The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call Member Services at 1-833-302-9785. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-833-302-9785 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300/Individual or $900/Family for In-Network/Out-of-Network combined	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Pediatric Vision Care, Pediatric dental check-ups and Prescription Drug Coverage In-Network and/or Out-of-Network, Preventive care, Primary Care and Specialist visits In-Network, and all services rendered at the Student Health Center (SHC) are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $60/Individual or $180/Family for Pediatric Dental In-Network/Out-of-Network combined. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$3,200/Individual or $6,400/Family In-Network and $6,500/Individual or $13,000/Family Out-of-Network; and for Pediatric Dental, $1,000/Individual or $2,000/Family In-Network/Out-of-Network combined. The combined out-of-pocket limit will never exceed the maximum amount permitted by law.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See http://berkeley.wellfleetinsurance.com/providers or call 1-833-302-9785 for a list of In-Network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. Please contact the Student Health Center (SHC) for referral to a specialist.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit; deductible does not apply	50% coinsurance	SHC referral required. See certificate for details.
	Specialist visit	$25 copay/visit; deductible does not apply	50% coinsurance	When requested and approved by the attending physician. SHC referral required. See certificate for details.
	Preventive care/screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Preventive care at an In-Network provider is provided with no cost sharing. SHC referral required for most services.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	50% coinsurance	SHC referral required. Pre-certification required for certain services. See certificate for details regarding Pre-certification
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	SHC referral. Pre-certification required for certain services. See certificate for details regarding Pre-certification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://uhs.berkeley.edu/insurance/ship-benefits/prescriptions	Tier 1 (Generic drugs)	$10 copay/prescription; (No charge at SHC); deductible does not apply	$10 copay/prescription then 50% coinsurance up to $250 copay/prescription plus all charges in excess of the In-Network prescription drug allowed amount; deductible does not apply	Copay waived for generic contraceptive and brand-name contraceptives for which there are no therapeutic equivalent. Up to a 12-month supply of contraceptives may be dispensed with a single prescription order. Covers up to a 30-day supply when filled at a Retail pharmacy. No cost sharing applies to ACA Preventive medications filled In-Network. Out-of-Network provider benefits are provided on a reimbursement basis. Claim forms must be submitted to us as soon as reasonably possible.
	Tier 2 (Preferred brand drugs)	$35 copay/prescription; ($25 copay/prescription at SHC); deductible does not apply	$35 copay/prescription then 50% coinsurance up to $250 copay/prescription plus all charges in excess of the In-Network prescription drug allowed amount; deductible does not apply	
	Tier 3 (Non-preferred brand drugs)	$50 copay/prescription; ($40 copay/prescription at SHC); deductible does not apply	$50 copay/prescription then 50% coinsurance up to $250 copay/prescription plus all charges in excess of the In-Network prescription drug allowed amount; deductible does not apply	
	Tier 4 (Specialty drugs)	20% coinsurance up to $250 max/prescription; ($75 copay/prescription at SHC); deductible does not apply	50% coinsurance up to $250 copay/prescription plus all charges in excess of the In-Network prescription drug allowed amount; deductible does not apply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	Pre-certification required. See certificate for details.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	SHC referral and Pre-certification required. See certificate for details.
If you need immediate medical attention	Emergency room care	$250 copay/visit; deductible does not apply	$250 copay/visit; deductible does not apply	For emergency services, Out-of-Network provider paid the same as In-Network provider subject to Usual and Customary Charge. Copay waived if admitted.
	Emergency medical transportation	10% of actual charge; deductible does not apply	10% of actual charge; deductible does not apply	Ground and/or air, water transportation.
	Urgent care	$50 copay/visit ($35 copay/visit at SHC); deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission then 10% coinsurance	$500 copay/admission then 50% coinsurance	Pre-certification required. See certificate for details.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	Pre-certification required for inpatient surgery. See certificate for details.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: Primary Care-$15 copay/visit; deductible does not apply All Other Outpatient Services: 10% coinsurance;	Office Visits: Primary Care-50% coinsurance All Other Outpatient Services: 50% coinsurance	SHC referral required. Office Visits including but not limited to physician visits, individual and group therapy, hormone therapy, medication management 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; and services/supplies provided in connection with Gender Dysphoria
	Inpatient services	$250 copay/admission then 10% coinsurance	$500 copay/admission then 50% coinsurance	Pre-certification required. See certificate for details.
If you are pregnant	Office visits	$15 copay/visit; deductible does not apply	50% coinsurance	Outpatient: SHC Referral required. No charge/prenatal and 1st postnatal visits. Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$250 copay/admission then 10% coinsurance	$500 copay/admission then 50% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	Limited to 100 visits/policy year. Separate limits apply to Rehabilitation Services and Habilitation Services. SHC referral and Pre-certification required. See certificate for details.
	Rehabilitation services	$15 copay/visit; deductible does not apply	50% coinsurance	Includes Cardiac, Pulmonary, Physical, Occupational, and Speech Therapies. SHC referral and Pre-certification required. See certificate for details.
	Habilitation services	$15 copay/visit; deductible does not apply	50% coinsurance	Includes Cardiac, Pulmonary, Physical, Occupational, and Speech Therapies. SHC referral and Pre-certification required. See certificate for details.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	$250 copay/admission then 10% coinsurance	$500 copay/admission then 50% coinsurance	Limited to 100 days/benefit period. This limit does not apply to mental health, behavioral health, or substance abuse services. Pre-certification required. See certificate for details.
	Durable medical equipment	10% coinsurance	50% coinsurance	SHC referral and Pre-certification required. See certificate for details.
	Hospice services	0% coinsurance	0% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	No charge	1 visit/policy year.
	Children's glasses	No charge	No charge	1 pair eyeglasses or contact lenses in lieu of eyeglasses/policy year.
	Children's dental check-up	No charge	No charge	1 exam/6-month period. Deductible does not apply to pediatric diagnostic/preventive care.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (Pre-certification and SHC referral required)
- Bariatric surgery (Pre-certification and SHC referral required)
- Chiropractic care (SHC referral required)
- Hearing aids (1 aid/ear every 3 years; SHC referral required)
- Most non-emergency care when traveling outside the U.S. (See certificate for details)
- Routine foot care (medically necessary)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: http://www.insurance.ca.gov/. For more information on your rights to continue coverage, contact the plan at 1-833-302-9785. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: http://www.insurance.ca.gov/ or California Department of Insurance, 300 S. Spring Street, 11th Floor, Los Angeles, CA 90013, Inside State Toll-Free:1-800-927-4357, Outside State:1-213-897-8921, TDD:1-800-482-4833.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-833-302-9785.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-302-9785.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-302-9785.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-302-9785.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

*For more information about limitations and exceptions, see the plan or policy document at http://berkeley.wellfleetinsurance.com/ship.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$300
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$70
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,630

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$300
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$900
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,460

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$300
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$80
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$580

The plan would be responsible for the other costs of these EXAMPLE covered services.