



# BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2023/2024

**DESIGNED EXCLUSIVELY FOR THE  
DOMESTIC AND INTERNATIONAL  
STUDENTS OF:**

**UNIVERSITY OF CALIFORNIA,  
BERKELEY**

Berkeley, CA

("the Policyholder")

**UNDERWRITTEN BY:**

Wellfleet Insurance Company

Fort Wayne, IN

("the Company")

**Policy Number: WI2324CASHIP40**

**Group Number: ST1359SH**

**Effective: 8/1/2023 – 7/31/2024**

**ADMINISTERED BY:**

Wellfleet Group, LLC dba Wellfleet

Administrators, LLC

## Table of Contents (Click on section title below to go to section in “Benefits at a Glance.”)

Welcome Students.....	2
Where to Find Help.....	3
When Coverage Begins.....	3
When Coverage Ends.....	4
Extension of Benefits .....	4
Premium Refund/Cancellation .....	4
How Do I Waive? .....	4
ID Cards.....	4
University Health Services .....	5
Where Do I Go For Services? .....	5
How Much Does It Cost? .....	6
Eligibility .....	7
Prescription Drug Benefits.....	8
How the Student Health Insurance Plan Works .....	9
Schedule of Benefits .....	10
Exclusions and Limitations.....	21
How to File a Claim .....	23
Complaint Notice .....	23
Academic Emergency Services.....	24
Teladoc .....	24

## Welcome Students...

We are pleased to provide you with this summary of the 2023 – 2024 Berkeley Student Health Insurance Plan (“Plan”), which is fully compliant with the Affordable Care Act. “Benefits at a Glance” includes effective dates and costs of coverage, as well as other helpful information. For additional details about the Plan, please consult the Plan Certificate and other materials at <https://www.studentinsurance.com/Client/1359>. For questions about medical benefits or claims, please call Member Services at (877) 657-5033.

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

### PENDING STATE APPROVAL

**The Plan described in “Benefits at a Glance” is awaiting approval by the CA Department of Insurance. If the Plan is changed during the approval process, a revision of this document will be provided. This is not an insurance policy and your receipt of this document does not constitute the issuance or delivery of a policy of insurance.**

## Where to Find Help

IMPORTANT CONTACTS		
Appointments – Tang Center	<b>University Health Services</b> <a href="https://uhs.berkeley.edu">uhs.berkeley.edu</a> Telephone: (510) 642-2000	
Eligibility, Benefits and General Questions	<b>Berkeley SHIP Office</b> <a href="mailto:ship@berkeley.edu">ship@berkeley.edu</a> Telephone: (510) 642-5700 M-F 8:00 a.m.- 4:45 p.m. PST, except Wednesdays 9:30 a.m.- 4:45 p.m. PST <a href="https://uhs.berkeley.edu/insurance">https://uhs.berkeley.edu/insurance</a>	
Benefits and Claims Questions	<b>Wellfleet Member Services</b> Telephone: (877) 657-5033 M-F 6:00 a.m.- 5:00 p.m. PST <a href="https://www.studentinsurance.com/Client/1359">https://www.studentinsurance.com/Client/1359</a>	
Eligibility and Enrollment	<b>Academic HealthPlans (AHP)</b> Telephone: (855) 854-3254 M-F 8:00 a.m.- 5:00 p.m. PST <a href="https://help.ahpcare.com">https://help.ahpcare.com</a>	<b>Plan Brokered By</b> Academic HealthPlans (AHP) CA License No OH64806
Pharmacy Benefits Manager	<b>Wellfleet Rx/ESI</b> Telephone: (877) 640-7940 Customer Service hours: 24/7 Prior-Authorization: 877-640-7938 24/7 Electronic Prior-Authorization: <a href="http://www.express-scripts.com">www.express-scripts.com</a>	
Find a Preferred Provider	<b>Wellfleet Providers</b> (877) 657-5033 <a href="http://www.wellfleetstudent.com/ucbprovidersearch">www.wellfleetstudent.com/ucbprovidersearch</a>	
24-Hour SHIP Nurse Line	Telephone: (800) 681-4065	24/7 Advice Nurse
24-Hour Teladoc	Telephone: (800) 835-2362 24-hours a day/7 days a week/365 days a year <a href="https://www.teladoc.com/wellfleetstudent">https://www.teladoc.com/wellfleetstudent</a>	24/7 Appointments with an MD
24-Hour Travel Assistance	<b>Academic Emergency Services</b> Toll-free: (855) 873-3555 Outside the U.S.: (610) 263-4660 Email: <a href="mailto:assistance@ahpcare.com">assistance@ahpcare.com</a>	24/7 Travel helpline when out of the Bay Area

## When Coverage Begins

Insurance takes effect on the effective date at 12:00 a.m. local time at the Policyholder's address.

Your coverage under the Plan will become effective at 12:00 a.m. on the later of:

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

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

## When Coverage Ends

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

- Date the Policy terminates; or
- End of the period of coverage for which premium has been paid; or
- The date the Insured Person ceases to be eligible for the insurance; or
- Date the Insured Person enters military service.

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

## Extension of Benefits

Coverage under the Plan ceases on the Termination Date of your insurance coverage. However, the Company will extend coverage for you as follows:

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

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

## Premium Refund/Cancellation

A refund of premium will be considered for the reasons listed below only. No other refunds will be granted.

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

## How Do I Waive?

All eligible registered full time domestic and international students will be automatically enrolled in the Berkeley Student Health Insurance Plan (SHIP). If you already have an insurance plan in place that meets all of the waiver criteria established by University of California, Berkeley, you may submit an online waiver application with your insurance information during the waiver period. The waiver periods are listed on page six of this brochure. To complete an online waiver, please visit:

<https://uhs.berkeley.edu/insurance/waiving-ship>.

Fall waiver applications are completed during the summer for the upcoming academic year. The fall semester waiver will be valid for the full academic year. A student who waives Berkeley SHIP for the fall semester 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 for the fall semester. A spring semester waiver is valid for the remainder of the academic year. A new waiver must be completed and approved during the fall waiver period prior to each academic year that the eligible student is registered. UC Berkeley will audit waiver submissions and has sole discretion on determining whether a plan meets the waiver criteria at any given time.

## ID Cards

You will have access to the electronic version of your ID card at My Wellfleet Account. By accessing your digital ID card, you don't have to keep the plastic version in your wallet anymore. If your ID card is lost/stolen, simply pull it up on your computer or mobile device at:

<https://www.studentinsurance.com/Client/1359>.

In My Wellfleet Account you will be able to:

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

To register for My Wellfleet Account, please follow the instructions below:

- Visit [www.wellfleetstudent.com](http://www.wellfleetstudent.com) and enter your school's name (UCB) into the search box.
- From your school's landing page, click the menu icon in the top right corner and select "My Wellfleet Account" to access your account.
- If you do not have an account on our system, click "Create a New Account" on the student sign in page using your school ID# and your Date of Birth.

- Please use the email address registered with your school when creating your account.
- If you already have an account, enter your email address and password to log in.

If you require assistance with your ID Card, please call Member Services at (877) 657-5033.

## University Health Services

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

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

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

## Where Do I Go For Services?

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

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

**You should request all of your provider services be performed by a PPO Provider when you use a PPO facility.** When Non-PPO providers are used, you may be subject to higher out-of-pocket expenses.

Additionally, PPO physicians agree to admit their patients to network hospitals, guaranteeing discounted charges and utilization management savings will occur.

With no claim forms to file, Insured Persons can focus on their health, not paperwork.

Insured Persons can find a PPO physician in their area by calling Member Services at (877) 657-5033 or [www.wellfleetstudent.com/ucbprovidersearch](http://www.wellfleetstudent.com/ucbprovidersearch).

