Plan Brokered by:
Wells Fargo Insurance Services USA, Inc.
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https://uhs.berkeley.edu/ship

Underwritten by:
Anthem Blue Cross Life and Health Insurance Company
Policy #280438

UC Berkeley SHIP

2016-2017 Berkeley Student Health Insurance Plan

Health Insurance Requirement and Eligibility

Hard Waiver Mandatory Enrollments

The following eligible students will automatically be enrolled in this Plan, unless an approved online Waiver Form has been received by the University by the specified enrollment deadline dates listed in the next section of this Benefit Booklet.

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

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

Voluntary Enrollments

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

- All non-registered "Filing Fee" status graduate students of the University of California, Berkeley who are completing work under the auspices of the University of California, Berkeley but are not attending classes. Students on Filing Fee status may purchase Plan coverage for a maximum of one semester by calling Wells Fargo Student Insurance at 800-853-5899. The student must have been covered by the Plan in the term immediately preceding the term the student wants to purchase or, if the student waived Plan enrollment, show proof of loss of the coverage used to obtain the waiver.
- All non-registered Concurrent Enrollment status undergraduate students of the University of California, Berkeley may purchase Plan coverage for a maximum of one semester by calling Wells Fargo Student Insurance at 800-853-5899. The student must have been covered by the Plan in the term immediately preceding the term the student wants to purchase or, if the student waived Plan enrollment, show proof of loss of the coverage used to obtain the waiver.

Continuation Coverage/Enrollments

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

To be an Insured under the Policy, the student must have paid the required premium and his/her name, student number and date of birth must have been included in the declaration made by the School or the Administrative Agent to the Insurer.

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

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

Dependent Coverage

Note: Dependent enrollment in this plan is voluntary. Eligible Insured Students, including those on the voluntary or continuation plans, may purchase Dependent coverage at the time of student's enrollment in the plan; or within 31 days of one of the following qualified events: marriage, addition of domestic partner, birth, or adoption. Eligible dependents are the spouse or legally registered and valid domestic partner which resides with the Insured Student, and the student's, the spouse's, or the domestic partner's natural child, stepchild, or legally adopted child under 26 years of age. A "Newborn" will automatically be covered for Nursery and Well Visits from birth until 31 days old, providing that the female student or dependent is covered under this plan. Coverage may be continued or added for that child when Wells Fargo Student Insurance is notified within 31 days from the date of birth and by payment of any additional premium. Dependents must be enrolled for the same term of coverage for which the Insured Student enrolls. Dependent coverage expires concurrently with that of the Insured Student and Dependents must re-enroll when coverage terminates to maintain coverage.

Dependents must be re-enrolled each term. It is the students responsibility to contact Wells Fargo Student Insurance prior to the enrollment deadline listed in this brochure. No reminder will be sent to students or dependents covered under the plan.

How much does it cost?

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

REGISTERED UNDERGRADUATES	FALL 8/15/2016 - 12/31/2016	SPRING/SUMMER 1/1/2017 - 7/31/2017
Waiver Start Date	5/16/2016	12/1/2016
Waiver Deadline Without Fee	7/15/2016	1/1/2017
Final Waiver Deadline	8/15/2016	1/15/2017
Student only	$1,306.00	$1,306.00
NOTE: Costs below are in addition to the student premium. Dependent enrollment in this plan is voluntary.		
Dependent Enrollment Start Date	7/15/2016	12/1/2016
Dependent Enrollment End Date	9/15/2016	2/1/2017
Spouse only	$1,306.00	$1,306.00
One Child Age 0-25 only	$1,306.00	$1,306.00
Two Children Age 0-25 only	$2,514.00	$2,514.00
Three Children Age 0-25 only	$2,543.00	$2,543.00

VOLUNTARY UNDERGRADUATES (CONCURRENT ENROLLMENT & CONTINUATION)	FALL 8/15/2016 - 12/31/2016	SPRING/SUMMER 1/1/2017 - 7/31/2017
Enrollment Start Date	7/15/2016	12/1/2016
Enrollment End Date	9/15/2016	2/1/2017
Student only	$1,306.00	$1,306.00
NOTE: Costs below are in addition to the student premium. Dependent enrollment in this plan is voluntary.		
Spouse only	$1,306.00	$1,306.00
One Child Age 0-25 only	$1,306.00	$1,306.00
Two Children Age 0-25 only	$2,514.00	$2,514.00
Three Children Age 0-25 only	$2,543.00	$2,543.00

