WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

STUDENT HEALTH CERTIFICATE OF COVERAGE

POLICYHOLDER:	Stanford University (Policyholder)
POLICY NUMBER:	WI2627CASHIP245
POLICY EFFECTIVE DATE:	September 1, 2026
POLICY TERMINATION DATE:	August 31, 2027
STATE OF ISSUE:	California

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Policy between Wellfleet Insurance Company (hereinafter referred to as "We", "Us" or "Our") and the Policyholder. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

INSURING AGREEMENTS

COVERAGE: Benefits are provided to cover the expenses incurred due to a Covered Sickness or a Covered Injury which results in Covered Medical Expenses.

We will pay the benefits under the terms of the Policy in consideration of:
1. The application for the Policy; and
2. The payment of all Premiums as set forth in the Policy.

This Certificate takes effect on the Policy Effective Date at 12:00 a.m. local time at the Policyholder's address. We must receive the Policyholder's signed application and the initial Premium for it to take place.

Termination of the Certificate
This Certificate terminates on the Policy Termination Date at 11:59 p.m. local time at the Policyholder's address.

The following pages form a part of this Certificate as fully as if the signatures below were on each page.

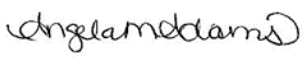
This Certificate is executed for the Company by its President and Secretary.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THIS CERTIFICATE. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

Non-Participating



President
Andrew M. DiGiorgio



Secretary
Angela Adams

Underwritten by: Wellfleet Insurance Company
5814 Reed Road, Fort Wayne, IN 46835

Administrator: Wellfleet Group, LLC dba Wellfleet Administrators, LLC
P.O. Box 15369
Springfield, MA 01115-5369
877-657-5030

The following applies to Insured Persons age 65 or older only:
THE POLICYHOLDER HAS THE RIGHT TO RETURN THE POLICY, BY MAIL OR OTHER DELIVERY METHOD, WITHIN 30 DAYS OF ITS RECEIPT, AND TO HAVE THE FULL PREMIUM AND ANY POLICY OR MEMBERSHIP FEE PAID REFUNDED.

Insured Persons who have complaints regarding their ability to access needed health care in a timely manner may complain to Us and to the California Department of Insurance. Our contact information can be found above and the Consumer Services Division of the Department of Insurance's contact information can be found below.

California Department of Insurance
300 S. Spring Street
11th Floor
Los Angeles, CA 90013
Inside State Toll-Free: 1-800-927-4357
Outside State: 1-213-897-8921
Fax: 1-213-897-9641
TDD: 1-800-482-4833
www.insurance.ca.gov

Limitations to Network Provider services can be found in the Preferred Provider Organization provision in Section IV- HOW THE PLAN WORKS AND DESCRIPTION OF BENEFITS.

If an Insured Person uses an In-Network Provider, this Certificate will pay the Coinsurance percentage of the Negotiated Charge shown in the Schedule of Benefits for Covered Medical Expenses. If an Out-of-Network Provider is used, this Certificate will pay the percentage of the Usual and Customary Charge for Covered Medical Expense shown in the Schedule of Benefits. Note, however, that We will pay at the Negotiated Charge level for Treatment by an Out-of-Network Provider if: there is no In-Network Provider available to treat the Insured Person for Medically Necessary health care services; or the Insured Person has an Emergency Medical Condition and immediate medical Treatment is needed.

If there is no In-Network Provider available to treat the Insured Person for Medically Necessary health care services, We will arrange for the required care with available and accessible Out-of-Network Providers, with the Insured Person responsible for paying only cost sharing in an amount equal to the cost sharing they would have paid for that health care service, or a similar service, provided by an In-Network Provider. In addition to In-Network Provider Copayments and Coinsurance, In-Network Provider cost sharing includes the In-Network Provider Deductible (if applicable) and accrual of cost sharing to the In-Network Provider Out-of-Pocket Maximum.

Fraud Warning:
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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SECTION I - ELIGIBILITY

An Eligible Student must attend classes for at least the first 31 days of the period for which he or she is enrolled and/or pursuant to his or her Visa requirements for the period for which coverage is elected.

Except in the case of withdrawal from School due to Sickness or Injury, any student who withdraws from the Policyholder's School during the first 31 days of the period for which he or she is enrolled shall not be covered under the insurance plan. A full refund of Premium will be made, minus the cost of any claim benefits paid by the Certificate. A student who graduates or withdraws after such 31 days of the period for which he or she is enrolled will remain covered under this Certificate for the term purchased and no refund will be made. However, an Insured Student who graduates, takes a Policyholder approved leave of absence, or who is no longer enrolled in the Policyholder's school, may request termination of their coverage. The request must be provided, in writing to the Policyholder, at least 30 days prior to the requested effective date of termination. Upon receipt of the written request, the Insured Student's coverage will terminate on the earliest of:

1. the last day of the calendar month in which the 30-day period ends (a pro rata refund of Premium will be made less any claims paid); or
2. the end of the term purchased.

Insurance for the student's covered Dependent(s) will end when insurance for the student ends.

