Berkeley SHIP
student health insurance plan

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2024/2025

DESIGNED EXCLUSIVELY FOR THE DOMESTIC AND INTERNATIONAL STUDENTS OF:

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

Policy Number: WI2425CASHIP40
Group Number: ST1359SH
Effective: 8/1/2024 – 7/31/2025

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

ADMINISTERED BY:
Wellfleet Group, LLC dba Wellfleet Administrators, LLC

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Welcome Students…

We are pleased to provide you with this summary of the 2024 – 2025 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 Wellfleet 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.

Where to Find Help

IMPORTANT CONTACTS		
Appointments – Tang Center	**University Health Services** uhs.berkeley.edu Telephone: (510) 642-2000	
Eligibility, Benefits and General Questions	**Berkeley SHIP Office** ship@berkeley.edu Telephone: (510) 642-5700 M-F 8:00 a.m.- 4:45 p.m. PST, except Wednesdays 9:30 a.m.- 4:45 p.m. PST https://uhs.berkeley.edu/insurance	
Benefits and Claims Questions	**Wellfleet Member Services** Telephone: (877) 657-5033 M-F 6:00 a.m.- 5:00 p.m. PST https://www.studentinsurance.com/Client/1359	
Eligibility and Enrollment	**Academic HealthPlans (AHP)** Telephone: (855) 854-3254 M-F 8:00 a.m.- 5:00 p.m. PST https://help.ahpcare.com	**Plan Brokered By** Academic HealthPlans (AHP) CA License No 0H64806
Pharmacy Benefits Manager	**Wellfleet Rx/ESI** Telephone: (877) 640-7940 Customer Service hours: 24/7 Prior-Authorization: 877-640-7938 24/7 Electronic Prior-Authorization: www.express-scripts.com	
Find a Preferred Provider	**Wellfleet Providers** (877) 657-5033 www.wellfleetstudent.com/ucbprovidersearch	
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 https://www.teladoc.com/wellfleetstudent	24/7 Appointments with an MD
24-Hour Travel Assistance	**Academic Emergency Services** Toll-free: (855) 873-3555 Outside the U.S.: (610) 263-4660 Email: assistance@ahpcare.com	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 for that Covered Injury or Covered Sickness 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 (less any claims paid) will be made for such person upon written request received by AHP within **45 days** of entry into service.

How Do I Waive?

All registered full time domestic and international students will be automatically enrolled in the Berkeley Student Health Insurance Plan (SHIP) and the premium will be added to the student's registration fees. 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. Simply download your ID card 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 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 and register using your student ID# and 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 Wellfleet 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 Wellfleet Member Services at (877) 657-5033 or 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 8/1/24 – 12/31/24	**SPRING/SUMMER 1/1/25 – 7/31/25**
Waiver Start Date	5/1/24	12/1/24
Waiver Deadline Without Fee	7/15/24	1/1/25
Final Waiver Deadline With Late Fee	8/15/24	1/15/25
Student Only	$2,014	$2,014
NOTE: Costs below are in addition to the student premium. Dependent enrollment in this plan is voluntary.		
Dependent Enrollment Start Date	7/1/24	12/1/24
Dependent Enrollment End Date	9/1/24	2/1/25
Spouse Only	$2,014	$2,014
One Child Age 0-25 Only	$2,014	$2,014
Two or More Children Age 0-25 Only	$3,919	$3,919

VOLUNTARY UNDERGRADUATES (CONCURRENT ENROLLMENT)		
	FALL 8/1/24 – 12/31/24	**SPRING/SUMMER 1/1/25 – 7/31/25**
Enrollment Start Date	7/1/24	12/1/24
Enrollment End Date	9/1/24	2/1/25
Student Only	$2,014	$2,014
NOTE: Costs below are in addition to the student premium. Dependent enrollment in this plan is voluntary.		
Spouse Only	$2,014	$2,014
One Child Age 0-25 Only	$2,014	$2,014
Two or More Children Age 0-25 Only	$3,919	$3,919