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

REGISTERED GRADUATES	FALL 8/15/2016 - 12/31/2016	SPRING/SUMMER 1/1/2017 - 7/31/2017
Waiver Start Date	5/16/2016	12/1/2016
Waiver Deadline Without Fee*	7/15/2016	1/1/2017
Final Waiver Deadline*	8/15/2016	1/15/2017
Student only	$2,073.00	$2,073.00
NOTE: Costs below are in addition to the student premium. Dependent enrollment in this plan is voluntary.		
Dependent Enrollment Start Date	7/15/2016	12/1/2016
Dependent Enrollment End Date	9/15/2016	2/1/2017
Spouse only	$2,073.00	$2,073.00
One Child Age 0-25 only	$2,073.00	$2,073.00
Two Children Age 0-25 only	$4,030.00	$4,030.00
Three Children Age 0-25 only	$4,058.00	$4,058.00

VOLUNTARY GRADUATES (FILING FEE & CONTINUATION)	FALL 8/15/2016 - 12/31/2016	SPRING/SUMMER 1/1/2017 - 7/31/2017
Enrollment Start Date	7/15/2016	12/1/2016
Enrollment End Date	9/15/2016	2/1/2017
Student only	$2,073.00	$2,073.00
NOTE: Costs below are in addition to the student premium. Dependent enrollment in this plan is voluntary.		
Spouse only	$2,073.00	$2,073.00
One Child Age 0-25 only	$2,073.00	$2,073.00
Two Children Age 0-25 only	$4,030.00	$4,030.00
Three Children Age 0-25 only	$4,058.00	$4,058.00

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

Please note waiver periods may be different for graduate programs on special insurance cycles. New incoming graduate students have until August 31 to submit their waiver without a late fee. For more information on these programs and their waiver dates, please contact the Berkeley SHIP Office at **510-642-5700 or **ship@berkeley.edu**.*

Custom PPO Student Health Plan with Student Health Center (& Rx)

In addition to dollar and percentage copays, insured persons (students) are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Insured persons are also responsible for all costs over the plan maximums.

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

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

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

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

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

This plan includes care needed when the student health center is closed, care during break or vacation periods or care needed when student is more than 50 miles from campus.

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

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

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

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

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

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

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

Benefit Year Maximum	**Unlimited**

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
Semi-private room, meals & special diets, & ancillary services	10%	40%[1]
Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	10%	40%[1]
Ambulatory Surgical Centers		
Outpatient surgery, services & supplies	10%	40%
Skilled Nursing Facility *(subject to utilization review)*		
Semi-private room, services & supplies *(limited to 100 days/benefit year; limit does not apply to mental health and substance abuse)*	10%	40%
Hospice Care		
Inpatient or outpatient services; family bereavement services	No copay[2]	No copay[2]
Home Health Care *(subject to utilization review)*		
Services & supplies from a home health agency *(limited to 100 visits/benefit year, one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care)*	10%	40%
Home Infusion Therapy *(subject to utilization review)*		
Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	40%
Physician Medical Services		
Office & home visits	$15 copay[3] *(deductible waived)*	40%
Hospital & skilled nursing facility visits	10%	40%
Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	40%
Allergy testing & treatment	10%	40%
Lab and X-ray		
Diagnostic Lab	10%	40%
Diagnostic X-ray	10%	40%
Advanced Imaging (subject to Utilization Management)	10%	40%
Preventive Care Services		
Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision), immunizations, health education, intervention services and HIV testing		
**This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law*	No copay *(deductible waived)*	40%
Pediatric Preventive Services (up to age 19)		
Dental Deductible *(deductibles are combined; satisfying one helps satisfy the other)*	$60/student/$180 family	$60/student/$180 family
Pediatric Dental OOP Maximum	$1,000 Student/$2000 family;	No maximum Non-PPO
Vision Exam & 1 pair glasses	No co-payment/co-insurance	See separate allowances
Dental Diagnostic & preventive exam	No co-payment/co-insurance	No co-payment/co-insurance
Dental Basic Restorative Care	30%	30%
Dental Major Restorative Care	30%	30%
Orthodontic Care	30%	30%

[1] For California facilities, a discount applies if the facility has a contract with us for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher out-of-pocket costs for insured persons.

[2] These providers are not represented in the PPO network.

[3] The dollar copay applies only to the visit itself. No additional copay applies for any services performed in office (i.e., X-ray, lab, surgery).