When the Insured Person receives Emergency Services, or Out-of-Network air Ambulance Services, or certain non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center without the Insured Person's consent, the Insured Person is protected from Surprise Billing. In these situations, the Insured Person's cost sharing responsibility is calculated as if the total amount that would be charged for the services by an In-Network Provider or facility were equal to the Recognized Amount for the services, which is the lesser of the Actual Amount billed by the provider or facility and the Qualifying Payment Amount. Refer to the Preferred Provider Organization provision in the How The Plan Works And Description Of Benefits section of the Certificate for additional information.

## How Much Does It Cost?

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

REGISTERED UNDERGRADUATES		
	FALL 8/1/23 - 12/31/23	SPRING/SUMMER 1/1/24 - 7/31/24
Waiver Start Date	5/1/23	12/1/23
Waiver Deadline Without Fee	7/17/23	1/1/24
Final Waiver Deadline With Late Fee	8/15/23	1/15/24
Student Only	\$1,929.00	\$1,929.00
NOTE: Costs below are in addition to the student premium. Dependent enrollment in this plan is voluntary.		
Dependent Enrollment Start Date	7/1/23	12/1/23
Dependent Enrollment End Date	9/1/23	2/1/24
Spouse Only	\$1,929.00	\$1,929.00
One Child Age 0-25 Only	\$1,929.00	\$1,929.00
Two or More Children Age 0-25 Only	\$3,749.00	\$3,749.00

VOLUNTARY UNDERGRADUATES (CONCURRENT ENROLLMENT)		
	FALL 8/1/23 - 12/31/23	SPRING/SUMMER 1/1/24 - 7/31/24
Enrollment Start Date	7/1/23	12/1/23
Enrollment End Date	9/1/23	2/1/24
Student Only	\$1,929.00	\$1,929.00
NOTE: Costs below are in addition to the student premium. Dependent enrollment in this plan is voluntary.		
Spouse Only	\$1,929.00	\$1,929.00
One Child Age 0-25 Only	\$1,929.00	\$1,929.00
Two or More Children Age 0-25 Only	\$3,749.00	\$3,749.00

For more information on the cost to add dependents, please go to <https://uhs.berkeley.edu/insurance/ship-fees-enrollment>.

REGISTERED GRADUATES		
	FALL 8/1/23 - 12/31/23	SPRING/SUMMER 1/1/24 - 7/31/24
Waiver Start Date	5/1/23	12/1/23
Waiver Deadline Without Fee	7/17/23	1/1/24
Final Waiver Deadline With Late Fee	8/15/23	1/15/24
Student Only	\$3,078.00	\$3,078.00
NOTE: Costs below are in addition to the student premium. Dependent enrollment in this plan is voluntary.		
Dependent Enrollment Start Date	7/1/23	12/1/23
Dependent Enrollment End Date	9/1/23	2/1/24
Spouse Only	\$3,078.00	\$3,078.00
One Child Age 0-25 Only	\$3,078.00	\$3,078.00
Two or More Children Age 0-25 Only	\$6,009.00	\$6,009.00

VOLUNTARY GRADUATES (FILING FEE)		
	FALL 8/1/23 - 12/31/23	SPRING/SUMMER 1/1/24 - 7/31/24
Enrollment Start Date	7/1/23	12/1/23
Enrollment End Date	9/1/23	2/1/24
Student Only	\$3,078.00	\$3,078.00
NOTE: Costs below are in addition to the student premium. Dependent enrollment in this plan is voluntary.		
Spouse Only	\$3,078.00	\$3,078.00
One Child Age 0-25 Only	\$3,078.00	\$3,078.00
Two or More Children Age 0-25 Only	\$6,009.00	\$6,009.00

For more information on the cost to add dependents, please go to <https://uhs.berkeley.edu/insurance/ship-fees-enrollment>.

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



## Eligibility

### Mandatory Enrollments

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

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

### Voluntary Enrollments

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

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

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

### Mandatory and Voluntary Enrollments

Except in the case of medical withdrawal from school due to sickness or injury, any student who cancels enrollment or withdraws from UC Berkeley prior to attending at least the first day of classes for the period for which he or she is enrolled shall not be covered under the insurance plan. A student who graduates or withdraws after attending the first day of classes for the period for which he or she is enrolled will remain covered under the Plan for the term purchased and no refund will be allowed. For additional information, please go to <https://uhs.berkeley.edu/ship>.

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

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

### Medical Leave of Absence

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

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

### Dependent Coverage

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

Eligible dependents are the insured student's lawful spouse, or domestic partner who resides with the insured student, and the insured student's, the spouse's, or the domestic partner's dependent biological or adopted child or stepchild under 26 years of age. To enroll your domestic partner, a Declaration of Domestic Partnership issued by the State of California; or proof of a same sex legal union other than marriage formed in another jurisdiction; or a completed Declaration of Domestic Partnership form issued by University Health Services is necessary. A "Newborn" will be covered from the moment of birth for medically necessary health care services for an initial period of **31 days** OR until the insured student's coverage terminates, if earlier. Coverage of a newborn may be continued beyond this initial 31 day period by notifying AHP within **31 days** from the date of birth and by payment of any additional premium. All newborn children should be reported to the Berkeley SHIP Office at [ship@berkeley.edu](mailto:ship@berkeley.edu). Dependents must be enrolled for the same term of coverage for which the insured student is enrolled. Dependent coverage expires concurrently with that of the insured student and dependents must re-enroll when coverage terminates to maintain coverage. Dependents must be re-enrolled each term. It is the student's responsibility to re-enroll your dependents each term, prior to the enrollment deadline date listed in the "Benefits at a Glance." To enroll your eligible dependent(s), you must go to:

<https://uhs.berkeley.edu/insurance/insurance-dependents>.

## Prescription Drug Benefits

To fill a prescription, take your prescription to a participating pharmacy and present your member ID card. The amount you pay for a covered prescription – your copayment – will be determined by the tier of the drug under the formulary. Higher tiers are associated with higher copays. Generic drug means a drug that is the same as its brand name drug

equivalent in dosage, strength, effect, how it is taken, quality, safety, and intended use. Brand name drugs are marketed under a proprietary, trademark-protected name. Tier 1 drugs are preferred generic drugs. Tier 2 drugs are preferred brand name drugs and high cost generics. Tier 3 drugs are non-preferred drugs. Some formulary drugs have coverage requirements and limits, such as prior authorization, quantity limits, and step therapy. Drugs identified as specialty drugs have a higher copay associated with them. The formulary is available online at <https://uhs.berkeley.edu/insurance/ship-benefits/prescriptions>. You or your provider may also contact Member Services at (877) 657-5033.

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

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

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

Covered Services (outpatient prescriptions only)	Per Member Copay for Each Prescription or Refill		
<b>Tang Pharmacy or Retail Participating Pharmacy</b> Preventive immunizations administered by a participating retail pharmacy and certain prescription contraceptives are covered at no charge.  The Deductible does not apply to outpatient prescription drugs.	<b>Tang Center</b> Tier 1: No Copay Tier 2: \$25 Copay Tier 3: \$40 Copay Specialty drugs: \$75 Copay	<b>Participating Retail</b> Tier 1: \$20 Copay Tier 2: \$40 Copay Tier 3: \$60 Copay Specialty drugs: 20% up to \$250 Copay	<b>Non-Participating Retail</b> Tier 1: \$20 Copay; then 50% up to \$250 Copay plus all charges in excess of the participating pharmacy's negotiated charge Tier 2: \$40 Copay; then 50% up to \$250 Copay plus all charges in excess of the participating pharmacy's negotiated charge Tier 3: \$60 Copay; then 50% up to \$250 Copay plus all charges in excess of the participating pharmacy's negotiated charge Specialty drugs: 50% up to \$250 Copay plus all charges in excess of the participating pharmacy's negotiated charge
<b>Supply Limits - Retail Pharmacy</b>	Prescription drugs are limited to a 30-day supply, except where provided for by federal or CA state law or regulation.		



