other Benefits section in the Certificate for more information.
34. Under the Prescription Drug Benefit shown in the Schedule of Benefits in the Certificate:
    - any drug or medicine which does not, by federal or state law, require a prescription order, i.e. over-the-counter drugs, even if a prescription is written, except as specifically provided under Preventive Services or in the Prescription Drug Benefit section of the Certificate. Insulin and OTC preventive medications required under ACA are exempt from this exclusion;
    - drugs with over-the-counter equivalents except as specifically provided under Preventive Services;
    - Brand-Name contraceptives with generic equivalents, unless the prescriber specifies: "Dispense as Written" (DAW);
    - Brand-Name Prescription Drugs used to treat acne with generic equivalents;
    - allergy sera and extracts administered via injection;
    - any drug or medicine for the purpose of weight control;
    - fertility drugs, except as provided under the Fertility Preservation Expense Benefit;
    - vitamins, and minerals, except as specifically provided under Preventive Services;
    - food supplements, dietary supplements; except as specifically provided in the Certificate;
    - cosmetic drugs or medicines, including but not limited to, products that improve the appearance of wrinkles or other skin blemishes;
    - refills in excess of the number specified or dispensed after 1 year of date of the prescription;
    - drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
    - any drug or medicine purchased after coverage under the Plan terminates;
    - any drug or medicine consumed or administered at the place where it is dispensed;
    - if the FDA determines that the drug is: contraindicated for the treatment of the condition for which the drug was prescribed; or Experimental for any reason;
    - bulk chemicals;
    - non-insulin syringes, surgical supplies, durable medical equipment/medical devices, except as specifically provided in the Prescription Drug Benefit section of the Certificate;
    - repackaged products;
    - blood components except factors;
    - immunology products.
35. Non-chemical addictions. For more information, please contact the Berkeley SHIP office.
36. Non-physical, occupational, speech therapies (art, dance, etc.).
37. Modifications made to dwellings.
38. General fitness, exercise programs.
39. Hypnosis, holistic medicine, homeopathy, aroma therapy, reiki therapy, herbal, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
40. Rolfing.
41. Biofeedback.

How to File a Claim

Usually, providers of healthcare will bill the Company directly for services to insured persons. But sometimes a physician, hospital or an ambulance company may send the bill directly to you. In these instances, the Company has no way of knowing about your claim. So, in the event medical and/or hospital bills are sent directly to you, mail a copy to the address below along with the patient's name and insured student's name, address, or student ID number and name of the University within 90 days of treatment, or as soon thereafter as is reasonably possible. A Company claim form is required for filing a claim. Claim forms are available at http://berkeley.wellfleetinsurance.com/ship. You are urged to send the Company each bill immediately upon receipt.

Mail claims to:
Claims Administrator:
HealthComp
621 Santa Fe Avenue
Fresno, CA 93721
(833) 302-9785

Complaint Notice

If you have complaints or questions regarding your coverage, please contact the Company at:

HealthComp
621 Santa Fe Avenue
Fresno, CA 93721
(833) 302-9785

If the issue is not resolved, please contact the California Department of Insurance at:

California Department of Insurance
Consumer Services Division
300 South Spring Street, 11th Floor
Los Angeles, CA 90013
(800) 927-HELP (4357) – In California
(213) 897-8921 – Out of California
(800) 482-4833 – Telecommunication Device for the Deaf
E-mail Inquiry "Consumer services" link at:
www.insurance.ca.gov

The following are not affiliated with Commercial Casualty Insurance Company and the services are not part of the Plan Underwritten by Commercial Casualty Insurance Company. These value-added options are provided by Wellfleet Student.

Travel Guard Emergency Medical And Travel Assistance Services

Wellfleet Student provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel assistance services coverage, please call Member Services at (833) 302-9785. **If you are traveling and need assistance in North America, call the Assistance Center toll-free at: (877) 283-1226 *or* if you are in a foreign country, call collect at: (715) 342-2431**. When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

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You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP network doctor, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
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- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

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- **Create an account at vsp.com**. Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you.** Visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe, CALVIN KLEIN, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more.[1] Visit **vsp.com** to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.[2] Prefer to shop online? Check out all of the brands at **eyeconic.com®**, VSP's preferred online eyewear store.

VSP Vision care for life

Enroll in VSP today.
You'll be glad you did.
Contact us. **800.877.7195**
vsp.com

Your VSP Vision Benefits Summary

UC Berkeley SHIP and VSP provide you with an affordable eye care plan.

VSP Provider Network: VSP Choice

Benefit	Description	Copay	Frequency
	Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness	$10	Every plan year*
Prescription Glasses		$25	See frame and lenses
Frame	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • $80 Costco® frame allowance	Included in Prescription Glasses	Every plan year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every plan year
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$55 $95 - $105 $150 - $175	Every plan year
Contacts (instead of glasses)	• $150 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)	$0	Every plan year
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit **vsp.com** for plan details.