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
Physical Therapy, Physical Medicine & Occupational Therapy	$15 copay *(deductible waived)*	40%
Chiropractor Services	$15 copay *(deductible waived)*	40%
Speech Therapy		
Outpatient speech therapy following injury or organic disease	$15 copay *(deductible waived)*	40%
Acupuncture		
Services for the treatment of disease, illness or injury	$15 copay[1] *(deductible waived)*	40%[1]
Temporomandibular Joint Disorders		
Splint therapy & surgical treatment	10%	40%
Pregnancy & Maternity Care		
Physician office visits *(in-network preventive prenatal services are covered at 100%; first post natal visit is also covered at 100%)*	$15 copay[2] *(deductible waived)*	40%
Prescription drug for abortion *(mifepristone)*	10%	40%
Normal delivery, cesarean section, complications of pregnancy & abortion		
Inpatient physician services	10%	40%
Hospital & ancillary services	10%	40%[3]
Ultrasound due to pregnancy	No copay	40%
Gender Reassignment Surgery Benefits		
Hospital-based care *(subject to utilization review)*	10%	40%
Inpatient physician visits	10%	40%
Gender Reassignment travel benefits *(student's transportation to & from facility is limited to $10,000 per surgery)*	No copay *(deductible waived)*	Not covered
Bariatric Surgery *(Subject to utilization review; covered only when performed at a Blue Distinction Center for Specialty Care [BDCSC])*		
Necessary surgery for weight loss, only for morbid obesity	10%	Not covered
Travel expenses for an authorized, specified surgery *(recipient & companion transportation limited to $3,000 per surgery)*	No copay *(deductible waived)*	Not covered

[1] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist.

[2] The dollar copay applies only to the visit itself. No additional copay applies for any services performed in office (i.e., X-ray, lab and surgery).

[3] For California facilities, a discount applies if the facility has a contract with us for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher out-of-pocket costs for insured persons.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
Diabetes Education Programs *(requires physician supervision)*		
Teach insured persons & their families about the disease process, the daily management of diabetic therapy & self-management training	$15 copay *(deductible waived)*	40%
Prosthetic Devices		
Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts for insured persons with diabetes	10%	40%
Durable Medical Equipment		
Rental or purchase of DME including hearing aids, dialysis equipment & supplies *(hearing aids benefit is available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	10%	40%
Related Outpatient Medical Services & Supplies		
Ground or air ambulance transportation, services & disposable supplies	10%[1]	10%[1]
Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%[1]	20%[1]
Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	20%[1]	20%[1]
Emergency Care		
Emergency room services & supplies *($100 copay waived if admitted; deductible waived)*	$100 copay	Covered as in-network
Physician services	10%	10%
Urgent Care		
Urgent Care *(physician services)*	$50 copay *(deductible waived)*	40%

[1] These providers are not represented in the PPO network.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
Organ & Tissue Transplants *(subject to utilization review; specified transplants covered only when performed at Centers of Medical Excellence [CME] and Blue Distinction Centers for Specialty Care [BDCSC] for California; Blue Distinction Centers for Specialty Care [BDCSC] for out of California)*		
Inpatient services provided in connection with non-investigative organ or tissue transplants	10%	Not covered
Physician office visits *(including specialists and consultants)*	$15/copay *(deductible waived)*	Not covered
Transplant travel expense for an authorized, specified transplant *(recipient & companion transportation limited to $10,000 per transplant)*	No copay *(deductible waived)*	Not covered
*Unrelated donor search, limited to $30,000 per transplant		
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
Facility-based care *(subject to utilization review; waived for emergency admission*	10%	40%[1]
Inpatient physician visits	10%	40%
Outpatient Care		
Facility-based care *(subject to utilization review; waived for emergency admission*	10%	40%[1]
Outpatient physician visits *(Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)*	$15 copay[2] *(deductible waived)*	40%
Psycho-educational Testing (deductible waived)	10%	40%
Outpatient Drugs and Medications *(not subject to deductible)*		
Retail		
Female oral contraceptives generic and single source brand	No copay	40%
Tier 1 drugs *(includes diabetic supplies)*	$5 copay	$5 copay + 40%
Tier 2 drugs	$25 copay	$25 copay + 40%
Tier 3 drugs	$40 copay	$40 copay + 40%
Supply Limits		
Retail Pharmacy *(participating and non-participating)*	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)	
Specialty Pharmacy	30-day supply	

[1] For California facilities, a discount applies if the facility has a contract with us for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher out-of-pocket costs for insured persons.

[2] The dollar copay applies only to the visit itself. No additional copay applies for any services performed in office (i.e., X-ray, lab, surgery).

This Summary of Benefits is a brief review of benefits. Once enrolled, insured persons will receive a Certificate of Insurance, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

PPO Student Health Plan—Prudent Buyer Plan Exclusions and Limitations

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

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

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

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

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

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

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

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

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

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

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

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

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

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

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

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

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

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

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

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

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

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

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

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

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Certificate.

Sterilization Reversal.

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

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

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

Air Conditioners. Air purifiers, air conditioners or humidifiers.

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

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

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

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

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

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

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

Acupuncture. Acupuncture treatment, as specified as covered in the Certificate. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

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

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

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

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

Third Party Liability – Anthem Blue Cross Life and Health Insurance Company is entitled to reimbursement of benefits paid if the insured person recovers damages from a legally liable third party.