<sup>1</sup> Dispense as Written: If a prescriber prescribes a covered brand name drug where a generic drug equivalent is available and specifies: "Dispense as Written" (DAW), You will pay the copayment for the brand name drug. If a prescriber does not specify DAW and you request a covered brand name drug where a generic drug equivalent is available, you will be responsible for the cost difference between the brand name drug and the generic drug equivalent, and the copayment that applies to brand name drugs. This DAW penalty does not apply to your out-of-pocket maximum or deductible.

#### Specialty Prescription Drugs with Copayment Assistance Program

Copayment Assistance Program - Prior Authorization May Be Required: Amounts You pay out-of-pocket for covered Specialty Prescription Drugs will not exceed the applicable Tier's cost share per 30 day supply and will be applied towards the Deductible (if applicable) and Out-of-Pocket Maximum. Copayment Assistance may be available to You for certain Specialty Prescription Drugs when Your prescription is filled at a participating network pharmacy. Visit [www.wellfleetstudent.com](http://www.wellfleetstudent.com) for the applicable Specialty Prescription Drugs. Copayment Assistance dollars paid by the drug manufacturer for covered Specialty Prescription Drugs will not be applied towards the Deductible (if applicable) or Out-of-Pocket Maximum. Any amounts paid by You for a covered Specialty Prescription Drug after Copayment Assistance will be applied to the deductible (if applicable) and Out-of-Pocket Maximum. For details, contact the Copayment Assistance Program at 636-271-5280.

Covered Services (outpatient prescriptions only)	Participating Retail	Non-Participating Retail
For each fill up to a 30 day supply.	25% of the Negotiated Charge for Covered Medical Expenses  Deductible Waived	Not Covered

## How the Student Health Insurance Plan Works

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

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

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

#### Preferred Provider Organization

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

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

Note, however, the Company will pay at the In-Network level for treatment by an Out-of-Network Provider and will calculate your cost sharing amount at the In-Network Provider level, and your cost share will be applied to your In-Network deductible and out-of-pocket maximum if:

1. There is no In-Network Provider within a 25-mile radius of the Preferred Provider service area available to provide a preventive service or treat you for a specific covered injury or covered sickness; or
2. You have an emergency medical condition and receive emergency services from an Out-of-Network Provider or facility. The most the Out-of-Network Provider or facility may bill you is the In-Network cost sharing amount (such as deductibles, copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless the Out-of-Network Provider or facility determines that you can travel using non-medical or non-emergency transportation, the Out-of-Network Provider provides proper notice and consent, and you are in a condition to receive notice of, and to consent to, Out-of-Network treatment; or
3. You receive non-emergency services from an In-Network hospital or ambulatory surgical center, but certain providers there may be Out-of-Network Providers. In these cases, the most those Out-of-Network Providers may bill you without consent is the In-Network cost sharing amount. You can't be balance billed or asked to give up your protections for ancillary services, including emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, intensivist services, and items and services provided by an Out-of-Network Provider if there is no In-Network Provider who can furnish such item or service at such facility, or items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network Provider satisfied proper notice and consent.

However, if you received notice from the Out-of-Network Provider of their non-network status under the following circumstances, we will pay covered medical expenses at the Out-of-Network level as shown in the Schedule of Benefits:

If the appointment is scheduled at least 72 hours prior to the date of service, and notice is provided not later than 72 hours prior to the date of service;

- If the appointment is scheduled within 72 hours prior to the date of service, and notice is provided on the date the appointment is scheduled; or
- If the appointment is scheduled on the date of service, and notice is provided no later than 3 hours prior to the service; and
- You gave written consent to treatment, this Certificate will pay covered medical expenses at the Out-of-Network level as shown in the Schedule of Benefits.

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

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

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

When you receive emergency services, or Out-of-Network air ambulance services, or certain non-emergency treatment by an Out-of-Network Provider at an In-Network hospital or ambulatory surgical center without your consent, you are protected from Surprise Billing. In these situations, your cost sharing responsibility will be calculated as if the total amount that would be charged for the services by an In-Network Provider or facility were equal to the recognized amount for the services, which is the lesser of the actual amount billed by the provider or facility and the qualifying payment amount. Refer to the Preferred Provider Organization provision above for additional information.

### How You Can Request a Cost Estimate for Proposed Covered Services

You may request an estimate of the costs You will have to pay when Your health care provider proposes a procedure, or other covered service. You can request this cost estimate by logging on to the [www.wellfleetstudent.com](http://www.wellfleetstudent.com) website, typing in the name of Your school and logging into Your secure Wellfleet school webpage. Click the "Cost of Care Estimator" link and follow the steps to perform the following:

- Search for a Provider
- Request a Cost Estimate for health care services, and
- View Ratings and Reviews of Providers

You can also print cost estimate results.

To request a cost estimate by phone, or if You need assistance with creating a cost estimate, call Wellfleet Member Services at (877) 657-5033.

## Schedule of Benefits

<b>Policy Year Deductible (other than Pediatric Dental Care):</b>	\$450 Individual/\$1,350 Family
<b>Pediatric Dental Care Deductible:</b>	\$60 Individual/\$180 Family

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

### Hospital Inpatient Facility Copayment (other than Mental Health Disorder or Substance Use Disorder Benefits):

In-Network Provider:	\$250 per hospital admission
Out-of-Network Provider:	\$500 per hospital admission
<b>Emergency Services Copayment:</b>	\$250 per visit (waived if admitted)

### Policy Year Out-of-Pocket Maximum:

#### For other than Pediatric Dental Care:

In-Network Provider/Tang Center combined:	\$3,200 Individual/\$6,400 Family
Out-of-Network Provider (not combined):	\$6,500 Individual/\$13,000 Family

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

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

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

**Policy Year Maximum:**

Unlimited

Covered Medical Expenses incurred for the treatment of cervical pre-cancer, diagnosed cervical cancer, primary cardiovascular hypertension, or diabetes mellitus are not subject to the Medical Deductible, Coinsurance, or Copayments when services are provided through an In-Network Provider. This would not apply to an underlying condition causing hypertension. All other policy provisions will apply.

**The Covered Medical Expense Below Will Be:**

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

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING
<b>Hospital Care</b>		
Inpatient hospital room & board expenses, subject to semi-private room rate unless intensive care unit is required, and miscellaneous services and supplies  <i>Pre-Certification Required</i>	\$250 Copayment per admission then 10% of the Negotiated Charge	\$500 Copayment per admission then 50% of Usual and Customary Charge
Outpatient surgery facility and miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma  <i>Pre-Certification Required</i>	10% of the Negotiated Charge	50% of Usual and Customary Charge
<b>Physician's Visits</b>		
While confined in a hospital or skilled nursing facility	10% of the Negotiated Charge	50% of Usual and Customary Charge
Physician's Office or Home Visits	\$15 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING
Telemedicine or Telehealth Services	\$15 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Specialist/Consultant Physician Services	\$25 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Retail Health Clinics	\$15 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Allergy Testing and Treatment	10% of the Negotiated Charge	50% of Usual and Customary Charge
<b>Inpatient or Outpatient Surgery</b> <i>Pre-Certification Required</i>		
Surgeon Services	10% of the Negotiated Charge	50% of Usual and Customary Charge
Anesthetist	10% of the Negotiated Charge	50% of Usual and Customary Charge
Assistant Surgeon	10% of the Negotiated Charge	50% of Usual and Customary Charge
<b>Skilled Nursing Facility Benefit</b>		
Limited to 100 days per benefit period. (This limitation does not apply to Mental Health Disorder or Substance Use Disorder Benefits) <i>Pre-Certification Required</i>	\$250 Copayment per admission then 10% of the Negotiated Charge	\$500 Copayment per admission then 50% of Usual and Customary Charge
Preventive Services mandated by the Patient Protection and Affordable Care Act including, but not limited to, physical exams, preventive screenings, (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision), immunizations, health education, intervention services and HIV testing. This is not an exhaustive list.	0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Inpatient Rehabilitation Facility Expense Benefit <i>Pre-Certification Required</i>	\$250 Copayment per admission then 10% of the Negotiated Charge	\$500 Copayment per admission then the plan pays 50% of Usual and Customary Charge

