2017-2018
UC Berkeley Domestic & International Student Health Insurance Plan (SHIP)

https://uhs.berkeley.edu/ship

You can view the standard Summary of Benefits & Coverage (SBC) which is required by Health Care Reform. It summarizes your coverage in a format that all insurance companies now use. To view your plan SBC, go to: https://uhs.berkeley.edu/insurance or call 510-642-5700 to request a paper copy free of charge.
When Coverage Begins

Coverage under the Plan once premium has been collected will become effective at 12:01 a.m. on the later of, but no sooner than:
- The Master Policy effective date;
- or The beginning date of the term for which premium has been paid.

IMPORTANT NOTICE - Premiums will not be pro-rated if the Insured enrolls past the first date of coverage for which he or she is applying. Final decisions regarding coverage effective dates are made by Anthem Blue Cross Life and Health. The below enrollments will be allowed a 30 day grace period from the term start date to enroll whereby the effective date will be backdated to the start of the term. No policy shall ever start prior to the term start date:
1. All hard-waiver and mandatory (insurance is required as a condition of enrollment on campus) insurance programs.
2. All voluntary enrollments processed within 30 days from the start of the term.

When Coverage Ends

Insurance of all Insured Persons terminates at 11:59 p.m. on the earlier of:
- Date the Master Policy terminates for all Insured Persons; or
- End of the period of coverage for which premium has been paid; or
- The start of the term if the Insured Person ceases to be eligible for the insurance; or
- Date the Insured Person enters military service. Dependent coverage will not be effective prior to that of the Insured Student or extend beyond that of the Insured Student.

Continuous Coverage

This Plan may be replacing a Prior Plan with another insurer. Prior Plan means (a) the SHIP or policies issued to University of California, Berkeley immediately before the current Policy; (b) other policies providing Creditable Coverage as defined in this Plan. Injury or Sickness shall include an Injury sustained, or a Sickness first manifesting itself, while the Insured Person is continuously insured under the Prior Plan and became insured under this Plan without a break in coverage. But no benefits shall be payable for such Injury or Sickness to the extent that such benefits are payable under the Prior Plan for the same expenses. This will apply even though the Prior Plan provided that it will not duplicate the benefits under another Policy.

Continuation of Benefits

Anthem Blue Cross Life and Health will extend benefits under the Plan for 30 days or upon replease from inpatient stay, whichever comes first, after the Insured’s coverage would otherwise end if on that date he or she is 1) Hospital Confined for an Injury or Sickness covered by the Plan, and 2) under a physician’s care. Any benefits payable under this provision will not exceed the benefit maximums shown in the Schedule of Benefits.

Premium Refund/Cancellation

Refund requests should be directed to Wells Fargo Student Insurance at 800-853-5899 or via email at studentinsurance@wellsfargo.com. A refund of premium will be granted for the reasons listed below only. No other refunds will be granted.
1. If you or your insured dependents enter the armed forces of any country you and your insured dependents will not be covered under the Master Policy as of the date of such entry. If you enter the armed forces the policy will be cancelled. If your dependent enters the armed forces, a pro-rata refund of premium will be made for such person, upon written request received by Wells Fargo Student Insurance within 45 days of entry into service.
2. Refunds will be granted for your or your insured dependents in case of a qualifying event such as legal separation, divorce or death within 31 days of the occurred event, provided that you or your insured dependents did not file a medical claim during the insurance period. Written proof of such qualifying event must be submitted. Refunds will not be prorated.

Insurance Payments With Personal Check
(Note: personal checks are not always a payment option. Please check your school’s enrollment form for available payment options.) If you make your or your dependents’ insurance payment via personal check payable to Wells Fargo Student Insurance and we are unable to process the check (due to insufficient funds, closure of account, etc.), your and your dependents insurance coverage will be terminated retroactive to the effective date of the enrolled term.
SHIP Waiver Information
All eligible registered students will be automatically enrolled in the UC Berkeley Student Health Insurance Plan (SHIP) unless an online waiver has been submitted and approved, by the specified enrollment deadline dates listed on page 2 of this brochure. Registered eligible students may provide evidence of health coverage through another plan and request a waiver of Berkeley SHIP. The coverage must meet the benefit criteria established by University of California, Berkeley. Please visit: https://uhsc.berkeley.edu/insurance/waiving-ship to complete an online waiver.
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
Download the Free StudentHealth App for Your ID Card and More
Paper ID cards have been replaced by the StudentHealth app. Download the app from Google Play or App Store® to get your ID card, order prescription refills, find coverage information and more, any time you need it.
The app gives you quick and easy access to all your Berkeley SHIP benefits, including:

• Your SHIP member ID card
• Student Health Center (SHC) information—location, hours, services
• A description of your SHIP plan benefits
• Anthem Blue Cross—for medical claims and other plan benefits
• VSP—for vision coverage and claims information
• Metlife—for dental coverage and claims information
• And much more!
After the app downloads, simply click “Register Now,” and provide the following:

• Your first and last name (Tip: If you are unable to register on the first try, adjust your input in the “first name” field to your first + middle names with no space, or your first name + middle initial with no space.)
• Your student ID number
• Date of birth (mm/dd/yyyy)

It’s important to register so you can also receive notifications about your Berkeley SHIP benefits. Don’t have a smartphone or tablet? Access the app using your computer’s browser at: www.mobilehealthconsumer.com/studenthealth.

University Health Services, Tang Center
The University Health Services, Tang Center is a complete outpatient health center that provides on campus medical, behavioral health, and preventive care. 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 University of California, Berkeley Student Health Insurance Plan (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.

Where Do I Go For Services?
A referral from Tang Center is required for most 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. See page 8 of the brochure for more information on the referral requirement.
Covering all California ZIP codes, the Prudent Buyer network is the most geographically extensive PPO network in the state. The suitcase icon on your SHIP ID card indicates that this plan can be used outside of California. The PPO network allows Insureds easy access to a wide range of medical providers. Insureds 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 covered persons at discounted rates as payment in full. This is the incentive for Insureds to use PPO providers and protects them from being balance-billed (except for coinsurance, co-payments and deductible amounts). Providers working within a PPO facility (example: a hospital) may not always be PPO providers. You should request that 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 that discounted charges and utilization management savings will occur. With no claim forms to file, Insureds can focus on their health, not paperwork.
Insureds can find a PPO physician in their area by calling Anthem at 844-728-5913 or by accessing the “Find a Doctor” link on www.anthem.com/ca/ucberkeley.
### How much does it cost?

Rates include premium payable to Anthem Blue Cross Life and Health Insurance Company, MetLife, and VSP, as well as administrative fees payable to UC Berkeley and Wells Fargo Student Insurance. Rates also include Medical Evacuation and Repatriation and Worldwide Emergency Travel Assistance benefits/services provided through On Call International and its contracted underwriting companies.

#### VOLUNTARY UNDERGRADUATES

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<thead>
<tr>
<th></th>
<th>FALL 8/1/2017 - 12/31/2017</th>
<th>SPRING/SUMMER 1/1/2018 - 7/31/2018</th>
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<tbody>
<tr>
<td>Waiver Start Date</td>
<td>5/1/2017</td>
<td>12/1/2017</td>
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<tr>
<td>Waiver Deadline Without Fee</td>
<td>7/15/2017</td>
<td>1/1/2018</td>
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<tr>
<td>Final Waiver Deadline</td>
<td>8/15/2017</td>
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<td>Student only</td>
<td>$1,415.00</td>
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**NOTE:** Costs below are in addition to the student premium. Dependent enrollment in this plan is voluntary.