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

REGISTERED GRADUATES		
	FALL 8/1/24 – 12/31/24	**SPRING/SUMMER 1/1/25 – 7/31/25**
Waiver Start Date	5/1/24	12/1/24
Waiver Deadline Without Fee	7/15/24	1/1/25
Final Waiver Deadline With Late Fee	8/15/24	1/15/25
Student Only	$3,221	$3,221
NOTE: Costs below are in addition to the student premium. Dependent enrollment in this plan is voluntary.		
Dependent Enrollment Start Date	7/1/24	12/1/24
Dependent Enrollment End Date	9/1/24	2/1/25
Spouse Only	$3,221	$3,221
One Child Age 0-25 Only	$3,221	$3,221
Two or More Children Age 0-25 Only	$6,294	$6,294

VOLUNTARY GRADUATES (FILING FEE)		
	FALL 8/1/24 – 12/31/24	**SPRING/SUMMER 1/1/25- 7/31/25**
Enrollment Start Date	7/1/24	12/1/24
Enrollment End Date	9/1/24	2/1/25
Student Only	$3,221	$3,221
NOTE: Costs below are in addition to the student premium. Dependent enrollment in this plan is voluntary.		
Spouse Only	$3,221	$3,221
One Child Age 0-25 Only	$3,221	$3,221
Two or More Children Age 0-25 Only	$6,294	$6,294

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.*

Eligibility

Mandatory Enrollments
The following students will automatically be enrolled in this Plan and the premium will be added to the their registration fees 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 registered domestic and international undergraduate and graduate students of the University of California Berkeley including students who are registered-in-absentia. Note: Students 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 students may enroll in the UC Berkeley SHIP on a voluntary basis directly with Academic HealthPlans (AHP) by the specified enrollment end 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 University of California Berkeley undergraduate students who are recovering from academic probation or in their final semester of study completing degree requirements through University of California Berkeley Extension's Concurrent Enrollment Program 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
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.

Registered 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 and Pregnancy Leave
A student withdrawing due to a University approved pregnancy leave or 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 pregnancy leave, Sickness or Injury. For additional information, please go to https://uhs.berkeley.edu/ship.

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

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

Eligible dependents are the insured student's lawful spouse, or domestic partner who resides with the insured student, and the insured student's, the spouse's, or the domestic partner's dependent biological or adopted child or stepchild under 26 years of age. To enroll your domestic partner, a Declaration of Domestic Partnership issued by the State of California; or 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. 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.

It is the student's responsibility to re-enroll their dependents each term, prior to the enrollment end 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 Wellfleet 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		
Tang Pharmacy or Retail Participating Pharmacy Preventive immunizations administered by a participating retail pharmacy and certain prescription contraceptives are covered at no charge. The Deductible does not apply to outpatient prescription drugs.	**Tang Center** Tier 1: No Copay Tier 2[1]: $25 Copay Tier 3: $40 Copay Specialty drugs: $75 Copay	**Participating Retail** Tier 1: $20 Copay Tier 2: $40 Copay Tier 3: $60 Copay Specialty drugs: 20% up to $250 Copay	**Non-Participating Retail** 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
Supply Limits - Retail Pharmacy	Prescription drugs are limited to a 30-day supply, except where provided for by federal or CA state law or regulation.		

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

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

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

Hospital Inpatient Facility Copayment (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
Emergency Services Copayment:	$250 per visit (waived if admitted)
Policy Year Out-of-Pocket Maximum:	
For Medical Care:	
In-Network Provider/Tang Center combined:	$3,200 Individual/$6,400 Family
Out-of-Network Provider (not combined):	$6,500 Individual/$13,000 Family
For Pediatric Dental Care – In-Network and Out-of-Network combined:	$1,000 Individual/$2,000 Family