A student withdrawing due to a medical withdrawal due to a Sickness or Injury, must submit documentation or certification of the medical withdrawal to Us at least 30 days prior to the medical leave of absence from the School, if the medical reason for the absence and the absence are foreseeable, or 30 days after the date of the medical leave from School. The student withdrawing due to a medical withdrawal due to a Sickness or Injury will remain covered under the Certificate for the term purchased and no refund will be allowed.

All International Students are required to have a J-1, F-1, or M-1 and their eligible Dependents (who are not U.S. citizens) are required to have a J-2, F-2, or M-2 Visa to be eligible for this insurance plan.

We maintain the right to investigate eligibility status and attendance records to verify that the Certificate eligibility requirements have been and continue to be met. If We discover that the Certificate eligibility requirements have not been met, Our only obligation is refund of Premium less any claims paid. Eligibility requirements must be met each time Premium is paid to continue coverage.

If the Insured Student or the Insured Student's Dependent has performed an act that constitutes fraud; or the Insured Student has made an intentional misrepresentation of material fact during their enrollment under this insurance plan in order to obtain coverage for a service, coverage will be terminated immediately upon written notice of termination delivered by Us to the Insured Student and/or the Insured Student's Dependent, as applicable. If termination is a result of the Insured Student's action, coverage will terminate for the Insured Student and the Insured Student's Dependents. If termination is a result of the Insured Student's Dependent's action, coverage will terminate for the Insured Student's Dependent.

Who is Eligible

Class 1	**Description of Class(es)**
	All students of the Policyholder taking at least 1 credit hour.

Class 1: All students, as determined by the Policyholder, are eligible for coverage under the Policy. Eligible Students are required to have health insurance coverage and will be automatically enrolled in the Student Health Insurance Plan at registration and pay the applicable Premium amount unless proof of minimum essential coverage is provided by completing the waiver.

Who is Not Eligible
Students taking distance learning, home study, correspondence, or television courses do not fulfill the eligibility requirements that the student attend classes and are not eligible to enroll in the insurance plan.

Dependent Eligibility
Dependents are eligible for coverage under this plan.

The Insured Student's Dependent may become eligible for coverage under this Certificate only when the Insured Student becomes eligible; or within 60 days of a Qualifying Life Event.

SECTION II – EFFECTIVE AND TERMINATION DATES

Effective Dates
The Insured Student's Insurance under this Certificate will become effective on the later of:
1. The Policy Effective Date;
2. The beginning date of the term of coverage for which Premium has been paid;
3. The day after Enrollment (if applicable) and Premium payment is received by Us, Our authorized agent or the School;
4. The day after the date of postmark if the Enrollment Form is mailed; or
5. For International Students or scholars, the departure date to his or her Home Country to travel to the Country of Assignment. The scheduled arrival in the Country of Assignment must be not more than 48 hours later than the departure from the Home Country.

Dependent's coverage, becomes effective on the later of:
1. The date the Insured Student's coverage becomes effective; or
2. The date the Insured Student's Dependent is enrolled for coverage, provided Premium is paid when due.
3. The day after the date of postmark if the Enrollment Form is mailed; or
4. The beginning date of the term of coverage for which Premium has been paid; or
5. The day after the date the required individual Enrollment Form and Premium payment are received by Us or Our authorized agent. This applies only when Premium payment is made within 31 days of the Insured Student's enrollment in the School's insurance plan; or
6. The Policy Effective Date.

Special Enrollment – Qualifying Life Event
The Insured Student, and the Insured Student's Spouse or Child can also enroll for coverage within 60 days of the loss of coverage in another health plan if coverage was terminated because the Insured Student, the Insured Student's Spouse or Child are no longer eligible for coverage under the other health plan due to:
1. Involuntary termination of the other health plan;
2. Death of the Spouse;
3. Legal separation, divorce or annulment;
4. A Child no longer qualifies for coverage as a Child under the other health plan.

The Insured Student, the Insured Student's Spouse or Child can also enroll 60 days from exhaustion of the Insured Student's COBRA or continuation coverage or if the Insured Student gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption.

We must receive notice and Premium payment within 60 days of the loss of coverage. The Effective Date of the Insured Person's coverage will depend on when We receive proof of the Insured Person's loss of coverage under another health plan and appropriate Premium payment. The Insured Person's coverage shall take effect on the latest of the following dates: (1) this Policy Effective Date; (2) the day after the date for which the Insured Person lost their coverage provided Premium for the Insured Person's coverage has been paid; (3) the date the Policyholder's term of coverage begins; or (4) the date the Insured Student becomes a member of an eligible class of persons.

In addition, the Insured Student, and the Insured Student's Spouse or Child can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. The Insured Student or the Insured Student's Spouse or Child lose eligibility for Medi-Cal or a state child health plan.
2. The Insured Student or the Insured Student's Spouse or Child become eligible for Medi-Cal or a state child health plan.

We must receive notice and Premium payment within 60 days of the loss of one of these events. The Effective Date of the Insured Person's coverage will depend on the date We receive the Insured Person's completed enrollment information and required Premium.