- **Spouse only:** $1,415.00
- **One Child Age 0-25 only:** $1,415.00
- **Two Children Age 0-25 only:** $2,725.00
- **Three Children Age 0-25 only:** $2,758.00

For more information on the cost to add dependents, including the cost to add more than three children, please contact Wells Fargo Student Insurance Customer Care by phone **800-853-5899** or by email **studentinsurance@wellsfargo.com**.

#### REGISTERED UNDERGRADUATES

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- **Spouse only:** $2,231.00
- **One Child Age 0-25 only:** $2,231.00
- **Two Children Age 0-25 only:** $4,337.00
- **Three Children Age 0-25 only:** $4,370.00

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For more information on the cost to add dependents, including the cost to add more than three children, please contact Wells Fargo Student Insurance Customer Care by phone **800-853-5899** or by email **studentinsurance@wellsfargo.com**.

*Please note waiver periods may be different for 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 enrollment deadline dates listed in the next section of this Benefit Booklet.

• All registered eligible 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 Office at https://uhs.berkeley.edu/insurance.

All students must actively attend classes for the first day following their effective date for the term purchased and/or pursuant to their visa requirements for the period for which coverage is purchased, except during school authorized breaks or in case of a medical withdrawal, approved by your school and any applicable regulatory authority. Please contact your school or Wells Fargo Student Insurance for details.

Voluntary Enrollments
The following classes of eligible students may enroll on a voluntary basis directly with Wells Fargo Insurance by the specified enrollment deadline dates listed in the next section of this Brochure.

• 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 Wells Fargo Student Insurance at 800-853-5899. The student must have been covered by the Plan in the term immediately preceding the term the student wants to purchase or, if the student waived Plan enrollment, show proof of loss of the coverage used to obtain the waiver.

• 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 Wells Fargo Student Insurance at 800-853-5899. The student must have been covered by the Plan in the term immediately preceding the term the student wants to purchase or, if the student waived Plan enrollment, show proof of loss of the coverage used to obtain the waiver.

Continuation Coverage/Enrollments
Eligible non-registered graduate or undergraduate students may purchase the voluntary plan for a maximum of one semester immediately following the last Fall or Spring semester in which they were a registered Hard Waiver Mandatory student on SHIP. Student who have graduated qualify for the continuation plan if they were a registered Hard Waiver Mandatory student enrolled in SHIP for the Spring or Fall semester immediately preceding their graduation. Another example of qualifying eligibility in the continuation plan includes a student who takes a semester off for maternity or a health situation. Students previously enrolled in a special summer only SHIP session must check with the SHIP office to see if they are eligible to purchase the continuation plan. To see if your leave qualifies for the continuation plan, please contact the SHIP office at 510-642-5700 or ship@berkeley.edu.

To be an Insured under the Policy, 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 the School or the Administrative Agent to the Insurer. Anthem Blue Cross and Wells Fargo Student Insurance maintain the right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever Anthem Blue Cross and/or Wells Fargo Student Insurance discover that the Policy eligibility requirements have not been met, the only obligation is a refund of premium.

Eligible students who involuntarily lose coverage under another group insurance plan are also eligible to purchase the Student Health Insurance Plan. These students must provide UC Berkeley with proof that they have lost insurance through another group (certificate and letter of ineligibility) within 31 days of the qualifying event. The effective date would be the later of the date the student enrolls and pays the premium or the day after prior coverage ends. Premium will not be prorated.

Dependent Coverage
Note: Dependent enrollment in this plan is voluntary. Eligible Insured Students, including those on the voluntary or continuation plans, may purchase Dependent coverage at the time of student’s enrollment in the plan; or within 31 days of one of the following qualified events: marriage, addition of domestic partner, birth, or adoption. Eligible dependents are the spouse or legally registered and valid domestic partner who resides with the Insured Student, and the student’s, the spouse’s, or the domestic partner’s natural child, stepchild, or legally adopted child under 26 years of age. A “Newborn” will automatically be covered from birth until 31 days old, providing that the student is covered under this plan. Coverage may be continued or added for that child when Wells Fargo Student Insurance is notified within 31 days from the date of birth and by payment of any additional premium. Dependents must be enrolled for the same term of coverage for which the Insured Student enrolls. Dependent coverage expires concurrently with that of the Insured Student and Dependents must re-enroll when coverage terminates to maintain coverage. Dependents must be re-enrolled each term. It is the students responsibility to contact Wells Fargo Student Insurance prior to the enrollment deadline listed in this brochure. No reminder will be sent to students or dependents covered under the plan.
Arbitration Agreement

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this plan or the Master Policy or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort, or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute or claim within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act will govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. The insured person and Anthem Blue Cross Life and Health Insurance Company agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The insured person and Anthem Blue Cross Life and Health Insurance Company agree to give up the right to participate in class arbitration against each other.

The arbitration findings will be final and binding except to the extent that California or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the insured person making written demand on Anthem Blue Cross Life and Health Insurance Company. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”) according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the insured person and Anthem Blue Cross Life and Health Insurance Company, or by order of the court, if the insured person and Anthem Blue Cross Life and Health Insurance Company cannot agree. The arbitration shall be held in the State of California.

Creditable Coverage

Creditable coverage means any individual or group plan that provides medical, hospital, and surgical coverage, including continuation or conversion coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefit Plan, programs of the Indian Health Services or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children’s Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. Creditable coverage does not include accident only, credit, coverage for onsite medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers’ compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable coverage is used to set up eligibility rules for children who cannot get a self-sustaining job due to a physical or mental condition.

Online Health Care Advisor

Estimate Your Cost is an innovative and interactive website that provides valuable tools to help covered persons make informed decisions regarding their specific health care needs. Covered persons link to the tool from the Anthem Blue Cross website through “Member Services” located on the home page at www.anthem.com/ca and logging in to the Secure Member Services site. First time users will need to register.

Reimbursement for Acts of Third Parties

Under some circumstances, an insured person may need services under this plan for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation. In that event, the insurer will provide the benefits of this plan subject to the following:

The Insurer will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party’s insurer, or the third party’s guarantor. The lien will be in the amount of benefits the Insurer has paid under this plan for the treatment of the illness, disease, injury or condition for which the third party is liable. You must advise the Insurer in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as the Insurer may require to facilitate enforcement of their rights. You must not take action which may prejudice the insurer’s rights or interests under your plan. Failure to give the Insurer such notice or to cooperate with the Insurer, or actions that prejudice the Insurer’s rights or interests will be a material breach of this plan and will result in your being personally responsible for reimbursing the Insurer.

The Insurer will be entitled to collect on their lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

Member Discounts

Vision and Hearing
1-800 CONTACTS® — Get contact lenses quick and easy — plus discounts only available to Anthem members, like $20 off when you spend $100 or more and free shipping.

Glasses.com™—Get the latest, brand-name frames for just a fraction of the cost at typical retailers—every day. Plus, you get an additional $20 off orders of $100 or more, free shipping and free returns.

Premier LASIK—Save 15% on LASIK with all in-network providers. Prices are as low as $695 per eye with select providers.

Fitness and Health
Jenny Craig®—Join Jenny Craig and obtain 50% off All Access Enrollment plus 5% off all Jenny Craig Food.

GlobalFit™—Save on gym memberships, home fitness equipment and GlobalFit’s Virtual Gym.

ChooseHealthy™ — Get preferred pricing on fitness club memberships and a one-week free trial. Enjoy discounts on acupuncture, chiropractors and massage—plus 40% off certain wellness products.

Garmin—Save 20% on the vivofit 2, vivosmart, vivoactive, or Forerunner 15 wearable activity trackers.