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING
Autologous Blood Banking (self-donated blood collection, testing, processing & storage for planned surgery)	10% of the Negotiated Charge	10% of Usual and Customary Charge
<p>Rehabilitation Therapy and Habilitation Services including, Physical Therapy, Occupational Therapy and Speech Therapy; Cardiac Rehabilitation and Pulmonary Rehabilitation</p> <p>For Mental Health Disorder and Substance Use Disorder benefits see below under Treatment for Mental Health Disorder, Substance Use Disorder including Gender Dysphoria and Behavioral Health Treatment for Pervasive Developmental Disorder or Autism.</p> <p><i>Pre-Certification required after the 12<sup>th</sup> visit.</i></p>	\$15 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Emergency Services & Supplies in an emergency department for Emergency Medical Conditions	<p>\$250 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)</p> <p>Copayment waived if admitted</p>	Paid the same as IN-NETWORK Provider subject to Usual and Customary Charge
Urgent Care Center for non-life-threatening conditions (includes ancillary services received during an Urgent Care visit)	<p>\$50 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)</p> <p>If Urgent Care at Tang Center, \$35 Copayment per visit then 10% of the Negotiated Charge for any ancillary services received during the visit (Deductible Waived)</p>	50% of Usual and Customary Charge
Laboratory Procedures (Outpatient)	10% of the Negotiated Charge	50% of Usual and Customary Charge
<p>Diagnostic Imaging Services, CT Scan, MRI and/or PET Scans (Outpatient)</p> <p><i>Pre-Certification required for certain services.</i></p>	10% of the Negotiated Charge	50% of Usual and Customary Charge
<p>Chemotherapy and Radiation Therapy</p> <p><i>Pre-Certification Required</i></p>	10% of the Negotiated Charge	50% of Usual and Customary Charge

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



BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING
Treatment for Mental Health Disorder, Substance Use Disorder including Gender Dysphoria and Behavioral Health Treatment for Pervasive Developmental Disorder or Autism: <b>Outpatient Benefits</b>		
Physician's Office Visits (including but not limited to: physician visits, individual and group therapy, hormone therapy, medication management)	\$15 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
<p>All other outpatient services including but not limited to: Intensive Outpatient Programs (IOP); Partial Hospitalization, Electronic Convulsive Therapy (ECT), Repetitive Transcranial Magnetic Stimulation (rTMS); Psychiatric and Neuro Psychiatric testing</p> <p>The Deductible is waived for Psycho-educational Testing.</p> <p><i>Pre-Certification Required for Surgery.</i></p>	10% of the Negotiated Charge	50% of Usual and Customary Charge
Community Based Care Program (CARE)	0% of the Negotiated Charge (Deductible Waived)	Paid the same as IN-NETWORK Provider subject to Usual and Customary Charge
Mobile Crisis Services/988 Center	10% of the Negotiated Charge	Paid the same as IN-NETWORK Provider subject to Usual and Customary Charge
<b>Ambulance Services</b>		
<p>Ambulance Service ground and/or air, water transportation</p> <p>Pre-Certification Required for non-emergency air Ambulance (fixed wing)</p>	<p>10% of the lesser of:</p> <ul style="list-style-type: none"> <li>The billed charge; or</li> <li>The Negotiated Charge</li> </ul> <p>(Deductible Waived)</p>	

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING
<b>Bariatric Surgery</b>		
<p>Bariatric Surgery</p> <p><i>Pre-Certification Required</i></p>	<p>10% of the Negotiated Charge when performed at a hospital or ambulatory surgical facility that is designated as a Bariatric Surgery Center of Excellence.</p>	<p>When performed at a facility in one of the 9 designated Southern California Counties that is not designated as a Bariatric Surgery Center of Excellence, not covered</p> <p>When performed at a facility located outside the 9 designated Southern California Counties, 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p><b>Designated Southern California Counties:</b> Imperial, Kern, Los Angeles, Orange Riverside, San Bernardino, San Diego, Santa Barbara, Ventura</p>
<p>Bariatric Surgery Travel Expenses (recipient and companion transportation) provided in connection with a covered bariatric surgical procedure. Refer to the Bariatric Surgery provision in the Certificate for details.</p> <p>All travel expenses must be authorized in advance.</p>	<p>0% of Actual Charge up to \$3,000 maximum per surgery (Deductible Waived)</p>	<p>Not covered</p>
<b>Diabetic Services and Supplies (including equipment and training)</b>		
<p>Self-management training and education</p> <p>Refer to the Diabetic Services and Supplies (including equipment and training) Benefits provision in the Certificate for details.</p> <p>Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.</p>	<p>0% of the Negotiated Charge (Deductible Waived)</p>	<p>50% of Usual and Customary Charge</p>
<p>Other diabetic services, supplies and equipment</p> <p>Refer to the Diabetic Services and Supplies (including equipment and training) Benefits provision in the Certificate for details.</p> <p>Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.</p>	<p>0% of the Negotiated Charge (Deductible Waived)</p>	<p>50% of Usual and Customary Charge</p>

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED’S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED’S RESPONSIBILITY FOR COST SHARING
Maternity Benefit: <b>Inpatient Benefits</b>		
Hospital Expenses	\$250 Copayment per admission then 10% of the Negotiated Charge	\$500 Copayment per admission then 50% of Usual and Customary Charge
Physician’s Visits while Confined	10% of the Negotiated Charge	50% of Usual and Customary Charge
Maternity Benefit: <b>Outpatient Benefits</b>		
Physician’s Office Visits	\$15 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Prenatal Services and First Postnatal Visit covered; breastfeeding support, supplies, and counseling, including breast pumps. Coverage of breast pumps is limited to one breast pump per pregnancy or as required by law.	0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
All other outpatient services	10% of the Negotiated Charge	50% of Usual and Customary Charge
Non-Emergency Care While Traveling Outside of the United States: <b>Inpatient Benefits:</b>		
Hospital Expenses	\$250 Copayment per admission then 10% of Actual Charge	
Physician’s Visits while Confined	10% of Actual Charge	
Non-Emergency Care While Traveling Outside of the United States: <b>Outpatient Benefits:</b>		
Physician’s Office Visits	\$15 Copayment per visit then 0% of the Actual Charge (Deductible Waived)	
Specialist/Consultant Physician Services	\$25 Copayment per visit then 0% of the Actual Charge (Deductible Waived)	
All other outpatient services	10% of the Actual Charge	
<b>Durable Medical Equipment, Prosthetics &amp; Orthotic Devices</b>		
Durable Medical Equipment and Prosthetic and Orthotic Devices  Including, but not limited to, breast prostheses, prosthetic devices to restore a method of speaking, internally implanted devices, artificial limbs or eyes, therapeutic shoes and inserts for insured persons with diabetes; hearing aids (limited to 1 hearing aid per ear every 3 years), rental or purchase of dialysis equipment & supplies,)  <i>Pre-Certification Required</i>	10% of the Negotiated Charge	50% of Usual and Customary Charge