The Out-of-Pocket Maximum is the amount of covered medical expenses you have to incur before covered medical expense will be paid at 100% for the 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 Medical 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
Hospital Care		
Inpatient hospital room & board expenses, subject to semi-private room rate unless intensive care unit is required, and miscellaneous services and supplies *Pre-Certification Required*	$250 Copayment per admission then 10% of the Negotiated Charge	$500 Copayment per admission then 50% of Usual and Customary Charge
Outpatient surgery facility and miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma *Pre-Certification Required*	10% of the Negotiated Charge	50% of Usual and Customary Charge
Physician's Visits		
While confined in a hospital or skilled nursing facility	10% of the Negotiated Charge	50% of Usual and Customary Charge
Physician's Office or Home Visits	$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
Inpatient or Outpatient Surgery *Pre-Certification Required*		
Surgeon Services	10% of the Negotiated Charge	50% of Usual and Customary Charge
Anesthetist	10% of the Negotiated Charge	50% of Usual and Customary Charge
Assistant Surgeon	10% of the Negotiated Charge	50% of Usual and Customary Charge
Skilled Nursing Facility Benefit		
Limited to 100 days per benefit period. (This limitation does not apply to Mental Health Disorder or Substance Use Disorder Benefits) *Pre-Certification Required*	$250 Copayment per admission then 10% of the Negotiated Charge	$500 Copayment per admission then 50% of Usual and Customary Charge
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 *Pre-Certification Required*	$250 Copayment per admission then 10% of the Negotiated Charge	$500 Copayment per admission then the plan pays 50% of Usual and Customary Charge

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
Rehabilitation Therapy and Habilitation Services including, Physical Therapy, Occupational Therapy and Speech Therapy; Cardiac Rehabilitation and Pulmonary Rehabilitation 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. *Pre-Certification required after the 12th visit.*	$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	$250 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived) Copayment waived if admitted	Paid the same as IN-NETWORK Provider subject to Usual and Customary Charge
Urgent Care Center for non-life-threatening conditions (includes ancillary services received during an Urgent Care visit)	$50 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived) 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)	50% of Usual and Customary Charge
Laboratory Procedures (Outpatient)	10% of the Negotiated Charge	50% of Usual and Customary Charge
Diagnostic Imaging Services, CT Scan, MRI and/or PET Scans (Outpatient) *Pre-Certification required for certain services.*	10% of the Negotiated Charge	50% of Usual and Customary Charge
Chemotherapy and Radiation Therapy *Pre-Certification Required*	10% of the Negotiated Charge	50% of Usual and Customary Charge

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING
Infusion Therapy Includes medication, ancillary services and supplies, caregiver training, durable medical equipment, and laboratory services. *Pre-Certification Required*	10% of the Negotiated Charge	50% of Usual and Customary Charge
Home Health Care Expenses Limited to 100 visits per Policy Year. (This limitation applies separately to Rehabilitation Services and Habilitation Services.) A visit of 4 hours or less by a home health aide shall be considered as one Home Health Care visit. *Pre-Certification Required*	10% of the Negotiated Charge	50% of Usual and Customary Charge
Hospice Care Coverage Inpatient or Outpatient care during the final stages of a terminal illness and during the bereavement	0% of the Negotiated Charge	0% of Usual and Customary Charge
Treatment for Mental Health Disorder, Substance Use Disorder including Gender Dysphoria and Behavioral Health Treatment for Pervasive Developmental Disorder or Autism: **Inpatient Benefits** *Pre-Certification Required*		
Hospital Expenses including Inpatient Psychiatric Hospitals and Residential Treatment Centers	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: **Outpatient Benefits**		
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
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 The Deductible is waived for Psycho-educational Testing. *Pre-Certification Required for Surgery.*	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
Ambulance Services		
Ambulance Service ground and/or air, water transportation Pre-Certification Required for non-emergency air Ambulance (fixed wing)	10% of the lesser of: • The billed charge; or • The Negotiated Charge (Deductible Waived)	