Medicine and Treatment
Allergy Control products — Save 25% on Allergy Control encasings for your bed. Plus, save 20% on a variety of doctor-recommended products for a healthier home and enjoy free shipping on orders of $150 or more.

National Allergy® supply — Save 15% on mattress encasings, air filtration products, compressors and other products that can help relieve your allergy, asthma and sinus symptoms.
Key Services

- Medical Referrals - an initial medical review and assessment by an appropriate medical professional. They will assist in finding the nearest appropriate provider for care.
- Medical Monitoring of Inpatient Care – Review the appropriateness of care. Review the case daily with the medical staff. Determine the patient’s medical transportation needs (i.e., transfer to a hospital closer to home or to the nearest appropriate medical facility).

Definitions

**Accidental injury:** is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

**Ambulatory surgical center:** is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

**Contracting Hospital:** is a Hospital that has a contract with Anthem Blue Cross Life and Health to provide care to covered persons; however, this does not necessarily make it a Participating Hospital. Verify participation with your Physician.

**Co-payment:** is a part of the Maximum Allowed Amount you are responsible for paying. Co-payment does not include charges for services that are not Covered Services or charges in excess of the Maximum Allowed Amount. Payment of the dollar Co-payment will be required at the time services are provided.

**Covered Services:** are services that are Medically Necessary services or supplies which are listed in the benefit section of this brochure and for which you are entitled to receive benefits.

**Deductible:** is a part of the Maximum Allowed Amount you must pay for Covered Services before any benefits are available to you under this plan. Your Plan Year Deductible is stated on page 8.

**Dependent:** is defined as:

- **Spouse:** A current legal spouse as recognized by state law. A legally separated or ex-spouse is not eligible for coverage.
- **Registered Domestic Partner:** Individual in a current domestic partnership registered with the State of California or a substantially equivalent partnership or union, other than a marriage, validly formed in another jurisdiction. A domestic partnership that has not been registered with the State of California must meet the following criteria to be a domestic partnership for SHIP purposes: – parties must be each other’s sole domestic partner in a long-term, committed relationship and must intend to remain so indefinitely – neither party may be legally married or be a partner in another domestic partnership – parties must not be related to each other by blood to a degree that would prohibit legal marriage in the State of California – both parties must be at least 18 years old and capable of consenting to the relationship – both parties must be financially interdependent – parties must share a common residence.
- **Children:**
  - Your biological child (child is eligible through the end of the month in which the child reaches age 26).
  - Your legally adopted child or a child placed with you in an equivalent partnership (child is eligible through the end of the month in which the child reaches age 26).
  - Your stepchild (child is eligible through the end of the month in which the child reaches age 26).
  - Your domestic partner’s child (child is eligible through the end of the month in which the child reaches age 26).
  - Your unmarried child for whom you have become legal guardian, who resides with you, is financially dependent on you for more than half of their support and maintenance, and is claimed as your tax dependent.
  - Any recognized children you are required to cover under the plan due to a Qualified Medical Child Support Order (QMC-SO), under age 19.
Definitions (continued)

- In most cases, a disabled child may be covered provided the disabled child meets all of the following: • unmarried • incapable of self-support due to a mental or physical disability incurred prior to age 26 • enrolled before age 26, • the coverage is continuous from the date of disability • must be approved before age 26 or by the carrier during the PIE for newly eligible employees or newly acquired dependents • chiefly dependent upon you, your spouse or eligible domestic partner for support and maintenance (50%+ support) • claimed as your, your spouse’s or your eligible domestic partner’s dependent for income tax purposes or, if not, is eligible for Social Security income or Supplemental Security Income as a disabled person. The average disabled child may be working in supported employment that may offset the Social Security or Supplemental Security Income.

Emergency: is a sudden, serious and unexpected acute illness, injury, condition (including without limitation sudden and unexpected severe pain), or a psychiatric emergency medical condition, which the insured person reasonably perceives could permanently endanger health if medical treatment is not received immediately. Anthem Blue Cross Life and Health will have sole and final determination as to whether services were rendered in connection with an emergency.

The Insurer: is Anthem Blue Cross Life and Health Insurance Company.

Insured Person: is the student or dependent.

Maximum Allowed Amount: is the maximum amount of reimbursement that is allowed for covered medical services and supplies under the plan.

Medically Necessary: are procedures, supplies, equipment or services that are considered to be:

• Appropriate and necessary for the diagnosis or treatment of a medical condition, and
• Provided for the diagnosis or direct care and treatment of the medical condition, and
• Within the standards of good medical practice within the organized medical community, and
• Not primarily for the convenience of the patient’s Physician or another provider, and
• Not more costly than an equivalent service or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of the patient’s illness, injury, or condition; and
• The most appropriate procedure, supply, equipment or service which can be safely provided that must satisfy the following requirements: 1) there must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the patient with the particular medical condition being treated than other possible alternatives; and 2) generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and 3) for Hospital stays, acute care as an inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

Non-Contracting Hospital: is a Hospital that does not have a standard contract nor a Prudent Buyer Participating Agreement with Anthem Blue Cross Life and Health. Only a portion of the amount which a Non-Contracting Hospital charges for services will be considered covered. The Insured will be responsible for any billed charges over the Maximum Allowed Amount.

Non-Prudent Buyer Provider (Non-PPO): is a provider who does NOT have a Prudent Buyer Plan Participating Provider Agreement with Anthem Blue Cross Life and Health in effect at the time services are rendered. Only a portion of the amount which a Non-Prudent Buyer Provider charges for services will be considered covered. The Insured will be responsible for any billed charges over the Maximum Allowed Amount.

Physician means:
1. A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice where the care is provided, or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, and such license is required to render that service, and is providing a service for which benefits are specified in this brochure:
   • A dentist (D.D.S. or D.M.D.);
   • An optometrist (O.D.);
   • A dispensing optician;
   • A podiatrist or chiropractor (D.P.M., D.S.P. or D.S.C.);
   • A licensed clinical psychologist;
   • A chiropractor (D.C.);
   • An acupuncturist (A.C.);
   • A licensed clinical social worker (L.C.S.W.);
   • A marriage and family therapist (M.F.T.);
   • A physical therapist (P.T. or R.P.T.);
   • A speech pathologist*;
   • An audiologist*;
   • An occupational therapist (O.T.R.*);
   • A respiratory care practitioner (R.C.P.*);
   • A psychiatric mental health nurse (R.N.);
   • A nurse midwife;
   • A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy only
   • A nurse practitioner
   • A physician assistant
   • A licensed educational psychologist for the provision of behavioral health treatment services for the treatment of pervasive developmental disorder or autism only

Note: The providers indicated by asterisks (*) are covered only by referral of a Physician (M.D. or D.O.) as defined in 1 above.

Prudent Buyer Provider (PPO): is one of the following providers which has a Prudent Buyer Plan Participating Provider Agreement with Anthem Blue Cross Life and Health in effect at the time services are rendered: A Hospital; A Physician; An Ambulatory Surgical Center; A durable medical equipment outlet; A clinical laboratory; A Skilled Nursing Facility; A facility which provides diagnostic imaging services; A home health agency; A home infusion therapy provider; A licensed ambulance company; A licensed qualified autism service provider.
Prescription Drug Benefits

To get a prescription filled, you will only need to take your prescription to a participating pharmacy and present your member ID card. The amount you pay for a covered prescription – your co-pay – will be determined by whether the drug is a brand-name or generic medication and whether it is a formulary or non-formulary medication.