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING
Pediatric Dental & Vision Care		
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19).		
See the Pediatric Dental Care Benefit description in the Certificate for further information.		
Diagnostic and Preventive Dental Care	0% of Usual and Customary Charge (Deductible Waived)	
Basic Restorative Care	30% of Usual and Customary Charge after satisfaction of the Pediatric Dental Care Deductible.	
Major Restorative Care	30% of Usual and Customary Charge after satisfaction of the Pediatric Dental Care Deductible.	
Orthodontic Services (Medically Necessary)	30% of Usual and Customary Charge after satisfaction of the Pediatric Dental Care Deductible.	
Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19)	0% of Usual and Customary Charge (Deductible Waived)	
Routine Eye Exam and one pair of glasses or contact lenses (in lieu of eyeglasses) per Policy Year	See the Pediatric Vision Care Benefit description in the Certificate for further information.	
Abortion Expense: Inpatient Benefits		
Hospital Expenses	0% of the Negotiated Charge (Deductible Waived)	0% of Usual and Customary Charge (Deductible Waived)
Physician's Visits while Confined	0% of the Negotiated Charge (Deductible Waived)	0% of Usual and Customary Charge (Deductible Waived)
Abortion Expense: Outpatient Benefits		
Physician's Office Visits	0% of the Negotiated Charge (Deductible Waived)	0% of Usual and Customary Charge (Deductible Waived)
All other outpatient services	0% of the Negotiated Charge (Deductible Waived)	0% of Usual and Customary Charge (Deductible Waived)
Acupuncture		
Acupuncture Expense Benefit (Medically Necessary Treatment only)	\$25 Copayment per visit then 0% of Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Pre-Certification required after the 12 <sup>th</sup> visit.		

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED’S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED’S RESPONSIBILITY FOR COST SHARING
Chiropractic Care		
Chiropractic Care Benefit  Pre-Certification required after the 12 <sup>th</sup> visit.	\$25 Copayment per visit then 0% of Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Gender Affirming Treatment Benefits: Inpatient Benefits Pre-Certification Required		
Gender Affirming Treatment Benefits Coverage includes, but is not limited to, medically necessary services related to gender affirming treatment such as gender reassignment surgery, hormone therapy, vocal training, electrolysis, and laser hair removal.		
Hospital Expenses Pre-Certification Required	\$250 Copayment per admission then 10% of the Negotiated Charge	\$500 Copayment per admission then 50% of Usual and Customary Charge
Physician’s Visits while Confined	10% of the Negotiated Charge	50% of Usual and Customary Charge
Gender Affirming Treatment Benefits: Outpatient Benefits		
Outpatient Surgery Pre-Certification Required	10% of the Negotiated Charge	50% of Usual and Customary Charge
Specialist/Consultant Physician Services	\$25 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
All other outpatient services	10% of the Negotiated Charge	50% of Usual and Customary Charge
Gender Affirming Treatment Benefit Travel Expenses provided in connection with an approved gender affirming surgery. Refer to the Gender Affirming Treatment Benefit provision in the Certificate for details. (Must be authorized in advance.)	0% of Actual Charge up to \$10,000 maximum per surgery or series of surgical stages (Deductible Waived)	
Fertility Preservation Pre-Certification Required		
Fertility Preservation Expense (When medically necessary due to a need for medical treatment that may directly or indirectly cause infertility. Includes annual storage costs while insured on Plan)		
Benefits, other than outpatient prescription drugs, are limited to a maximum of \$20,000 per lifetime.		
This benefit does not provide any coverage for the testing or treatment of infertility.		
Consultation	\$25 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Treatment	\$250 Copayment per round of treatment then 10% of the Negotiated Charge	\$250 Copayment per round of treatment then 50% of Usual and Customary Charge

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED’S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED’S RESPONSIBILITY FOR COST SHARING
Organ and Tissue Transplant Surgery: <b>Inpatient Benefits</b> <i>Pre-Certification Required</i>		
Hospital Expenses	\$250 Copayment per admission then 10% of the Negotiated Charge	\$500 Copayment per admission then 50% of Usual and Customary Charge
Physician’s Visits while Confined	10% of the Negotiated Charge	50% of Usual and Customary Charge
Organ and Tissue Transplant Surgery: <b>Outpatient Benefits</b> <i>Pre-Certification Required</i>		
Physician’s Office Visits	\$15 Copayment per visit the 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Specialist/Consultant Physician Services	\$25 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
All other outpatient services	10% of the Negotiated Charge	50% of Usual and Customary Charge
An unrelated donor search is limited to \$30,000 per transplant (inpatient and/or outpatient).		
Organ and Tissue Transplant Surgery Travel Expenses (recipient and companion or donor transportation) provided in connection with a covered organ or tissue transplant. Refer to the Organ and Tissue Transplant Surgery provision in the Certificate for details.  All travel expenses must be authorized in advance.	0% of Actual Charge up to \$10,000 maximum per transplant (Deductible Waived)	
<b>Miscellaneous Dental Services</b>		
Treatment for Temporomandibular Joint (TMJ) Disorders	10% of the Negotiated Charge	50% of Usual and Customary Charge
Accidental Injury Dental Treatment	10% of the Negotiated Charge	50% of Usual and Customary Charge

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

#### ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If, as the result of a covered accident, You sustain any of the following losses, the Company will pay the benefit shown below. The loss must occur within 365 days of the date of a covered accident.

Principal Sum .....	\$10,000
..... Percentage of Principal Sum	
Loss of Life .....	100%
Loss of hand .....	50%
Loss of Foot .....	50%
Loss of either one hand, one foot or sight of one eye .....	50%
Loss of more than one of the above losses due to one Accident.....	100%

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

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



## Exclusions and Limitations

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

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

1. **International Students Only** - Eligible expenses incurred within your home country or country of origin or medical treatment that is available under any governmental or national health plan except when a charge is made which You are required to pay.
2. Treatment, service or supply which is not medically necessary for the diagnosis, care or treatment of the sickness or injury involved. This applies even if they are prescribed, recommended or approved by the Student Health Center or by your attending physician or dentist.
3. Medical services rendered by a provider employed for or contracted with the Policyholder, including team physicians or trainers, except as specifically provided in the Schedule of Benefits or as part of the Student Health Center benefits provided by this Plan.
4. Professional services rendered by an immediate family member or anyone who lives with you.
5. Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be medically necessary because of injury, infection or disease.
6. Infertility treatment (male or female)-this includes but is not limited to:
  - Procreative counseling;
  - Premarital examinations;
  - Genetic counseling and genetic testing;
  - Impotence, organic or otherwise;
  - Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
  - In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
  - Costs for an ovum donor or donor sperm;
  - Ovulation induction and monitoring;
  - Artificial insemination;
  - Hysteroscopy;
  - Laparoscopy;
  - Laparotomy;
  - Ovulation predictor kits;
  - Reversal of tubal ligations;
  - Reversal of vasectomies;
  - Costs for and relating to surrogate motherhood (maternity services are covered for insured persons acting as surrogate mothers);
  - Cloning; or
  - Medical and surgical procedures that are experimental or investigative, unless the Company's denial is overturned by an External Appeal Agent.
7. Expenses paid by any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid or Medi-Cal, or outside of California, Medicaid.
8. Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services covered by Student Health Fees.
9. Any expenses in excess of usual and customary charges except where noted and as provided in the Certificate.
10. Treatment, services, supplies or facilities in a hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which you are required to pay.
11. Services that are duplicated when provided by both a licensed midwife and a Physician.
12. Expenses payable under any prior policy which was in force for the person making the claim.