Termination Dates

The Insured Person's insurance will terminate on the earliest of:

1. The date this Certificate terminates; or
2. The end of the term of coverage for which Premium has been paid; or
3. The date the Insured Student ceases to be eligible for the insurance; or
4. The date the Insured Student enters military service; or
5. For International Students, the date the Insured Student ceases to meet Visa requirements; or
6. For International Students, the date the Insured Student departs the Country of Assignment for their Home Country (except for scheduled School breaks); or
7. On any Premium due date the Policyholder fails to pay the required Premium for the Insured Student except as the result of an inadvertent error and subject to any Grace Period provision.

The Insured Student's Dependent's insurance will terminate on the earliest of:

1. The date the Insured Student's insurance ends; or
2. The date the Insured Student's Dependent ceases to be eligible for the insurance; or
3. The end of the term of coverage for which Premium has been paid.

Dependent Child Coverage

Newly Born Children

A newly born child of the Insured Person will be covered from the moment of birth. Such newborn child will be covered for Medically Necessary health care services for an initial period of 31 days. This includes the necessary care and Treatment of medically diagnosed congenital defects and birth abnormalities from the moment of birth. If additional Premium is required, to continue coverage beyond this initial 31-day period, the Insured Student must notify Us of the birth so We can generate an updated Premium bill so a timely Premium payment is made. If an additional Premium is not required, We request that the Insured Student notify Us of the birth to ensure proper claims adjudication.

Adopted Children

Dependent Child coverage also applies to any child adopted or placed for adoption irrespective of whether the adoption has become final.

We must receive:

1. Notification of a child's placement for adoption within 31 days of the placement; and

2. Any Premium required for the child.

We will provide coverage for the child placed for adoption as long as the Insured Student:
1. Has custody of the child;
2. The Insured Student's coverage under this Certificate remains in effect; and
3. The required Premiums are furnished to Us.

As it pertains to this provision:
Child means, in connection with an adoption or placement for adoption, an individual who has not attained the age of 18 as of the date of the adoption or placement for adoption.

Placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of a child. The child's placement with a person terminates upon the termination of the legal obligation.

Disabled Children
If:
1. There is Dependent coverage; and
2. This Certificate provides that coverage of a Dependent child will terminate upon attainment of a specified age,

We will not terminate the coverage of such child due to attainment of that age while the child is and continues to be both:
1. Incapable of self-sustaining employment by reason of developmental or physical disability, mental illness or disorder; and
2. Chiefly dependent upon the Insured Student for support and maintenance.

Proof of such incapacity and dependence shall be furnished to Us within 31 days of the child's attainment of the limiting age. Upon request, We may require proof satisfactory to Us of the continuance of such incapacity and dependency. We may not request this more frequently than annually after the 2-year period following the child's attainment of the limiting age.

Extension of Benefits
Coverage under this Certificate ceases on the Termination Date of Your insurance coverage. However, coverage for You will be extended as follows:
1. If You are Hospital Confined for a Covered Injury or Covered Sickness on the date Your insurance coverage terminates, We will continue to pay benefits for that Covered Injury or Covered Sickness for up to 90 days from the Termination Date while such Confinement continues.

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

Reinstatement Of Reservist After Release From Active Duty
If the Insured Student's insurance or an eligible Dependent's insurance ends due to the Insured Student being called or ordered to active duty, such insurance will be reinstated without any waiting period when the student returns to School and satisfies the eligibility requirements defined by the School.

Refund of Premium
Premiums received by Us are fully earned upon receipt. Refund of Premium will be considered only:
1. If a student ceases to be eligible for the insurance and coverage is terminated prior to the next Premium due date, a pro rata refund of Premium (less any claims paid) will be made for such person. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.

2. For any student who withdraws from School during the first 31 days of the period for which he or she is enrolled for a reason other than withdrawal due to Sickness or Injury. Such a student will not be covered under this Certificate and a full refund of the Premium will be made (less any claims paid) when written request is made within 90 days of withdrawal from School. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.
3. For an Insured Student entering the Armed Forces of any country. Such a student will not be covered under this Certificate as of the date of his/her entry into the service. A pro rata refund of Premium (less any claims paid) will be made upon written request received by Us within 90 days of withdrawal from School. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.
4. For an Insured International Student, Scholar, departing School to return to his or her Home Country on a permanent basis. We will refund a pro rata refund of Premium (less any claims paid) when written request and proof from the Policyholder that the student is no longer an eligible person is received by Us within 60 days of such departure. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.

SECTION III – DEFINITIONS

These are key words used in this Certificate. They are used to describe the Policyholder's rights as well as Ours. Reference should be made to these words as the Certificate is read.

Accident means a sudden, unforeseeable external event which results in an Injury.

Actual Charge means the charge for the Treatment by the provider who furnishes it.

Ambulance means any conveyance designed and constructed or modified and equipped to be used, maintained, or operated to transport individuals who are sick, wounded, or otherwise incapacitated.

Ambulance Service means transportation to or from a Hospital by a licensed Ambulance whether ground, air or water Ambulance, in a Medical Emergency.

Ambulatory Surgical Center means a facility which meets licensing and other legal requirements and which:
1. Is equipped and operated to provide medical care and Treatment by a Physician;
2. Does not provide services or accommodations for overnight stays, unless the expected duration of services is less than 24 hours;
3. Has a medical staff that is supervised full-time by a Physician;
4. Has full-time services of a licensed registered Nurse at all times when patients are in the facility;
5. Has at least one operating room and one recovery room and is equipped to support any surgery performed;
6. Has x-ray and laboratory diagnostic facilities;
7. Maintains a medical record for each patient; and
8. Has a written agreement with at least one Hospital for the immediate transfer of patients who develop complications or need Confinement.