A generic drug contains the same effective ingredients, meets the same standards of purity as its brand-name counterpart and typically costs less. In many situations, you have a choice of filling your prescription with a generic medication or a brand-name medication. The plan’s formulary is a list of approximately 600 recommended brand and generic medications. These medications have undergone extensive review for therapeutic value for a particular medical condition, safety and cost. Copies of the formulary list are furnished to your providers and are available online at [www.anthem.com/ca/ucberkeley](http://www.anthem.com/ca/ucberkeley).

You or your provider may also contact Anthem Blue Cross Life and Health’s Customer Service at 844-728-5913.

The Prescription Drug Benefit covers the following:

1. Outpatient prescription drugs and medications which the law restricts to sale by prescription.
2. Formulas prescribed by a physician for the treatment of phenylketonuria. These formulas are subject to the co-pay for brand name drugs.

Prescription drug co-pays apply toward the Annual Out-of-Pocket Maximums.

<table>
<thead>
<tr>
<th>Covered Services (outpatient prescriptions only)</th>
<th>Per Member Co-pay for Each Prescription or Refill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tang Pharmacy or Retail Participating Pharmacy (exception: Preventive immunizations administered by a retail pharmacy &amp; prescription contraceptives per insured co-pay is no charge)</td>
<td>Generic drugs $5 (includes diabetic supplies) Brand drugs $25 Non-Formulary drugs $40 (includes compound drugs)</td>
</tr>
<tr>
<td>Specialty Pharmacy Program</td>
<td>Applicable copay applies</td>
</tr>
<tr>
<td>Certain specialty pharmacy drugs must be obtained through the specialty pharmacy program and are limited to a 30 day supply.</td>
<td>Please contact customer service number on the back of your ID card to see if your drug is on the specialty pharmacy program or you can get a list of drugs required to be dispensed by our specialty pharmacy program at <a href="http://www.anthem.com/ca">www.anthem.com/ca</a>. From our home page: Click on Customer Care; Then select “I need to: Choose: Download Forms”; In the pharmacy library section, click on “Specialty Drug List.”</td>
</tr>
<tr>
<td>Supply Limits 4</td>
<td>30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)</td>
</tr>
<tr>
<td>Retail Pharmacy (participating and non-participating)</td>
<td></td>
</tr>
<tr>
<td>Supply Limits 4</td>
<td>30-day supply</td>
</tr>
<tr>
<td>Specialty Pharmacy</td>
<td></td>
</tr>
</tbody>
</table>

1. Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program.
2. Preferred Generic Program. If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost of that type of prescription drug. The Preferred Generic Program does not apply when the physician has specified “dispense as written” (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.
3. Compound drugs are not covered through home delivery; only covered through certain retail participating pharmacies.
4. Supply limits for certain drugs may be different. Please refer to the EOC/Certificate for complete information.
Anthem Blue Cross Life and Health Notice of Privacy Practices

Information that’s important to you: Every year, we’re required to send you specific information about your rights, your benefits and more. This can use up a lot of trees, so we’ve combined a couple of these required annual notices. Please take a few minutes to read about:

• State notice of privacy practices
• HIPAA notice of privacy practices
• Breast reconstruction surgery benefits

Want to save more trees? Go to www.anthem.com/ca/ucberkeley and sign up to receive these types of notices by e-mail.

State notice of privacy practices: As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your personal information: We may collect, use and share your non-public personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter. We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company — without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity. You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgements about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you. A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

HIPAA notice of privacy practices: This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully. We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information: We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy Rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan.
For health care operations: We use and share PHI for our health care operations.
For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. For example: we keep information about your premium and deductible payments; we may give information to a doctor’s office to confirm your benefits; we may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes; we may share PHI with your health care provider so that the provider may treat you; we may use PHI to review the quality of care and services you get; we may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury; we may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations or treatment purposes in health information exchanges, please visit: www.anthem.com/ca/ucberkeley for more information.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: In most cases, if we use or disclose your PHI outside of treatment, payment, operations or research activities, we must get your OK in writing first. We must receive your written OK before we can use your PHI for certain marketing activities. We must get your written OK before we sell your PHI. If we have them, we must get your OK before we disclose your provider’s psychotherapy notes. Other uses and disclosures of your PHI not mentioned in this notice may also require your written OK. You always have the right to revoke any written OK you provide. You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents). PHI can also be shared with organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers’ Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law. If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper. If your employer pays your premium or part of your premium, but does not pay your health insurance claims, your employer is not allowed to receive your PHI — unless your employer promises to protect your PHI and makes sure the PHI will be used for legal reasons only.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

Your rights: Under federal law, you have the right to:

Continued on next page
Anthem Blue Cross Life and Health Notice of Privacy Practices (continued)

- Send us a written request to see or get a copy of certain PHI, or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.

**Right to a restriction for services you pay for out of your own pocket:** If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or disclosure of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to Anthem Blue Cross (Anthem), Anthem does not have to agree to a restriction (see Your Rights section above). If a law requires the disclosure, Anthem does not have to agree to your restriction.

**How we protect information:** We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure. We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

**Potential impact of other applicable laws:** HIPAA (the federal privacy law) generally does not preempt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

**Contacting You:** We, including our affiliates or vendors, may call or text any telephone numbers provided by you using an automated telephone dialing system and/or a prerecorded message. Without limitations, these calls may concern treatment options, other health-related benefits and services, enrollment, payment or billing.

**Complaints:** If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

**Contact information:** Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

**Copies and changes:** You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.”

**Breast reconstruction surgery benefits:** If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance. Contact Customer Service for more information.

Usually, all providers of healthcare will bill Anthem Blue Cross Life and Health directly for services to Insureds. This is the preferred procedure - you are not bothered with claim forms, and Anthem Blue Cross Life and Health often needs more details than are ordinarily provided on bills to patients.

But sometimes a physician or an ambulance company may not bill Anthem Blue Cross Life and Health directly. In these instances, Anthem Blue Cross Life and Health has no way of knowing about your claim. So, you must mail the bills to Anthem Blue Cross Life and Health within **90 days** of treatment and include a claim form. Claim forms are available at [www.anthem.com/ca/ucberkeley](http://www.anthem.com/ca/ucberkeley).

You are urged to send Anthem Blue Cross Life and Health each bill immediately upon receipt. Mail to:

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 60007, Los Angeles, CA 90060

Complete instructions for use of the claim form are on the form.
On Call International does not replace your medical insurance. All medical costs incurred should be submitted to your health plan and are subject to the Master Policy limits of your health coverage. All assistance services must be arranged and provided by On Call International. Claims for reimbursement will not be accepted.

Program Guidelines
U.S. students studying in a U.S. location are eligible for services when traveling more than 100 miles away from their permanent residence or campus location for up to one year. Medical transportation services and repatriation of deceased remains services are available at campus location.*

U.S. students studying abroad are eligible for services both at and away from their new campus location for up to one year.*

Foreign national students studying in the U.S. are eligible for On Call International’s services, both on or away from campus or while traveling in a country that is not their country of origin.*

*Member shall be eligible for services during the term of his/her defined Program as long as his/her program is still effective and the membership fee has been paid prior to departure. All care and travel coordinated through OnCall, no retroactive benefits will be granted and no reimbursement will be approved.

Key Services

Emergency Medical Evacuation
If adequate medical facilities are not available locally, On Call will make arrangements to use whatever mode of transport, equipment and medical personnel necessary to evacuate a member to the nearest facility capable of providing a high standard of care.

Medical Repatriation
If after seeking medical attention, it is medically advisable for the member to seek further care at home, On Call will transport the member home or to a medical facility closer to home with a medical or non-medical escort, as necessary.

Compassionate Visit
If a member is traveling alone and will be hospitalized for more than seven days, On Call will provide economy, round-trip, common carrier transportation to the place of hospitalization and arrange lodging for a designated family member or friend.