13. Expenses incurred after:
  - the date insurance terminates as to an insured person, except as specified in the extension of benefits provision; and
  - the end of the Policy Year specified in the Policy.
14. Elective surgery or elective treatment unless such coverage is otherwise specifically covered under the Plan.
15. Weight management. Weight reduction. Nutrition programs. This does not apply to nutritional counseling or any screening or assessment specifically provided under the Preventive Services benefit, or otherwise specifically covered under the Plan.
16. Treatment for obesity except surgery for morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat.
17. Charges for hair growth or removal unless otherwise specifically covered under the Plan.
18. Expenses for radial keratotomy.
19. Adult vision care.
20. Charges for office visit exam for the fitting of prescription contact lenses, duplicate spare eyeglasses, lenses or frames, non-prescription lenses or contact lenses that are for cosmetic purposes unless otherwise covered under the Pediatric Vision Care Benefit.
21. Charges for hearing screening, hearing aids and the fitting or repair or replacement of hearing aids except as specifically provided in the Certificate.
22. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma, or otherwise covered under the Gender Affirming Treatment Benefit.
23. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
24. Extraction of impacted wisdom teeth or dental abscesses.
25. You are:
  - committing or attempting to commit a felony, or
  - engaged in an illegal occupation.
26. Custodial Care service and supplies.
27. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
28. Services of private duty Nurse except as provided in the Certificate.
29. Expenses that are not recommended and approved by a physician as defined in the Certificate.
30. Physician's charges for diagnosis and treatment of structural imbalance, distorting or subluxation in vertebral column or elsewhere in body by manual, mechanical means, through muscular-skeletal adjustments, manipulations, and related modalities or except as specifically covered under the Plan.
31. Routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal or artificial organs or tissues unless such animal or artificial organs or tissues are approved and generally accepted for use.
32. Experimental or investigative drugs, devices, treatments or procedures unless otherwise covered under covered clinical trials or covered under clinical trials (routine patient costs). See the Other Benefits section in the Certificate for more information.
33. Under the Prescription Drug Benefit shown in the Schedule of Benefits in the Certificate:
  - Any drug or medicine which does not, by federal or state law, require a prescription order, i.e. over-the-counter drugs, even if a prescription is written, except as specifically provided under Preventive Services or in the Prescription Drug Benefit section of the Certificate. Insulin and OTC preventive medications required under ACA are exempt from this exclusion;
  - Drugs with over-the-counter equivalents except as specifically provided under Preventive Services;
  - Allergy sera and extracts administered via injection;
  - Fertility drugs, except as provided under the Fertility Preservation Expense Benefit;
  - Vitamins, and minerals, except as specifically provided under Preventive Services;
  - Food supplements, dietary supplements; except as specifically provided in the Certificate;
  - Cosmetic drugs or medicines, including but not limited to, products that improve the appearance of wrinkles or other skin blemishes;
  - Refills in excess of the number specified or dispensed after 1 year of date of the prescription;
  - Drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;

- Any drug or medicine purchased after coverage under the Plan terminates;
  - Any drug or medicine consumed or administered at the place where it is dispensed;
  - If the FDA determines that the drug is: contraindicated for the treatment of the condition for which the drug was prescribed; or Experimental for any reason;
  - Bulk chemicals;
  - Non-insulin syringes, surgical supplies, durable medical equipment/medical devices, except as specifically provided in the Prescription Drug Benefit section of the Certificate;
  - Repackaged products;
  - Blood components except factors;
  - Immunology products.
34. Modifications made to dwellings.
  35. General fitness, exercise programs.
  36. Hypnosis, holistic medicine, homeopathy, aroma therapy, reiki therapy, herbal, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
  37. Rolfing.
  38. Biofeedback.

## How to File a Claim

Usually, providers of healthcare will bill the Company directly for services to insured persons. But sometimes a physician, hospital or an ambulance company may send the bill directly to you. In these instances, the Company has no way of knowing about your claim. In the event medical and/or hospital bills are sent directly to you, mail a copy to the address below along with the patient's name and insured student's name, address, or member ID number and name of the University within 90 days of treatment, or as soon thereafter as is reasonably possible. A Company claim form is required for filing a claim. Claim forms are available at <https://www.studentinsurance.com/Client/1359>. You are urged to send the Company each bill immediately upon receipt.

Mail claims to:

**Claims Administrator:**

**Wellfleet Group, LLC dba Wellfleet Administrators, LLC**

PO Box 15369

Springfield, MA 01115-5369

(877) 657-5033

## Complaint Notice

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

**Wellfleet Group, LLC dba Wellfleet Administrators, LLC**

PO Box 15369

Springfield, MA 01115-5369

(877) 657-5033

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

**California Department of Insurance**

Consumer Services Division

300 South Spring Street, 11<sup>th</sup> Floor

Los Angeles, CA 90013

(800) 927-HELP (4357) – In California

(213) 897-8921 – Out of California

(800) 482-4833 – Telecommunication Device for the Deaf

E-mail Inquiry "Consumer services" link at:

[www.insurance.ca.gov](http://www.insurance.ca.gov)

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

### **Academic Emergency Services**

Academic HealthPlans and your school have you covered while studying or traveling away from home.

To ensure you have immediate access to assistance if you experience a travel related crisis, Academic HealthPlans has included Academic Emergency Services (AES) in your Student Health Insurance Plan coverage. AES offers a wide range of services and benefits to provide everything you need to prepare for your international experience, as well as get the help or information you need in a crisis.

Academic Emergency Services are available to you 24 hours a day, 7 days a week.

Simply call the number on the membership card to get access to knowledgeable assistance coordinators who will help you navigate any unfamiliar cultures or circumstances.

GROUP ID: GHS9999AHPCO

MEMBERSHIP TYPE: GLOBAL MEDICAL & TRAVEL ASSISTANCE SERVICES

- To contact Academic Emergency Services from the U.S. or Canada, call toll-free: (855) 873-3555
- To contact Academic Emergency Services from outside the U.S. or Canada, dial the country access code followed by: 1 (610) 263-4660
- Country access codes can be found through local directory assistance or [https://www.att.com/support\\_media/images/pdf/Country\\_Code\\_List.pdf](https://www.att.com/support_media/images/pdf/Country_Code_List.pdf).
- If there is no access code, proceed with calling direct to: 1 (610) 263-4660

If you need medical or travel assistance, regardless of the nature or severity of your situation, please contact AES 24 hours a day / 7 days a week.

TOLL FREE 1 (855) 873-3555

OUTSIDE THE US 1 (610) 263-4660

EMAIL [assistance@ahpcare.com](mailto:assistance@ahpcare.com)

### **Teladoc**

By phone or internet, **Teladoc** gives you 24/7 access to board-certified physicians for General Medical, Behavioral Health and Dermatology services. Whether you are at school, home or traveling, Teladoc can diagnose and treat most minor medical conditions wherever and whenever you need treatment.

Register your account today and request a visit at <https://www.teladoc.com/wellfleetstudent> or call (800)-Teladoc (835-2362).



## Academic Emergency Services

### We have you covered while studying or traveling away from home

To ensure you have immediate access to assistance if you experience a travel related crisis, we have included Academic Emergency Services (AES) in your Student Health Insurance Plan coverage. AES offers a wide range of services and benefits to provide everything you need to prepare for your international experience.



#### **Academic Emergency Services provide solutions to small challenges.**

Finding an adequate doctor in an unfamiliar location, getting a prescription filled when away from home, finding an interpreter quickly when you need to share or receive information, help in locating lost luggage or replacing a passport.



#### **As well as during a critical crisis.**

Ensuring adequate care is available locally if you need medical care or are hospitalized, and if it isn't, getting you emergency medical transportation to an adequate facility or to your home, or hospital nearest to your home, when medically advisable.