Anesthetist means a Physician or Nurse who administers anesthesia during a surgical procedure. He or she may not be an employee of the Hospital where the surgical procedure is performed.

Assistant Surgeon means a Physician who assists the Surgeon who actually performs a surgical procedure.

Brand-Name Prescription Drug means a Prescription Drug whose manufacture and sale is controlled by a single company as a result of a patent or similar right. Refer to the Formulary for the tier status.

Certificate: The Certificate issued by Us, including the Schedule of Benefits and any attached riders.

Coinsurance means the percentage of Covered Medical Expenses that We pay. The Coinsurance percentage is stated in the Schedule of Benefits. The Coinsurance is separate and not part of any Deductible and/or Copayment.

Complications of Pregnancy means conditions that require Hospital Confinements before the pregnancy ends and whose diagnoses are distinct from but caused or affected by pregnancy. These conditions are acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar conditions as severe as these.

Complications of Pregnancy also include non-elective cesarean section, termination of an ectopic pregnancy, and spontaneous termination when a live birth is not possible. (This does not include a non-therapeutic abortion.)

Complications of Pregnancy do not include false labor, occasional spotting or Physician prescribed rest during the period of pregnancy, morning Sickness, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.

Confinement/Confined means an uninterrupted stay following admission to a health care facility. The readmission to a health care facility for the same or related condition, within a 7 day period, will be considered a continuation of the Confinement. Confinement does not include Observation Services, which is a review or assessment of 48 hours or less, of a condition that does not result in admission to a Hospital or health care facility.

Copayment means a specified dollar amount You must pay for specified Covered Medical Expenses. Any Copayment amounts are shown in the Schedule of Benefits.

Country of Assignment means the country in which an Eligible International Student, scholar or visiting faculty member is:

1. Temporarily residing; and
2. Actively engaged in education or educational research related activities sponsored by the National Association for Foreign Student Affairs or its Member Organizations.

Covered Injury/Injury means a bodily injury which results from an Accident. All injuries sustained in any one Accident, all related conditions and recurrent symptoms of these injuries are considered a single Injury.

Covered Medical Expense means those Medically Necessary charges for any Treatment, service, or supplies that are:

1. Not in excess of the Usual and Customary Charge therefore;
2. Not in excess of the charges that would have been made in the absence of this insurance;
3. Not in excess of the Negotiated Charge; and
4. Incurred while this Certificate is in force, except with respect to any expenses payable under the Extension of Benefits Provision.

Covered Sickness/Sickness means an illness, disease or condition, including pregnancy and Complications of Pregnancy, that impairs Your normal function of mind or body and which is not the direct result of an Injury which results in Covered Medical Expenses. Covered Sickness includes Mental Health and Substance Use Disorders.

Custodial Care means care that is mainly for the purpose of meeting non-medical personal needs. This includes help with activities of daily living and taking medications. Activities of daily living include: bathing, dressing or grooming, eating, toileting, walking and getting in and out of bed. Custodial Care can usually be provided by someone without professional and medical skills or training.

Deductible means the dollar amount of Covered Medical Expenses You must incur before benefits are payable under this Certificate. The amount of the Deductible, if any, will be shown in the Schedule of Benefits.

Dental Provider means any individual legally qualified to provide dental services or supplies.

Dependent means:
1. An Insured Student's lawful Spouse, or lawful Domestic Partner;
2. An Insured Student's dependent biological or adopted child or stepchild under age 26; and
3. An Insured Student's unmarried biological or adopted child or stepchild who has reached age 26 and who is:
   a. primarily dependent upon the Insured Student for support and maintenance; and
   b. incapable of self-sustaining employment by reason of developmental or physical disability, mental illness or disorder.

   Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when an Insured Student enrolls a new disabled child under the plan.

Domestic Partner means two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. A Domestic Partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division, and, at the time of filing, all of the following requirements are met:
1. Neither person is married to someone else or is a member of another Domestic Partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
2. The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
3. Both persons are at least 18 years of age, except as provided in Section 297.1.
4. Both persons are capable of consenting to the Domestic Partnership.

A Domestic Partnership that has not been registered with the State of California must meet the following requirements to be considered a Domestic Partnership under this Certificate:
1. Both persons must be each other's sole Domestic Partner in a long-term, committed relationship and must intend to remain so indefinitely.
2. Neither person is married to someone else or is a member of another Domestic Partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
3. The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
4. Both persons must be at least 18 years of age and capable of consenting to the relationship.
5. Both persons must be financially interdependent.
6. The two persons must share a common residence.
7. The Policyholder's Declaration of Domestic Partnership Form must be completed and accepted by the Policyholder.

Any references herein to Spouse and marriage include Domestic Partners and Domestic Partnerships.

Durable Medical Equipment means a device which:
1. Is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of Sickness or Injury and is able to withstand repeated use;
2. Is used exclusively by You;
3. Is not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment;
4. Is suited for use in the home;
5. Can be expected to make a meaningful contribution to treating Your Sickness or Injury; and
6. Is prescribed by a Physician and the device is Medically Necessary for Rehabilitation.