Care of Minor Children
If a member is traveling with dependent children and is hospitalized as a result of a medical emergency for more than seven days, On Call will arrange for the transportation of the unattended children to their home, with an attendant if necessary.

Return of Deceased Remains
On Call will assist with the logistics of returning a member’s remains home in the event of his or her death. This service includes arranging the preparation of the remains for transport, procuring required documentation, providing the necessary shipping container as well as paying for transport.

Prescription Assistance
If a member needs a replacement prescription while traveling, On Call will assist in filling that prescription. Any expenses associated with prescription replacement are the member’s responsibility.

Emergency Message Transmission
On Call will receive and transmit authorized emergency messages for members.

Legal Consultation and Referral
If a member is away from home and requires the services of an attorney, On Call shall arrange for an initial telephone consultation with an attorney without charge to the member. If necessary, the member will be referred to a local attorney.

Lost Luggage Assistance
On Call will assist the member with the tracking of luggage lost or delayed in transit.

Lost/Stolen Travel Document Assistance
On Call will provide assistance by arranging for the replacement of passports, visas, airline documents, birth certificates and other travel-related documents. Any expenses related to replacing lost travel documents are the member’s responsibility.

Interpreter & Legal Referrals
On Call will refer members to local translators and interpreters if communication problems cannot be solved via telephone.

Pre-trip Information
On Call offers members reports via email, fax or postal mail including visa, passport and inoculation requirements, cultural information, weather conditions, embassy and consulate referrals, foreign exchange rates, and travel advisories for any destination.

As a member, you can call upon doctors, hospitals, pharmacies and other services whenever traveling 100 miles or more from your permanent address, campus location or abroad, 24 hours a day, 365 days a year. One phone call connects you to a state-of-the art Global Response Center staffed around-the-clock with trained multilingual professionals to handle medical emergencies quickly and efficiently. As the U.S. member of the International Assistance Group, a 36-partner global network of independent assistance companies, including more than 53 alarm centers, On Call International has immediate response capabilities worldwide with a global network of pre-qualified medical providers, including air and ground ambulance services.

Conditions & Exclusions
On Call International will not pay for services in the following instances:

- Services rendered without the coordination and approval of On Call
- Intentionally self-inflicted injuries, suicide or any attempted threat except when hospitalized as an inpatient.
- Expenses incurred if the original or ancillary purpose of the member’s trip is to obtain medical treatment.
- Participation in a declared or undeclared act of war, civil disturbance or insurrection or an accident occurring while the member is serving on full-time or active duty in the Armed Forces of any country. *Participation in an international authority flight (by exception the Military Aircraft Command of the United States or similar air transport Services Account of other) or while serving as a member of the crew of any aircraft.

Continued on next page
Emergency Assistance Services: On Call International (continued)

- Use of any alcohol or drug unless prescribed by a physician or except if hospitalized as an inpatient. *Any services provided to an injured person where the member is entitled to receive reimbursement for such expenses under any group insurance program maintained by the member’s insurance company or employer.
- Routine or non-disabling medical problems, such as simple fractures, or sickness, which can be treated by local doctors and do not prevent the injured person from continuing the trip or returning home.
- Any treatment or expense related to childbirth, miscarriage or pregnancy except for any abnormal pregnancy or vital complication of pregnancy which endangers the life of the mother and/or unborn child during the first twenty-four weeks of pregnancy.
- A member on an organ transplant list prior to enrollment will not be entitled to a transport for that transplant.

On Call cannot be held responsible for failure to provide services or for delays caused by conditions beyond its control including, but not limited to, flight or weather conditions, strikes, unforeseen changes to airport regulations or restrictions, failure to comply with On Call’s recommendations, or where rendering of service is prohibited by local laws or regulatory agencies.

Member may be required to release On Call or any healthcare provider from liability during emergency evacuation and/or repatriation. Without limiting the foregoing, On Call’s actions and obligations under this Agreement are ministerial in nature, and all medical care is provided by medical professionals ultimately selected by a Member. On Call is not liable for any malpractice performed by a local doctor, healthcare provider, or attorney.

On Call, at its sole discretion, will assist Members on a fee-for-service basis for interventions falling under the Limitations and Uncovered Services. On Call reserves the right, at its sole discretion, to request additional financial guarantees or pre-payment or indemnification from the Member prior to rendering such service on a fee-for-service basis.

Emergency Assistance Services Provided by: On Call International
877-318-6901 (Toll-free within the U.S.)
603-328-1909 (Outside the U.S.)
www.oncallinternational.com

How to File a Claim

Usually, all providers of healthcare will bill Anthem Blue Cross Life and Health directly for services to Insureds. This is the preferred procedure - you are not bothered with claim forms, and Anthem Blue Cross Life and Health often needs more details than are ordinarily provided on bills to patients.

But sometimes a physician or an ambulance company may not bill Anthem Blue Cross Life and Health and may send the bill directly to you. In these instances, Anthem Blue Cross Life and Health has no way of knowing about your claim. So, you must mail the bills to Anthem Blue Cross Life and Health within 365 days of treatment and include a claim form. Claim forms are available at www.anthem.com/ca/ucberkeley. You are urged to send Anthem Blue Cross Life and Health each bill immediately upon receipt. Mail to:

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 60007
Los Angeles, CA 90060

Complete instructions for use of the claim form are on the form.

Complaint Notice

Should you have any complaints or questions regarding your coverage, you may contact Anthem Blue Cross Life and Health at:

Anthem Blue Cross Life and Health Insurance Company
(Anthem Blue Cross Life and Health)
Customer Service
21555 Oxnard Street, Woodland Hills, CA 91367
844-728-5913

If the problem is not resolved, you may also contact the California Department of Insurance at:

California Department of Insurance
Claims Service Bureau, 11th Floor
300 South Spring Street, Los Angeles, California 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
WELLS FARGO INSURANCE PRIVACY INFORMATION
We know that your privacy is important to you and we strive to protect the confidentiality of your personal information. We do not disclose any personal information about our plan participants, except as permitted or required by law (e.g., information you provide to us may be shared with your school to process your insurance transaction). To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. You may obtain a detailed copy of our privacy policy through your school or by calling us at 800-853-5899 or by visiting us at https://studentinsurance.wellsfargo.com.

Important Contacts

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY
www.anthem.com/ca/ucberkeley
Claims, Eligibility and Coverage Questions
844-728-5913
Prescriptions, Pharmacy Benefits Manager
800-700-2541
Dependents: Find a Preferred Provider:
PPO Prudent Buyer Plan
800-888-2108
Medical Assistance Abroad:
BlueCard Worldwide
800-810-BLUE (2583) or collect: 804-673-1177

BERKELEY SHIP OFFICE
Benefits and General Questions
510-642-5700
M-F 8am - 4:45pm, Thursdays 9:30am-4:45pm
ship@berkeley.edu
www.uhs.berkeley.edu/insurance

TANG CENTER APPOINTMENTS
Students: A referral from Tang Center is required for most services prior to receiving treatment.
510-642-2000
www.uhs.berkeley.edu

24/7 NURSELINE
800-681-4065

ON CALL INTERNATIONAL
International Travel Assistance
877-318-6901 (Toll-free within the U.S.)
603-328-1909 (Outside the U.S.)
One Delaware Drive, Salem, NH 03079
www.oncallinternational.com

WELLS FARGO INSURANCE SERVICES USA, INC.
Enrollment Questions, Plan Broker
800-853-5899
Mon - Fri, 8am-5pm PST
CA License No 0D08408
https://studentinsurance.wellsfargo.com

IMPORTANT NOTE
This information is a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in Policy Number 280438 issued to University of California, Berkeley. The Master Policy is subject to the laws of the state in which it was issued. Coverage may not be available in all states or certain terms may be different if required by state law. Please keep this information as a reference.
In addition to dollar and percentage copays, insured persons (students) are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Insured persons are also responsible for all costs over the plan maximums.