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING
Bariatric Surgery		
Bariatric Surgery *Pre-Certification Required*	10% of the Negotiated Charge when performed at a hospital or ambulatory surgical facility that is designated as a Bariatric Surgery Center of Excellence.	When performed at a facility in one of the 9 designated Southern California Counties that is not designated as a Bariatric Surgery Center of Excellence, not covered When performed at a facility located outside the 9 designated Southern California Counties, 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses **Designated Southern California Counties**: Imperial, Kern, Los Angeles, Orange Riverside, San Bernardino, San Diego, Santa Barbara, Ventura
Bariatric Surgery Travel Expenses (recipient and companion transportation) provided in connection with a covered bariatric surgical procedure. Refer to the Bariatric Surgery provision in the Certificate for details. All travel expenses must be authorized in advance.	0% of Actual Charge up to $3,000 maximum per surgery (Deductible Waived)	Not covered
Diabetic Services and Supplies (including equipment and training)		
Self-management training and education Refer to the Diabetic Services and Supplies (including equipment and training) Benefits provision in the Certificate for details. Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Other diabetic services, supplies and equipment Refer to the Diabetic Services and Supplies (including equipment and training) Benefits provision in the Certificate for details. Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	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
Maternity Benefit: **Inpatient Benefits**		
Hospital Expenses	$250 Copayment per admission then 10% of the Negotiated Charge	$500 Copayment per admission then 50% of Usual and Customary Charge
Physician's Visits while Confined	10% of the Negotiated Charge	50% of Usual and Customary Charge
Maternity Benefit: **Outpatient Benefits**		
Physician's Office Visits	$15 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Prenatal Services, including ultrasounds, 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: **Inpatient Benefits:**		
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: **Outpatient Benefits:**		
Physician's Office Visits	$15 Copayment per visit then 0% of the Actual Charge (Deductible Waived)	
Specialist/Consultant Physician Services	$25 Copayment per visit then 0% of the Actual Charge (Deductible Waived)	
All other outpatient services	10% of the Actual Charge	
Durable Medical Equipment, Prosthetics & Orthotic Devices		
Durable Medical Equipment and Prosthetic and Orthotic Devices Including, but not limited to, breast 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,) *Pre-Certification Required*	10% of the Negotiated Charge	50% of Usual and Customary Charge

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING
Pediatric Dental & Vision Care		
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19). See the Pediatric Dental Care Benefit description in the Certificate for further information.		
Diagnostic and Preventive Dental Care	0% of Usual and Customary Charge (Deductible Waived)	
Basic Restorative Care	30% of Usual and Customary Charge after satisfaction of the Pediatric Dental Care Deductible.	
Major Restorative Care	30% of Usual and Customary Charge after satisfaction of the Pediatric Dental Care Deductible.	
Orthodontic Services (Medically Necessary)	30% of Usual and Customary Charge after satisfaction of the Pediatric Dental Care Deductible.	
Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19) Routine Eye Exam and one pair of glasses or contact lenses (in lieu of eyeglasses) per Policy Year	0% of Usual and Customary Charge (Deductible Waived) See the Pediatric Vision Care Benefit description in the Certificate for further information.	
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) *Pre-Certification required after the 12th visit.*	$25 Copayment per visit then 0% of 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
Chiropractic Care		
Chiropractic Care Benefit *Pre-Certification required after the 12th 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: **Inpatient Benefits** *Pre-Certification Required*		
Hospital Expenses	$250 Copayment per admission then 10% of the Negotiated Charge	$500 Copayment per admission then 50% of Usual and Customary Charge
Physician's Visits while Confined	10% of the Negotiated Charge	50% of Usual and Customary Charge
Organ and Tissue Transplant Surgery: **Outpatient Benefits** *Pre-Certification Required*		
Physician's Office Visits	$15 Copayment per visit the 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
Specialist/Consultant Physician Services	$25 Copayment per visit then 0% of the Negotiated Charge (Deductible Waived)	50% of Usual and Customary Charge
All other outpatient services	10% of the Negotiated Charge	50% of Usual and Customary Charge
An unrelated donor search is limited to $30,000 per transplant (inpatient and/or outpatient).		
Organ 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)	
Miscellaneous Dental Services		
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.

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

The following are not affiliated with 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.
- 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.
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