Exam ..... up to $47	Lined Bifocal Lenses ..... up to $50	Progressive Lenses ..... up to $50
Frame ..... up to $45	Lined Trifocal Lenses ..... up to $60	Contacts ..... up to $100
Single Vision Lenses ..... up to $30		

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

*Plan year begins in August

Contact us. **800.877.7195** | **vsp.com**

1. Brands/Promotion subject to change.
2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.

MetLife Dental Plan

UC Berkeley
Student Health Plan (SHIP)
Group Number 151675

MetLife Dental Plan Summary

Network: PDP Plus

Coverage Type	In-Network % of Negotiated Fee*	Out-of-Network % of R&C Fee**
Type A: Preventive (cleanings, exams, X-rays)	100%	80%
Type B: Basic Restorative (filings, extractions)	80%	60%
Type C: Major Restorative (bridges, dentures)	70%	40%

Deductible[†]		
Individual	$25	$50
Annual Maximum Benefit		
Per Person	$2,000	$2,000

Child(ren)'s eligibility for dental coverage is from birth up to age 26.

*Negotiated Fee refers to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

**R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by Metlife.[†]
Applies only to Type B & C Services.

List of Primary Covered Services & Limitations

Type A • Preventive	How Many/How Often
Prophylaxis (cleanings)	• Two per plan year
Oral Examinations	• Two exams per plan year
Topical Fluoride Applications	• Two fluoride treatments per plan year
X-rays	• Full mouth X-rays: one per five plan years • Bitewing X-rays: one set per plan year for adults; two sets per plan year for children
Space Maintainers	
Type B • Basic Restorative	**How Many/How Often**
Fillings	• Composite fillings allowed on all teeth
Simple Extractions	
Endodontics	• Root canal treatment
General Anesthesia	• When dentally necessary in connection with oral surgery, extractions or other covered dental services
Oral Surgery	
Periodontics	• Periodontal scaling and root planing once per quadrant, every 24 months • Periodontal surgery once per quadrant, every 36 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a plan year
Sealants	• One application of sealant material every 24 months for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 16th birthday
Type C • Major Restorative	**How Many/How Often**
Crown, Denture, and Bridge Repair/ Recementations	
Relining and Rebasing of Dentures	• Once per 36 months
Bridges and Dentures	• Initial placement to replace one or more natural teeth, which are lost while covered by the Plan • Dentures and bridgework replacement: one every 5 plan years • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
Crowns/Inlays/Onlays	• Replacement once every 5 plan years
Implant supported Cast Restorations	• Replacement once every 5 plan years
Core Build up; Post and Cores	• Once per 5 plan years

The service categories and plan limitations shown above represent an overview of your plan benefits.
This document presents the majority of services within each category, but is not a complete description of the plan.

Frequently Asked Questions

Who is a participating dentist?
A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members. Negotiated fees typically range from 15%-45% below the average fees charged in a dentist's community for the same or substantially similar services.[†]

How do I find a participating dentist?
There are thousands of general dentists and specialists to choose from nationwide --so you are sure to find one that meets your needs. You can receive a list of these participating dentists online at www.metlife.com/mybenefits or call 1-800-942-0854 to have a list faxed or mailed to you.

What services are covered under this plan?
All services defined under the group dental benefits plan are covered.

May I choose a non-participating dentist?
Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist, your out-of-pocket costs may be higher. He/she hasn't agreed to accept negotiated fees. So you may be responsible for any difference in cost between the dentist's fee and your plan's benefit payment.

Can my dentist apply for participation in the network?
Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.
[††] The website and phone number are for use by dental professionals only.

How are claims processed?
Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-800-942-0854.

Can I find out what my out-of-pocket expenses will be before receiving a service?
Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Can MetLife help me find a dentist outside of the U.S. if I am traveling?
Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

How does MetLife coordinate benefits with other insurance plans?
Coordination of benefits provisions in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan, subject to applicable law. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan, subject to applicable law.

Do I need an ID card?
No. You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in the MetLife Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

†Based on internal analysis by MetLife. Negotiated Fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
††Due to contractual requirements, MetLife is prevented from soliciting certain providers.
*AXA Assistance USA, Inc. provides Dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations.
**Refer to your dental benefits plan summary for your out-of-network dental coverage.

Exclusions

This plan does not cover the following services, treatments and supplies:

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
  - Scaling and polishing of teeth; or
  - Fluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
  - Covered under any workers' compensation or occupational disease law;
  - Covered under any employer liability law;
  - For which the employer of the person receiving such services is not required to pay; or
  - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis:
  - Claim form completion;
  - Infection control such as gloves, masks, and sterilization of supplies; or
  - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Implants including, but not limited to any related surgery, placement, restorations, maintenance, and removal;
- Repair of implants;
- Fixed and removable appliances for correction of harmful habits;

- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota;
- Repair or replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extraoral photographic images

Limitations

Alternate Benefits: Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre- treatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out-of-pocket expense. Procedure charge schedules are subject to change each plan year. You can obtain an updated procedure charge schedule for your area via fax by calling 1-800-942-0854 and using the MetLife Dental Automated Information Service. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99) issued by MetLife. Coverage terminates when your membership ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. For complete details of coverage and availability, please refer to the group policy form GPNP99 or contact MetLife.