Excess Coverage – Anthem Blue Cross Life and Health Insurance Company will reduce the amount payable under this plan if expenses are covered under any other plan. We will determine the amount of benefits provided by other plans without reference to any coordination of benefits, non-duplication of benefits, or other similar provisions. The amount from other plans includes any amount to which the insured person is entitled, whether or not a claim is made for the benefits. The coverage under this policy is secondary coverage to all other policies.

UC Berkeley
Student Health Insurance Plan (SHIP)
Group Number: 151675

MetLife

MetLife Dental Insurance Plan Summary

Network: PDP Plus

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

Deductible†		
Individual	$25	$50
Annual Maximum Benefit		
Per Person	$1,700	$1,700

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

*Negotiated Fee refers to the fees that participating dentists have agreed to accept as payment in full, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
**R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.
†Applies to Type B and C Services

List of Primary Covered Services & Limitations

Type A - Preventive	How Many/How Often
Prophylaxis (cleanings)	• Two per plan year
Oral Examinations	• Two per plan year
Topical Fluoride Applications	• Two per plan year
X-rays	• Full mouth X-rays: one per 5 years • Bitewing X-rays: one set per plan year for adults; two sets per plan year for children to age 18.
Space Maintainers	• No Limit
Type B - Basic Restorative	**How Many/How Often**
Fillings	• Composite fillings allowed on all teeth
Simple Extractions	
Endodontics	• Root canal treatment
General Anesthesia	• When dentally necessary in connection with oral surgery, extractions or other covered dental services
Sealants	• Once per non-decayed 1st or 2nd permanent molar every 24 months to age 16
Oral Surgery	
Periodontics	• Periodontal scaling and root planing once per quadrant, every 24 months • Periodontal surgery once per quadrant, every 36 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a plan year
Type C - Major Restorative	**How Many/How Often**
Bridges and Dentures	• Initial placement to replace one or more natural teeth, which are lost while covered by the Plan • Dentures and bridgework replacement: one every 5 years • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
Relining and Rebasing of Dentures	• Once per 36 months
Crowns/Inlays/Onlays	• Replacement once every 5 year.
Implant Supported Cast Restorations	• Replacement once every 5 year.
Core Buildup; Post and Cores	• Once every 5 year.

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

Frequently Asked Questions

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

*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.

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

What services are covered under this plan?
All services defined under the group dental benefits plan are covered. Please review the enclosed plan benefits to learn more.

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

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

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

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

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

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

*Travel Assistance services are administered by AXA Assistance USA, Inc. Certain benefits provided under the Travel Assistance program are underwritten by Virginia Surety Company, Inc. AXA Assistance and Virginia Surety are not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife.
**Refer to your dental benefits plan summary for your out-of-network dental coverage.

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

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

Exclusions

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

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

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

Service. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99 / G.2130-S) issued by MetLife. Coverage terminates when your membership ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details.

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VSP Plan and Rate Confirmation
UC Berkeley Students
Effective: August 15, 2016

	Choice Plan	
Network	**Choice Network/Retail Chain Providers**	
Copay	$10 Exam / $25 Materials	
Exam Every:	Every plan year	
Lenses Every:	Every plan year	
Frame Every:	Every plan year	
VSP PROVIDER		
Examination	Covered after copay	
Lenses:		
Single Vision	Covered after copay	
Lined Bifocal	Covered after copay	
Lined Trifocal	Covered after copay	
Lenticular	Covered after copay	
Copay on Lens Enhancements:		
	Lens enhancements are covered after a copay, saving members an average of 20% - 25%	
	Single Vision	***Multifocal***
Anti-reflective coating	$41	$41
Polycarbonate	$31	$35
Polycarbonate for children	Covered	Covered
Progressive - standard	N/A	$55
Photochromic	$70	$82
Scratch-resistant coating	$17	$17
Frames	$130.00	
Frames at Costco	$70.00	
Elective Contact Lenses	$120.00	
Necessary Contact Lenses	Covered after copay	
ADDITIONAL SAVINGS		
	Extra $20 on featured frame brands	
	20% off amount over frame allowance	
	20% off additional pairs of prescription glasses and/or non-prescription sunglasses from any VSP doctor within 12 months of exam	
	Laser Vision Correction - Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.	
NON-VSP PROVIDER		
Examination	$47.00	
Lenses:		
Single Vision	$30.00	
Bifocal	$50.00	
Trifocal	$60.00	
Progressive	$50.00	
Frames	$45.00	
Elective Contact Lenses	$100.00	
Necessary Contact Lenses	$210.00	