Durable Medical Equipment does not include:

1. Comfort and convenience items;
2. Health exercise equipment; and
3. Equipment that may increase the value of Your residence.

Effective Date means the date coverage becomes effective.

Elective Surgery or Elective Treatment means those health care services or supplies not Medically Necessary for the care and Treatment of an Injury or Sickness. Elective surgery does not include Plastic, Cosmetic, or Reconstructive Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

Eligible Student means a student who meets all eligibility requirements of the School named as the Policyholder.

Emergency Medical Condition means a Sickness or Injury for which immediate medical Treatment is sought at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:
1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition: transportation services, including but not limited to Ambulance Services, a medical screening examination that is within the capability of the emergency department, including ancillary services routinely available to the emergency department, and covered inpatient and outpatient services furnished by a Hospital, independent freestanding emergency department, or Physician qualified to furnish those services that are needed to evaluate or Stabilize an Emergency Medical Condition. Coverage also includes Post-Stabilization services after You are Stabilized. Post-Stabilization services include undergoing outpatient Observation Services, or an inpatient or outpatient stay with respect to the visit in which the other Emergency Services are furnished. The Post-Stabilization services will no longer qualify as Emergency Services once You can travel using non-medical or non-emergency transportation and You are in a condition to receive notice of, and to consent to, Out-of-Network Treatment.

Essential Health Benefits means benefits that are defined in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes the following categories of covered services:
1. Ambulatory patient services;
2. Emergency Services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental Health and Substance Use Disorder services, including behavioral health Treatment;
6. Prescription drugs;
7. Rehabilitation and Habilitation services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

Experimental and Investigational services are medical procedures, equipment, medications, and cosmetic procedures that are not Medically Necessary and are not covered. These services are considered experimental and investigational if they meet any of the following criteria:

- The service does not have unrestricted market approval from the Food and Drug Administration (FDA) or final approval from any other governmental regulatory body.
- There is insufficient or inconclusive medical and scientific evidence to evaluate the service's therapeutic value.
- The service is not Medically Necessary and there is a safe and medically accepted alternative available.
- The service is a medical device established by the FDA as Category A, which are generally not covered because their safety and effectiveness have not yet been established.

Formulary means a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary indicates the type of drug and tier status.

Generic Prescription Drug means any Prescription Drug that is not a Brand-Name Prescription Drug. Refer to the Formulary for the tier status.

Habilitation Services means health care services that help You keep, learn, or improve skills and functions for daily living. Habilitation Services may include such services as Physical Therapy, occupational therapy, and speech therapy.

Home Country means the Insured Student's country of citizenship. If the Insured Student has dual citizenship, the Insured Student's Home Country is the country of the passport the Insured Student used to enter the United States. The Insured Student's Home Country is considered the Home Country for any International Dependent of the Insured Student while insured under this Certificate.

Home Health Care Agency means an agency that:
1. Is constituted, licensed and operated under the provision of Title XVIII of the Federal Social Security Act, or qualified to be so operated if application was made, and certified by the jurisdiction in which the Home Health Care plan is established; and
2. Is engaged primarily in providing Skilled Nursing Facility services and other therapeutic services in Your home under the supervision of a Physician or a Nurse; and
3. Maintains clinical records on all patients.

Home Health Care means the continued care and Treatment if:
1. Your institutionalization would have been required if Home Health Care was not provided; and
2. Your Physician establishes and approves in writing the plan of treatment covering the Home Health Care service; and
3. Home Health Care is provided by:
   a. a Hospital that has a valid operating certificate and is certified to provide Home Health Care services; or
   b. a public or private health service or agency that is licensed as a Home Health Care Agency under title 19, subtitle 4 of the General Health Article to provide coordinated Home Health Care.

Hospice: means a coordinated plan of home and inpatient care which treats the terminally ill patient and family as a unit. It provides care to meet the special needs of a family unit during the final stages of a terminal illness and during the bereavement. Care is provided by a team of: trained medical personnel, homemakers, and counselors. The team acts under an independent Hospice administration. It helps the family unit cope with: physical, psychological, spiritual, social, and economic stresses.

Hospital: A facility which provides diagnosis, Treatment, and care of persons who need acute inpatient Hospital care under the supervision of Physicians and provides 24-hour nursing service by Registered Nurses on duty or call. It must be licensed as a general acute care Hospital according to state and local laws. Hospital shall also include a psychiatric health facility for the Treatment of mental or psychoneurotic disorders. Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital also includes an Ambulatory Surgical Center or ambulatory medical center; and a birthing facility certified and licensed as such under the laws where located. It shall also include an Inpatient Rehabilitation Facility if such is specifically required for Treatment of physical disability.

Facilities primarily treating drug addiction or alcoholism that are licensed to provide these services are also included in this definition. Hospital does not include a place primarily for rest, the aged, a place for educational or Custodial Care or Hospice.

Immediate Family Member means the Insured Student and the Insured Student's Spouse or the parent, child, brother or sister of the Insured Student or Insured Student's Spouse.

In-Network Providers are Physicians, Hospitals and other healthcare providers who have contracted with Us to provide specific medical care at negotiated prices.