**There are also services and benefits to help you and your family with expenses that you may not consider until faced with an emergency.** We can get a family member or friend to you if you are hospitalized, get you home in the event you have an illness or death in the family, or return remains to your family in the unfortunate event of death.

### Preparing for your time away from home is easy.

Simply visit the Academic Emergency Services portal at [aes.myahpcare.com](https://aes.myahpcare.com)





## Academic Emergency Services

**As a participant in the student health plan, you have access to the following services and benefits:**

### Emergency Medical Evacuation, Repatriation and Emergency Family Assistance Services

- Medical Evacuation, Unlimited
- Medical Repatriation, Unlimited
- Repatriation of Mortal Remains, Unlimited; up to a maximum of \$3,000 for the immediate family to use for expenses associated with traveling to a funeral or actual funeral related expenses such as an urn, casket, coffin, burial or funeral expenses and up to a maximum of \$2,500 for air travel expenses for a family member/companion to join the insured's body during the repatriation
- Emergency Family Travel Arrangement for a family member or friend to visit student, up to \$10,000 with 3-day hospitalization, limit to \$300 per day for lodging and a limit to \$50 per day for daily meals
- Return of Dependent Children, up to \$5,000, if left unattended
- Emergency Family Reunion Arrangements, up to \$10,000, in the event of illness or death of family member

- Return of Personal Belongings, up to \$1,000 in the event of evacuation or death
- Accidental Death and Dismemberment, \$25,000

### Medical, Travel, Safety, and Legal Assistance

- Pre-travel information portal
- Physician referrals outside of the U.S.
- Medical monitoring during an emergency evacuation to ensure adequate care
- Prescription assistance
- Luggage lost in transit
- Passport replacement assistance
- Emergency travel arrangements
- Emergency translation assistance and/or interpreter referral
- Legal referral

### Additional Benefits

- Political Emergency and Natural Disaster Evacuation Coverage
- Emergency Family Travel, 3-Day Threshold

**\*\*Benefits and services described above are available when you are traveling over 100 miles from home or outside your home country, this 100 mile limitation does not apply to the Accidental Death & Dismemberment benefit and the Repatriation of Mortal Remains benefit.**

**Academic Emergency Services are available to you 24 hours a day, 7 days a week.**

Simply call the number on the membership card to get access to knowledgeable assistance coordinators who will help you navigate any unfamiliar cultures or circumstances.

TAKE A SCREENSHOT OF THE CARD OR CUT IT OUT TO KEEP WITH YOU AT ALL TIMES.

GROUP ID:  
GHS9999AHPCO

MEMBERSHIP TYPE:  
GLOBAL MEDICAL & TRAVEL ASSISTANCE SERVICES

**ACADEMIC EMERGENCY SERVICES SUPPORT 24/7**

To contact Academic Emergency Services from the U.S. or Canada, call toll-free: (855) 873-3555  
To contact Academic Emergency Services from outside the U.S. or Canada, dial the country access code followed by: 1 (610) 263-4660  
Country access codes can be found through local directory assistance or [https://www.att.com/support\\_media/images/pdf/Country\\_Code\\_List.pdf](https://www.att.com/support_media/images/pdf/Country_Code_List.pdf).  
If there is no access code, proceed with calling direct to: 1 (610) 263-4660



Academic  
Emergency Services



If you need medical or travel assistance, regardless of the nature or severity of your situation, please contact  
**AES 24 hours a day / 7 days a week**

**TOLL FREE**  
1(855) 873-3555

**OUTSIDE THE US**  
1(610) 263-4660

**EMAIL**  
[assistance@ahpcare.com](mailto:assistance@ahpcare.com)

To obtain additional pre-travel information or advice, or in the event of a medical, travel or security crisis, call Academic Emergency Services immediately.

Terms, limitations and conditions apply to all services and benefits. Academic Emergency Services and AD&D coverage are underwritten by 4 Ever Life International Limited and administered by Worldwide Insurance Services, LLC, separate and independent companies from Academic HealthPlans, Inc.



# A Look at Your VSP Vision Coverage

With VSP and UC BERKELEY SHIP, your health comes first.



**As a member, you'll get access to savings and personalized vision care from a VSP network doctor for you and your family.**

## **Value and savings you love.**

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over \$3,000 in savings.

## **Provider choices you want.**



Maximize your benefits at a Premier Program location, which is part of our incredible network of doctors.

## **Shop online and connect your benefits.**



Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

## **Quality vision care you need.**

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

## **Using your benefit is easy!**

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

**vsp**  
vision care

## More Ways to Save

**Extra  
\$20  
to spend on  
Featured Brands<sup>†</sup>**

bebe	CALVIN KLEIN
COLE HAAN	DRAGON.
FLEXON	LACOSTE
	and more

See all brands and offers  
at **vsp.com/offers**.

+

**Up to  
40%  
Savings on  
lens enhancements<sup>‡</sup>**

Create an account today.  
Contact us: **800.877.7195** or **vsp.com**

## Your VSP Vision Benefits Summary

UC BERKELEY SHIP and VSP provide you with an affordable vision plan.

### PROVIDER NETWORK:

VSP Choice

### EFFECTIVE DATE:

08/01/2023



BENEFIT	DESCRIPTION	COPAY	FREQUENCY
<b>Your Coverage with a VSP Provider</b>			
<b>WELLVISION EXAM</b>	<ul style="list-style-type: none"> <li>Focuses on your eyes and overall wellness</li> </ul>	\$10	Every plan year*
<b>ESSENTIAL MEDICAL EYE CARE</b>	<ul style="list-style-type: none"> <li>Retinal screening for members with diabetes</li> <li>Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more.</li> <li>Coordination with your medical coverage may apply. Ask your VSP doctor for details.</li> </ul>	\$0 per screening \$20 per exam	Available as needed
<b>PRESCRIPTION GLASSES</b>		<b>\$25</b>	
<b>FRAME*</b>	<ul style="list-style-type: none"> <li>\$170 featured frame brands allowance</li> <li>\$150 frame allowance</li> <li>20% savings on the amount over your allowance</li> <li>\$80 Walmart*/Sam's Club*/Costco* frame allowance</li> </ul>	Included in Prescription Glasses	Every plan year
<b>LENSES</b>	<ul style="list-style-type: none"> <li>Single vision, lined bifocal, and lined trifocal lenses</li> <li>Impact-resistant lenses for dependent children</li> </ul>	Included in Prescription Glasses	Every plan year
<b>LENS ENHANCEMENTS</b>	<ul style="list-style-type: none"> <li>Standard progressive lenses</li> <li>Premium progressive lenses</li> <li>Custom progressive lenses</li> <li>Average savings of 30% on other lens enhancements</li> </ul>	\$0 \$95 - \$105 \$150 - \$175	Every plan year
<b>CONTACTS (INSTEAD OF GLASSES)</b>	<ul style="list-style-type: none"> <li>\$150 allowance for contacts and contact lens exam (fitting and evaluation)</li> <li>15% savings on a contact lens exam (fitting and evaluation)</li> </ul>	\$0	Every plan year
<b>EXTRA SAVINGS</b>	<b>Glasses and Sunglasses</b> <ul style="list-style-type: none"> <li>Extra \$20 to spend on featured frame brands. Go to <a href="https://vsp.com/offers">vsp.com/offers</a> for details.</li> <li>20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.</li> </ul>		
	<b>Routine Retinal Screening</b> <ul style="list-style-type: none"> <li>No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam</li> </ul>		
	<b>Laser Vision Correction</b> <ul style="list-style-type: none"> <li>Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities</li> </ul>		

### YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to [vsp.com](https://vsp.com) to find an in-network provider. Your plan provides the following out-of-network reimbursements:

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

\*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.

†Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington.

©2022 Vision Service Plan. All rights reserved.

VSP, Eyeconic, and WellVision Exam are registered trademarks of Vision Service Plan. Flexon and Dragon are registered trademarks of Marchon Eyewear, Inc. All other brands or marks are the property of their respective owners. 102898 VCCM

## Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

### Network: PDP Plus

	In-Network <sup>1</sup> % of Negotiated Fee <sup>2</sup>	Out-of-Network <sup>1</sup> % of R&C Fee <sup>**</sup>
<b>Coverage Type</b>		
<b>Type A: Preventive</b> (cleanings, exams, X-rays)	100%	80%
<b>Type B: Basic Restorative</b> (fillings, extractions)	80%	60%
<b>Type C: Major Restorative</b> (bridges, dentures)	70%	40%
<b>Deductible<sup>†</sup></b>		
Individual	\$25	\$50
<b>Annual Maximum Benefit</b>		
Per Person	\$2,000	\$2,000

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

<sup>1</sup> "In-Network Benefits" refers to benefits provided to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.

<sup>2</sup> Negotiated fees refer 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.

<sup>\*\*</sup> 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.

<sup>†</sup> Applies only to Type B & C Services.

## List of Primary Covered Services & Limitations

The service categories and plan limitations shown 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.

Plan Type	How Many/How Often
<b>Type A — Preventive</b>	
Prophylaxis (cleanings)	Two per fiscal year
Oral Examinations	Two exams per fiscal year
Topical Fluoride Applications	Two fluoride treatment per fiscal year
X-rays	<ul style="list-style-type: none"> <li>Full mouth X-rays; one per 60 months</li> <li>Bitewings X-rays; one set per fiscal year for adults; two sets per fiscal year for children</li> </ul>
Space Maintainers	

## Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

Plan Type	How Many/How Often
<b>Type B — Basic Restorative</b>	
Fillings	
Simple Extractions	
Oral Surgery	
Endodontics	Root canal treatment
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services
Periodontics	<ul style="list-style-type: none"> <li>• Periodontal scaling and root planing once per quadrant, every 24 months</li> <li>• Periodontal surgery once per quadrant, every 36 months</li> <li>• Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a fiscal year</li> </ul>
Sealants	One application of sealant material every 24 months for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to his/her 16th birthday
<b>Type C — Major Restorative</b>	
Crown, Denture and Bridge Repair/ Recementations	1 time in 5 fiscal years
Oral Surgery	
Implants	Replacement once every 5 years
Bridges and Dentures	<ul style="list-style-type: none"> <li>• Initial placement to replace one or more natural teeth, which are lost while covered by the plan</li> <li>• Dentures and bridgework replacement; one every 5 fiscal years</li> <li>• 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</li> </ul>
Crowns, Inlays and Onlays	Replacement once every 5 fiscal years

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

## Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

### Exclusions

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

1. 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;
2. Services for which you would not be required to pay in the absence of Dental Insurance;
3. Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
4. Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
5. 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:
  - a. Scaling and polishing of teeth; or
  - b. Fluoride treatments;
6. Services or appliances which restore or alter occlusion or vertical dimension;
7. Restoration of tooth structure damaged by attrition, abrasion or erosion;
8. Restorations or appliances used for the purpose of periodontal splinting;
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
10. Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
11. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
12. Missed appointments;
13. Services:
  - a. Covered under any workers' compensation or occupational disease law;
  - b. Covered under any employer liability law;
  - c. For which the employer of the person receiving such services is not required to pay; or
  - d. Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
14. Services covered under other coverage provided by the Employer;
15. Temporary or provisional restorations;
16. Temporary or provisional appliances;
17. Prescription drugs;
18. Services for which the submitted documentation indicates a poor prognosis;
19. The following when charged by the Dentist on a separate basis:
  - a. Claim form completion;
  - b. Infection control such as gloves, masks, and sterilization of supplies; or
  - c. Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
20. 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;
21. Caries susceptibility tests;
22. Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
23. Other fixed Denture prosthetic services not described elsewhere in the certificate;
24. Precision attachments, except when the precision attachment is related to implant prosthetics;
25. Initial installation of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
26. Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
27. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
28. Implants including, but not limited to any related surgery, placement, restorations, maintenance, and removal;
29. Repair of implants;
30. Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;

## Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

31. Fixed and removable appliances for correction of harmful habits;
32. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
33. Diagnosis and treatment of temporomandibular joint (TMJ) disorders.
34. Repair or replacement of an orthodontic device;
35. Duplicate prosthetic devices or appliances;
36. Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
37. Intra and extraoral photographic images

## Limitations

**Alternate Benefits:** Where two or more professionally acceptable dental treatments for a dental condition exist, payment 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 payment for those services, and your out-of-pocket expense. 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 / G.2130-S) issued by Metropolitan Life Insurance Company (MetLife). Coverage terminates when your participation 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.

Group dental insurance policies featuring the Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, New York, NY 10166.

Like most group benefits programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Ask your MetLife group representative for costs and complete details.

## Questions & Answers

### Q. Who is a participating dentist?

- A. 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 30% – 45% below the average fees charged in a dentist's community for the same or substantially similar services.<sup>†</sup>

### Q. How do I find a participating dentist?

- A. 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](http://www.metlife.com/mybenefits) or call 1-800-942-0854 to have a list faxed or mailed to you.

### Q. What services are covered under this plan?

- A. The Plan documents set forth the services covered by your plan. The List of Primary Covered Services & Limitations herein contains a summary of covered services. In the event of a conflict between the Plan documents and this summary, the terms of the Plan documents shall govern.

### Q. May I choose a non-participating dentist?

- A. 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.

### Q. Can my dentist apply for participation in the network?

- A. 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](http://www.metdental.com), or call 1-866-PDP-NTWK for an application.<sup>††</sup> The website and phone number are for use by dental professionals only.





## Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

### Q. How are claims processed?

- A. 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](http://www.metlife.com/mybenefits) or request one by calling 1-800-942-0854

### Q. Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?

- A. 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](http://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.

### Q. Can MetLife help me find a dentist outside of the U.S. if I am traveling?

- A. 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.

### Q. How does MetLife coordinate benefits with other insurance plans?

- A. 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.

### Q. Do I need an ID card?

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

†Based on internal analysis by MetLife. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

††Due to contractual requirements, MetLife is prevented from soliciting certain providers.

\*AXA Assistance USA, Inc. provides Dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations. Exclusions: The AXA Travel Assistance Program is available for participants in traveling status. Whenever a trip exceeds 120 days, the participant is no longer considered to be in traveling status and is therefore no longer eligible for the services. Also, AXA Assistance USA will not evacuate or repatriate participants without medical authorization; with mild lesions, simple injuries such as sprains, simple fractures or mild sickness which can be treated by local doctors and do not prevent the member from continuing his/her trip or returning home; or with infections under treatment and not yet healed. Benefits will not be paid for any loss or injury that is caused by or is the result from: pregnancy and childbirth except for complications of pregnancy, and mental and nervous disorders unless hospitalized. Reimbursements for non-medical services such as hotel, restaurant, taxi expenses or baggage loss while traveling are not covered. The maximum benefit per person for costs associated with evacuations, repatriations or the return of mortal remains is US\$500,000. Treatment must be authorized and arranged by AXA Assistance's designated personnel to be eligible for benefits under this program. All services must be provided and arranged by AXA Assistance USA, Inc. No claims for reimbursement will be accepted.

\*\*Refer to your dental benefits plan summary for your out-of-network dental coverage.

Group dental plans featuring the Preferred Dentist Program are provided by Metropolitan Life Insurance Company, New York, NY.