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.

Plan maximums and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of the policy.

**Referral Requirements**
A referral from Tang Center is required for all students. Except in specific instances (e.g. emergency care or urgent care), a referral is required from Tang Center prior to receiving treatment outside of the Tang Center.

A separate per visit/per service referral is required for each individual condition at the beginning of each semester prior to receiving care for ongoing conditions. Referrals for outpatient mental health counseling are required once per policy year. If a referral is not obtained prior to treatment, benefits are not payable. A referral is not required in the following circumstances:

- Treatment is for an emergency medical condition,
- Treatment is for an emergency mental health condition,
- Services in an urgent care setting,
- Obstetric and gynecological treatment and
- Preventive/routine services (services considered preventive according to Health Care Reform and/or services rendered not to diagnose or treat an Accident or Sickness).

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

**Explanation of Maximum Allowed Amount**
Maximum allowed amount is the total reimbursement payable under the plan for covered services received from participating and non-participating providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.

**PPO Providers**—The rate the provider has agreed to accept as reimbursement for covered services. Students and dependents are not responsible for the difference between the provider's usual charges & the maximum allowed amount.

**Non-PPO Providers**—For non-emergency care, reimbursement amount is based on an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. Students and dependents are responsible for the difference between the provider's usual charges & the maximum allowed amount.

For medical emergency care rendered by a non-participating provider or non-contracting hospital, reimbursement is based on the reasonable and customary value. Students, dependents and voluntary plan members may be responsible for any amount in excess of the reasonable and customary value.

**When using Non-PPO and Other Health Care Providers, insured persons are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.**

<table>
<thead>
<tr>
<th>Benefit year deductible</th>
<th>$300/student; $900/family</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Providers</td>
<td></td>
</tr>
<tr>
<td>Copay for Non-PPO Inpatient hospital</td>
<td>$500/admission</td>
</tr>
<tr>
<td>Copay for emergency room services</td>
<td>$100/visit (waived if admitted directly from ER)</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximums (no cross application)</strong></td>
<td></td>
</tr>
<tr>
<td>PPO Providers &amp; Other Health Care Providers</td>
<td>$3,200/student; $6,400 family</td>
</tr>
<tr>
<td>Non-PPO Providers</td>
<td>$6,500/student; $13,000 family</td>
</tr>
</tbody>
</table>

The following do not apply to out-of-pocket maximums: percentage copays for non-covered expense. After an insured person reaches the out-of-pocket maximum, the insured person no longer pays copays, coinsurance or pharmacy copays for the remainder of the year. However, insured person remains responsible for non-PPO providers & other health care providers, costs in excess of the covered expense.

**Benefit Year Maximum**
**Unlimited**
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>PPO: Per Insured Person Copay</th>
<th>Non-PPO: Per Insured Person Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Medical Services</strong> <em>(subject to utilization review for inpatient services; waived for emergency admissions)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-private room, meals &amp; special diets, &amp; ancillary services</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td>Outpatient medical care, surgical services &amp; supplies <em>(hospital care other than emergency room care)</em></td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Ambulatory Surgical Centers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery, services &amp; supplies</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong> <em>(subject to utilization review)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-private room, services &amp; supplies <em>(limited to 100 days/benefit year; limit does not apply to mental health and substance abuse)</em></td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient or outpatient services; family bereavement services</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td><strong>Home Health Care</strong> <em>(subject to utilization review)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services &amp; supplies from a home health agency <em>(limited to 100 visits/benefit year, one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care)</em></td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Home Infusion Therapy</strong> <em>(subject to utilization review)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes medication, ancillary services &amp; supplies; caregiver training &amp; visits by provider; monitor therapy; durable medical equipment; lab services</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Physician Medical Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office &amp; home visits</td>
<td>$15 copay$1</td>
<td>40%</td>
</tr>
<tr>
<td>Hospital &amp; skilled nursing facility visits</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td>Surgeon &amp; surgical assistant; anesthesiologist or anesthetist</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td>Allergy testing &amp; treatment</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Lab and X-ray</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Lab</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td>Diagnostic X-ray</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td>Advanced Imaging</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td><em>(The annual deductible and co-insurance does not apply to emergency room laboratory and x-ray services; please refer to Emergency Care)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care Services including physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision), immunizations, health education, intervention services and HIV testing</td>
<td>No copay $(deductible waived)$</td>
<td>40%</td>
</tr>
<tr>
<td><em>This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Well Baby &amp; Well-Child Care for Dependent Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine physical examinations <em>(birth through age six)</em></td>
<td>No copay $(deductible waived)$</td>
<td>40%</td>
</tr>
<tr>
<td>Immunizations <em>(birth through age six)</em></td>
<td>No copay $(deductible waived)$</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Pediatric Preventive Services (up to age 19)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Deductible <em>(deductibles are combined; satisfying one helps satisfy the other)</em></td>
<td>$60/student/$180 family</td>
<td>$60/student/$180 family</td>
</tr>
<tr>
<td>Pediatric Dental OOP Maximum</td>
<td>$1,000 Student/$2000 family</td>
<td>No maximum Non-PPO</td>
</tr>
<tr>
<td>Vision Exam &amp; 1 pair glasses</td>
<td>No co-payment/co-insurance$2</td>
<td>No co-payment/co-insurance$2</td>
</tr>
<tr>
<td>Dental Diagnostic &amp; preventive exam</td>
<td>No co-payment/co-insurance</td>
<td>No co-payment/co-insurance</td>
</tr>
<tr>
<td>Dental Basic Restorative Care</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Dental Major Restorative Care</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Orthodontic Care</td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>

1. The dollar copay applies only to the visit itself. Additional copays may apply for any services performed in office (i.e., X-ray, lab, surgery).
2. Coverage limited to one exam and one pair of eyeglasses per Benefit Period. Limited reimbursement for Non-PPO Providers.
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>PPO: Per Insured Person Copay</th>
<th>Non-PPO: Per Insured Person Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Therapy, Physical Medicine &amp; Occupational Therapy</strong></td>
<td>$15 copay[^1] (deductible waived)</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Chiropractor Services</strong></td>
<td>$15 copay[^1] (deductible waived)</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Speech Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient speech therapy following injury or organic disease</td>
<td>$15 copay[^1] (deductible waived)</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Acupuncture</strong></td>
<td>$15 copay[^1,2] (deductible waived)</td>
<td>40%[^2]</td>
</tr>
<tr>
<td><strong>Temporomandibular Joint Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Splint therapy &amp; surgical treatment</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Pregnancy &amp; Maternity Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician office visits <em>(in-network preventive prenatal services are covered at 100%; first post natal visit is also covered at 100%)</em></td>
<td>$15 copay[^1] (deductible waived)</td>
<td>40%</td>
</tr>
<tr>
<td>Normal delivery, cesarean section, complications of pregnancy</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td>Inpatient physician services</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td>Hospital &amp; ancillary services</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td>Ultrasound due to pregnancy</td>
<td>No copay (deductible waived)</td>
<td>40%</td>
</tr>
<tr>
<td>Abortion</td>
<td>No copay (deductible waived)</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Gender Reassignment Surgery Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital-based care <em>(subject to utilization review)</em></td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td>Inpatient physician visits</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Gender Reassignment Travel Benefits</strong></td>
<td>No copay (deductible waived)</td>
<td>Not covered</td>
</tr>
<tr>
<td><em>(student’s transportation to &amp; from facility is limited to $10,000 per surgery)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Additional Gender Reassignment Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing <em>(limited to 100 days)</em></td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td>Male to Female (MTF) top surgery</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td>Laser Hair Removal and Electrolysis</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td>Tracheal Shave</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Fertility Preservation</strong> <em>(limited to fertility preservation services only. This plan does not provide any coverage for the testing or treatment of infertility. Fertility preservation includes annual storage costs when enrolled on SHIP; limited to $20,000/lifetime maximum)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultation</td>
<td>$15 copay (deductible waived)</td>
<td>40%</td>
</tr>
<tr>
<td>Treatment</td>
<td>$250 copay + 10%</td>
<td>$250 copay + 40%</td>
</tr>
</tbody>
</table>

[^1]: The dollar copay applies only to the visit itself. Additional copays may apply for any services performed in office (i.e., X-ray, lab, surgery).