Inpatient Rehabilitation Facility means a licensed institution devoted to providing medical and nursing care over a prolonged period, such as during the course of the Rehabilitation phase after an acute Sickness or Injury.

Insured Person means an Insured Student or Dependent of an Insured Student while insured under this Certificate.

Insured Student means a student of the Policyholder who is eligible and insured for coverage under this Certificate.

International Student means an international student:
1. With a current passport and a student Visa;
2. Who is temporarily residing outside of his or her Home Country; and
3. Is actively engaged as a student or in educational research activities through the Policyholder.

In so far as this Certificate is concerned, permanent residents or those who have applied for Permanent Residency Status are not considered to be an International Student.

Loss means medical expense caused by an Injury or Sickness which is covered by this Certificate.

Medically Necessary or **Medical Necessity,** with regards to medical and surgical benefits, means health care services that a Physician, exercising prudent clinical judgment, would provide for the purpose of preventing, evaluating, diagnosing or treating an illness, Injury, disease or its symptoms, and that are:
1. In accordance with "generally accepted standards of medical practice";
2. Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for an illness, Injury or disease; and
3. Not primarily for the economic benefit of Us or the Insured Person, or for the convenience of the Insured Person, treating Physician or other health care provider.

The fact that any particular Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Medically Necessary or Medical Necessity, with regards to Mental Health and Substance Use Disorders, means a service or product addressing the specific needs of the Insured Person, for the purpose of preventing, diagnosing, or treating a Sickness, Injury, condition, or its symptoms, including minimizing the progression of a Sickness, Injury, condition, or its symptoms, in a manner that is all of the following:

1. In accordance with the Generally Accepted Standards of Mental Health or Substance Use Disorder Care.

2. Clinically appropriate in terms of type, frequency, extent, site, and duration.
3. Not primarily for the economic benefit of Us or the Insured Person or for the convenience of the Insured Person, treating Physician, or other health care provider.

   Generally Accepted Standards of Mental Health and Substance Use Disorder Care means standards of care and clinical practice that are generally recognized by Health Care Providers practicing in relevant clinical specialties, such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines, and recommendations of nonprofit health care provider professional associations, specialty societies, and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

Mental Health and Substance Use Disorders means a mental health condition or substance use disorder listed in the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems (ICD-10), or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM).

Negotiated Charge means the amount an In-Network Provider will accept as payment in full for Covered Medical Expenses.

Nurse means a licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who:
1. Is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
2. Provides medical services which are within the scope of the Nurse's license or certificate who does not ordinarily reside in Your home or is not related to You by blood or marriage.

Observation Services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

Organ Transplant means the moving of an organ from one (1) body to another or from a donor site to another location of the person's own body, to replace the recipient's damaged, absent or malfunctioning organ.

Out-of-Network Providers are Physicians, Hospitals and other healthcare providers who have not agreed to any pre-arranged fee schedules.

Out-of-Pocket Maximum means the most You will incur during a Policy Year before Your coverage begins to pay 100% of the allowed amount for Covered Medical Expenses. Refer to the Out-of-Pocket Maximum in the Description of Benefits section for details on how the Out-of-Pocket Maximum applies. This limit will never include Premium, balance-billed charges or health care this Certificate does not cover.

Physical Therapy means any form of the following:
1. Physical or mechanical therapy;
2. Diathermy;
3. Ultra-sonic therapy;
4. Heat Treatment in any form; or
5. Manipulation or massage.

Physician means a health care professional practicing within the scope of his or her license and is duly licensed by the appropriate state regulatory agency to perform a particular service which is covered under this Certificate, and who

is not:
1. You;
2. An Immediate Family Member; or
3. A person employed or retained by You.

Policy Year means the period of time measured from the Policy Effective Date to the Policy Termination Date.

Preadmission Testing means tests done in conjunction with and within 5 working days of a scheduled surgery where an operating room has been reserved before the tests are done.

Qualifying Life Event means an event that qualifies a student to apply for coverage for him/herself or for the Insured Student's Dependent due to a Qualifying Life Event under this Certificate.

Qualifying Payment Amount means the median Negotiated Charge for:
1. The same or similar services;
2. Furnished in the same or similar facility;
3. By a provider of the same or similar specialty;
4. In the same or similar geographic area.

Quantity Limits means limits that restrict the amount dispensed per Prescription Drug order or refill and/or the amount dispensed per month's supply and are applied to ensure the Insured Person receives clinically appropriate and Medically Necessary drugs.

Recognized Amount means the lesser of:
1. the actual amount billed by the provider or facility; or
2. the Qualifying Payment Amount.

Rehabilitation means the process of restoring Your ability to live and work after a disabling condition by:
1. Helping You achieve the maximum possible physical and psychological fitness;
2. Helping You regain the ability to care for Yourself;
3. Offering assistance with relearning skills needed in everyday activities, with occupational training and guidance with psychological readjustment.

Reservist means a member of a reserve component of the Armed Forces of the United States. Reservists also includes a member of the State National Guard and the State Air National Guard.

School means the college or university attended by the Insured Student.