[^2]: Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist.
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>PPO: Per Insured Person Copay</th>
<th>Non-PPO: Per Insured Person Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes Education Programs</strong> <em>(requires physician supervision)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teach insured persons &amp; their families about the disease process, the daily management of diabetic therapy &amp; self-management training</td>
<td>$15 copay(^1) (deductible waived)</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Prosthetic Devices</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; &amp; therapeutic shoes &amp; inserts for insured persons with diabetes</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rental or purchase of DME including hearing aids, dialysis equipment &amp; supplies <em>(hearing aids benefit is available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)</em></td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Related Outpatient Medical Services &amp; Supplies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground or air ambulance transportation, services &amp; disposable supplies <em>(deductible waived)</em></td>
<td>10%(^2)</td>
<td>10%(^2)</td>
</tr>
<tr>
<td>Blood transfusions, blood processing &amp; the cost of unreplaced blood &amp; blood products</td>
<td>10%(^2)</td>
<td>10%(^2)</td>
</tr>
<tr>
<td>Autologous blood <em>(self-donated blood collection, testing, processing &amp; storage for planned surgery)</em></td>
<td>10%(^2)</td>
<td>10%(^2)</td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room services &amp; supplies <em>($100 copay waived if admitted; deductible waived)</em></td>
<td>$100 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Physician services</td>
<td>No copay</td>
<td>No copay</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care <em>(physician services)</em></td>
<td>$50 copay (deductible waived)</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Bariatric Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(Subject to utilization review; covered only when performed at a Blue Distinction Center for Specialty Care [BDCSC])</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Necessary surgery for weight loss, only for morbid obesity</td>
<td>10%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Travel expenses for an authorized, specified surgery <em>(recipient &amp; companion transportation limited to $3,000 per surgery)</em></td>
<td>No copay (deductible waived)</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

\(^1\) The dollar copay applies only to the visit itself. Additional copays may apply for any services performed in office (i.e., X-ray, lab, surgery).

\(^2\) These providers are not represented in the PPO network.
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>PPO: Per Insured Person Copay</th>
<th>Non-PPO: Per Insured Person Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organ &amp; Tissue Transplants</strong> (subject to utilization review; specified transplants covered only when performed at Centers of Medical Excellence [CME] and Blue Distinction Centers for Specialty Care [BDCSC] for California; Blue Distinction Centers for Specialty Care [BDCSC] for out of California)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient services provided in connection with non-investigative organ or tissue transplants</td>
<td>10%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Physician office visits</td>
<td>$15 copay¹</td>
<td>Not covered</td>
</tr>
<tr>
<td>(including specialists and consultants)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transplant travel expense for an authorized, specified transplant (recipient &amp; companion transportation limited to $10,000 per transplant)</td>
<td>No copay</td>
<td>Not covered</td>
</tr>
<tr>
<td>*Unrelated donor search, limited to $30,000 per transplant</td>
<td>¹</td>
<td></td>
</tr>
</tbody>
</table>

**Mental or Nervous Disorders and Substance Abuse**

**Inpatient Care**

<table>
<thead>
<tr>
<th>Facility-based care (subject to utilization review; waived for emergency admission)</th>
<th>10%</th>
<th>40%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient physician visits</td>
<td>10%</td>
<td>40%</td>
</tr>
</tbody>
</table>

**Outpatient Care**

<table>
<thead>
<tr>
<th>Facility-based care (subject to utilization review; waived for emergency admission)</th>
<th>10%</th>
<th>40%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient physician visits</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td>(Behavioural Health treatment for Autism or Pervasive Development disorders require pre-service review)</td>
<td>$15 copay¹</td>
<td>40%</td>
</tr>
<tr>
<td>Psycho-educational Testing (deductible waived)</td>
<td>10%</td>
<td>40%</td>
</tr>
</tbody>
</table>

**Medical Evacuation Benefit**

Expenses for transporting insured person back to home country for medical care and treatment; limited to $50,000 see Certificate for specific details. Charges do not apply toward out of pocket maximum.

No co-payment/co-insurance (deductible waived)

**Repatriation of Remains**

(in the event of insured person's death, expenses for preparing and transporting the insured person's bodily remains back to home country limited to $25,000; valid for students traveling abroad or international students attending classes in the U.S.; See Certificate for specific details.) Charges do not apply toward out of pocket maximum.

No co-payment/co-insurance (deductible waived)

**Care Outside of Plan Service Area**

(Benefits provided through the BlueCard® Program are paid at the participating level. Member's cost share will be either a copayment or coinsurance based on the lower of billed charges or the negotiated allowable amount for participating providers as agreed upon with the local Blue's Plan).

<table>
<thead>
<tr>
<th>Within US</th>
<th>See applicable benefit</th>
<th>See applicable benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outside of US: Blue Cross Blue Shield Global Core (including non-emergency foreign claims)</td>
<td>See applicable benefit</td>
<td>See applicable benefit</td>
</tr>
</tbody>
</table>

¹ The dollar copay applies only to the visit itself. Additional copays may apply for any services performed in office (i.e., X-ray, lab, surgery)
Covered Services

**Outpatient Drugs and Medications (not subject to deductible)**

**Retail**
- Female oral contraceptives generic and single source brand: No copay (PPO), 40% up to $250/prescription (Non-PPO)
- Tier 1 drugs (includes diabetic supplies): $5 copay (PPO), $5 copay + 40% up to $250/prescription (Non-PPO)
- Tier 2 drugs: $25 copay (PPO), $25 copay + 40% up to $250/prescription (Non-PPO)
- Tier 3 drugs: $40 copay (PPO), $40 copay + 40% up to $250/prescription (Non-PPO)

**Supply Limits**
- Retail Pharmacy (participating and non-participating): 30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)
- Specialty Pharmacy: 30-day supply

This Summary of Benefits is a brief review of benefits. Once enrolled, insured persons will receive a Certificate of Insurance, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.
PPO Student Health Plan—Prudent Buyer Plan Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigatory procedure or medication.

But, if insured person is denied benefits because it is determined that the requested treatment is experimental or investigative, the insured person may request an independent medical review, as described in the Certificate.

Services Received Outside of the United States. Services rendered by providers located outside the United States, unless the services are for an emergency, emergency ambulance or urgent care.

Crime or Nuclear Energy. Conditions that result from (1) the insured person's commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the insured person's effective date. Services received after the insured person's coverage ends, except as specified as covered in the Certificate.

Excess Amounts. Any amounts in excess of covered expense or the benefit maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjustments to settlement or otherwise, where any worker's compensation, employer's liability law or occupational disease law, whether or not the insured person claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the Certificate.