Skilled Nursing Facility means a facility, licensed, and operated as set forth in applicable state law, which:
1. Mainly provides inpatient care and Treatment for persons who are recovering from a Sickness or Injury;
2. Provides daily skilled care given by, or under the direct supervision of, skilled nursing or therapy staff;
3. Provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. Is not a place primarily for the care of the aged, Custodial or Domiciliary Care, or Treatment of alcohol or drug dependency; and
5. Is not a rest, educational, or custodial facility or similar place.

Sound, Natural Teeth means natural teeth. The major portion of a tooth must be present, regardless of fillings, and not carious, abscessed or defective. Sound, Natural Teeth will not include capped teeth.

Spouse means an eligible individual who is legally married to the Insured Student under the laws of the state or

jurisdiction in which the marriage was performed. A Spouse also includes the Insured Student's Domestic Partner with whom an affidavit of Domestic Partnership has been established, attesting to the relationship with another person.

Stabilize/Stabilization and Post-Stabilization means, with respect to an Emergency Medical Condition, to provide such medical Treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Surgeon means a Physician who actually performs surgical procedures.

Surprise Billing is an unexpected balance bill. This can happen when You can't control who is involved in Your care-like when You have an Emergency Medical Condition or when You schedule a visit at an In-Network Hospital or Ambulatory Surgical Center but are unexpectedly treated by an Out-of-Network Provider.

Telemedicine or Telehealth means the practice by a contracted Telemedicine or Telehealth provider, if applicable of health care delivery, diagnosis, consultation, Treatment, transfer of medical data, and education using interactive audio, video, or data communications involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information. Neither a telephone conversation nor an electronic messaging between a Physician and You constitutes "Telemedicine".

We will pay telehealth services on the same basis and to the same extent as if services were delivered through in-person diagnosis, consultation, or Treatment. Coverage will not be limited only to services delivered by select third-party telehealth providers.

Treatment means the medical care of a Covered Injury or Covered Sickness by a Physician who is operating within the scope of his or her license. Such care includes diagnostic, medical, surgical or therapeutic services, medical advice, consultation, recommendation, and/or the taking of drugs or medicines or the prescriptions thereof.

Urgent Care means short-term medical care performed in an Urgent Care Center for non-life-threatening conditions that can be mitigated or require care within 48 hours of onset.

Urgent Care Center is a category of walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency department. Urgent Care Centers primarily treat non-life-threatening conditions that require immediate care but are not serious enough to require an emergency department visit.

Usual and Customary Charge is the amount of an Out-of-Network Provider's charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The Usual and Customary Charge depends on the geographic area where You receive the service or supply. The table below shows the method for calculating the Usual and Customary Charge for specific services or supplies:

Service or Supply	**Usual and Customary Charge**
Professional services and other services or supplies not mentioned below	The Reasonable amount rate
Services of Hospitals and other facilities	The Reasonable amount rate

Special terms used

- Geographic area is normally based on the first 3 digits of the U.S. Postal Service zip codes. If We determine We need more data for a particular service or supply, We may base rates on a wider geographic area such as an entire state.
- "Reasonable amount rate" means Your plan has established a reasonable rate amount as follows:

Service or Supply	Reasonable Amount Rate
Professional services and Inpatient and outpatient charges of Hospitals	The lesser of: 1. The billed charge for the services; or 2. An amount determined using current publicly-available data which is usual and customary when compared with the charges made for a) similar services and supplies and b) to persons having similar medical conditions in the geographic area where service is rendered; or 3. An amount based on information provided by a third-party vendor, which may reflect 1 or more of the following factors: 1) the complexity or severity of Treatment; 2) level of skill and experience required for the Treatment; or 3) comparable providers' fees and costs to deliver care; or 4. In the case of Emergency Services from an Out-of-Network Provider or facility, including air Ambulance, and non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center without Your consent, the Recognized Amount.

Our reimbursement policies

We reserve the right to apply Our reimbursement policies to all Out-of-Network services including involuntary services. Our reimbursement policies may affect the Usual and Customary Charge. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an Assistant Surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the provider

In some instances, We may negotiate a lower rate with Out-of-Network Providers.

Our reimbursement policies are based on Our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate;
- Generally accepted standards of medical and dental practice;
- The views of Physicians and dentists practicing in the relevant clinical areas.

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

No payment will be made under this Certificate for any expenses incurred which, in Our judgment, are in excess of Usual and Customary Charges.

You, or Your(s) means an Insured Person, Insured Student, or Dependent of an Insured Student while insured under this Certificate.

Visa means the document issued by the United States Government that permits an individual to participate in the educational activities of a college, university or other institution of higher learning either as a student or in another academic capacity. An International Student must have and maintain a valid Visa, either an F-1 (Academic), J-1 (Exchange) or M-1(Vocational) in order to continue as a student in the United States.

We, Us, or **Our** means Wellfleet Insurance Company or its authorized agent. Also referred to as the Company.

SECTION IV – HOW THE PLAN WORKS AND DESCRIPTION OF BENEFITS

Schedule of Benefits

The following are shown in the Schedule of Benefits:

- Deductible;
- Any specified benefit maximums;
- Coinsurance percentages;
- Copayment amounts; and
- Out-of-Pocket Maximums.

How the Deductible Works

Medical Deductible

The Medical Deductible amount (if any) is shown in the Schedule of Benefits.