Government Treatment. Any services the insured person actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the insured person is not required to pay them or they are given to the insured person for free.

Services of Relatives. Professional services received from a person living in the insured person's home or who is related to the insured person by blood or marriage, except as specified as covered in the Certificate.

Voluntary Payment. Services for which the insured person has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the insured person and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders and alcohol or drug dependence, including rehabilitative care in relation to these conditions, except as specified as covered in the Certificate.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the Certificate.

Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests. Hearing aids and routine hearing tests, except as specified as covered in the Certificate.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics, routine eye exams and routine eye refractions, eyeglasses or contact lenses, except as specified as covered in the Certificate.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or infusion therapy provider, except as specified as covered in the Certificate.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the Certificate.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement.

Hair loss or growth treatment. Items and services for the promotion, prevention, or other treatment of hair loss or hair growth, except hair removal in the face and neck and only in the treatment of gender dysphoria or hypertrichosis (hair growth in excess of normal), but not androgen—dependent hirsutism. Hair removal must be ordered by a physician.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss), and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Certificate.

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Gene Therapy. Gene therapy as well as any drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic Supplies. Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications, except as specified as covered in the Certificate.

Air Condioners. Air purifiers, air conditioners or humidifiers.

Nonsurgical Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the Certificate.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the Certificate. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the Certificate.

Acupuncture. Acupuncture treatment, as specified as covered in the Certificate. Acupuncture may not be covered in the Certificate. This exclusion does not apply to acupuncture for the treatment of infertility, including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the Certificate.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the Certificate.

Medical Equipment, Devices and Supplies. This plan does not cover the following: • Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft. • Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury. • Enhancements to standard equipment and devices that is not medically necessary. • Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is medically necessary in your situation. This exclusion does not apply to the medically necessary treatment as specifically stated as covered in the EOC/Certificate.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility or residential treatment center.

Third Party Liability. Any services for which the insured person is entitled to reimbursement of benefits paid if the insured person recovers damages from a legally liable third party.

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Get the best in eye care and eyewear with UC Berkeley SHIP and VSP® Vision Care.

Why enroll in VSP? We invest in the things you value most—the best care at the lowest out-of-pocket costs. Because we’re the only national not-for-profit vision care company, you can trust that we’ll always put your wellness first.

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 provider, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider.
- **Great Eyewear.** It’s easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Create an account at vsp.com.** Once your plan is effective, review your benefit information.
- **Find an eye care provider who’s right for you.** To find a VSP provider, 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. Visit vsp.com to find a Premier Program location that carries these brands. Prefer to shop online? Check out all of the brands at Eyeconic.com, VSP’s online eyewear store.
Your VSP Vision Benefits Summary

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

### VSP Provider Network:

**VSP Choice**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>Copay</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WellVision Exam</strong></td>
<td>Focuses on your eyes and overall wellness</td>
<td>$10</td>
<td>Every plan year*</td>
</tr>
<tr>
<td><strong>Prescription Glasses</strong></td>
<td></td>
<td>$25</td>
<td>See frame and lenses</td>
</tr>
<tr>
<td><strong>Frame</strong></td>
<td>• $150 allowance for a wide selection of frames</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• $170 allowance for featured frame brands</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 20% savings on the amount over your allowance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• $80 Costco® frame allowance</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Standard progressive lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Premium progressive lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Custom progressive lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Average savings of 20-25% on other lens enhancements</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lens Enhancements</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Standard progressive lenses</td>
<td>$55</td>
<td>Every plan year</td>
</tr>
<tr>
<td></td>
<td>• Premium progressive lenses</td>
<td>$95 - $105</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Custom progressive lenses</td>
<td>$150 - $175</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Average savings of 20-25% on other lens enhancements</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contacts (instead of glasses)</strong></td>
<td>$150 allowance for contacts and contact lens exam (fitting and evaluation)</td>
<td>$0</td>
<td>Every plan year</td>
</tr>
<tr>
<td></td>
<td>• 15% savings on a contact lens exam (fitting and evaluation)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Extra Savings**

- Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details.
- 20% savings on additional glasses and sunglasses, incuding 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

Visit vsp.com for details, if you plan to see a provider other than a VSP network provider.

- Exam .............................................. up to $47
- Lined Bifocal Lenses ....................... up to $60
- 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.

*Plan year begins in August

Contact us. 800.877.7195 | vsp.com

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### Network: PDP Plus

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>In-Network % of Negotiated Fee</th>
<th>Out-of-Network % of R&amp;C Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type A: Preventive</strong></td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>(cleanings, exams, X-rays)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Type B: Basic Restorative</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>(fillings, extractions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Type C: Major Restorative</strong></td>
<td>70%</td>
<td>40%</td>
</tr>
<tr>
<td>(bridges, dentures)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deductible†</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$25</td>
<td>$50</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annual Maximum Benefit</th>
<th>$2,000</th>
<th>$2,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Person</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Type</th>
<th>How Many/How Often</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type A - Preventive</strong></td>
<td></td>
</tr>
<tr>
<td>Prophylaxis (cleanings)</td>
<td>• Two per plan year.</td>
</tr>
<tr>
<td>Oral Examinations</td>
<td>• Two exams per plan year.</td>
</tr>
<tr>
<td>Topical Fluoride Applications</td>
<td>• Two fluoride treatments per plan year.</td>
</tr>
<tr>
<td>X-rays</td>
<td>• Full mouth X-rays: one per five plan years;</td>
</tr>
<tr>
<td></td>
<td>• Bitewing X-rays: one set per plan year for adults; two sets per plan year for children.</td>
</tr>
<tr>
<td>Space Maintainers</td>
<td></td>
</tr>
<tr>
<td><strong>Type B - Basic Restorative</strong></td>
<td></td>
</tr>
<tr>
<td>Fillings</td>
<td>• Composite fillings allowed on all teeth.</td>
</tr>
<tr>
<td>Simple Extractions</td>
<td></td>
</tr>
<tr>
<td>Endodontics</td>
<td>• Root canal treatment.</td>
</tr>
<tr>
<td>General Anesthesia</td>
<td>• When dentally necessary in connection with oral surgery, extractions or other covered dental services.</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td></td>
</tr>
<tr>
<td>Periodontics</td>
<td>• Periodontal scaling and root planing once per quadrant, every 24 months;</td>
</tr>
<tr>
<td></td>
<td>• Periodontal surgery once per quadrant, every 36 months;</td>
</tr>
<tr>
<td></td>
<td>• Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a plan year.</td>
</tr>
<tr>
<td>Sealants</td>
<td>• 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.</td>
</tr>
<tr>
<td><strong>Type C – Major Restorative</strong></td>
<td></td>
</tr>
<tr>
<td>Crown, Denture, and Bridge Repair/Recementations</td>
<td></td>
</tr>
<tr>
<td>Relining and Rebasing of Dentures</td>
<td>• Once per 36 months.</td>
</tr>
<tr>
<td>Bridges and Dentures</td>
<td>• Initial placement to replace one or more natural teeth, which are lost while covered by the Plan;</td>
</tr>
<tr>
<td></td>
<td>• Dentures and bridgework replacement: one every 5 plan years;</td>
</tr>
<tr>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td>Crowns/Inlays/Onlays</td>
<td>• Replacement once every 5 plan years.</td>
</tr>
<tr>
<td>Implant Supported Cast Restorations</td>
<td>• Replacement once every 5 plan years.</td>
</tr>
<tr>
<td>Core Buildup; Post and Cores</td>
<td>• Once per 5 plan years.</td>
</tr>
</tbody>
</table>

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.
**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

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.