This dollar amount is what the Insured Person has to incur in Covered Medical Expenses before benefits are payable under this Certificate. This amount will apply on an individual or family basis. The Medical Deductible applies to all Covered Medical Expenses, unless specifically noted. Any expenses that the Insured Person incurs that are not Covered Medical Expenses are not applied toward the Insured Person's Medical Deductible.

Covered Medical Expenses applied to the In-Network Provider Medical Deductible will not apply to the Out-of-Network Provider Medical Deductible. Covered Medical Expenses applied to the Out-of-Network Provider Medical Deductible will not apply to the In-Network Provider Medical Deductible.

Individual

The Medical Deductible is an amount the individual must incur for In-Network Provider and Out-of-Network Provider Covered Medical Expenses before the plan pays. This Medical Deductible applies separately to the Insured Student and each of the Insured Student's covered Dependents. After the amount of Covered Medical Expenses the Insured Person incurs reaches the Medical Deductible, this plan will pay for Covered Medical Expenses as shown on the Schedule of Benefits for the rest of the Policy Year.

Family

This is the amount of Covered Medical Expenses the Insured Student and the Insured Student's covered Dependents must incur for In-Network Provider and Out-of-Network Provider Covered Medical Expenses. After the amount of Covered Medical Expenses the Insured Student and the Insured Student's covered Dependents incur reach this Family Medical Deductible, then this plan will begin to pay for Covered Medical Expenses as shown on the Schedule of Benefits for the rest of the Policy Year.

To satisfy this Family Medical Deductible limit for the rest of the Policy Year, the following must happen:

- The combined Covered Medical Expenses that the Insured Student and each of the Insured Student's covered Dependents incur towards the individual Medical Deductibles must reach this Family Medical Deductible limit in a Policy Year.

When this occurs in a Policy Year, the individual Medical Deductibles for the Insured Student and the Insured Student's covered Dependents will be considered to be met for the rest of the Policy Year.

Coinsurance is the percentage of Covered Medical Expenses that We pay. The Coinsurance percentage is stated in the Schedule of Benefits. The Coinsurance is separate and not part of any Deductible and/or Copayment.

Copayment is a specified dollar amount You must pay for specified Covered Medical Expenses. Any Copayment amounts are shown in the Schedule of Benefits.

How Your Out-of-Pocket Maximum Works
The In-Network Provider and Out-of-Network Provider Out-of-Pocket Maximums are shown in the Schedule of Benefits. The Out-of-Pocket Maximum is the amount of Covered Medical Expenses the Insured Person has 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, balance-billed charges, and Premium do not count toward meeting the Out-of-Pocket Maximum.

Covered Medical Expenses applied to the In-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the Out-of-Network Provider Out-of-Pocket Maximum and Covered Medical Expenses applied to the Out-of-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the In-Network Provider Out-of-Pocket Maximum.

The Out-of-Pocket Maximum is the maximum amount of Covered Medical Expenses the Insured Person will incur for Copayments, Coinsurance, and Deductibles during the Policy Year. This plan has an individual and family Out-of-Pocket Maximum. As to the individual Out-of-Pocket Maximum, each Insured Person must meet their Out-of-Pocket Maximum separately.

Individual
Once the amount of the Copayments, Coinsurance, and Deductibles the Insured Student and the Insured Student's covered Dependents have incurred for Covered Medical Expenses during the Policy Year meets the:

- In-Network Provider individual Out-of-Pocket Maximum, this plan will pay:
  - 100% of the Negotiated Charge for In-Network Provider Covered Medical Expenses
- Out-of-Network Provider individual Out-of-Pocket Maximum, this plan will pay:
  - 100% of the Usual and Customary Charge for Out-of-Network Covered Medical Expenses

that apply towards the limits for the rest of the Policy Year for that covered individual.

Family
Once the amount of the Copayments, Coinsurance, and Deductibles the Insured Student and the Insured Student's covered Dependents have incurred for Covered Medical Expenses during the Policy Year meets the:

- In-Network Provider family Out-of-Pocket Maximum, this plan will pay:
  - 100% of the Negotiated Charge for In-Network Provider Covered Medical Expenses
- Out-of-Network Provider family Out-of-Pocket Maximum, this plan will pay:
  - 100% of the Usual and Customary for Out-of-Network Covered Medical Expenses

that apply towards the limits for the rest of the Policy Year for all covered family members.

To satisfy this family Out-of-Pocket Maximum for the rest of the Policy Year, the following must happen:

- The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all covered family members. The family Out-of-Pocket Maximum can be met by a combination of covered family members with no single individual within the family contributing more than the individual Out-of-Pocket Maximum amount in a Policy Year.

The Out-of-Pocket Maximum is the maximum amount of Covered Medical Expenses the Insured Person is responsible to incur during the Policy Year. This plan has an individual and family Out-of-Pocket Maximum.

Essential Health Benefits
Essential Health Benefits are not subject to annual or lifetime dollar limits. If additional specific care, Treatment or services are added to the list of Essential Health Benefits by a governing authority, the Certificate benefits will be amended to comply with such changes.

Treatment of Covered Injury and Covered Sickness Benefit
If:
1. You incur expenses as the result of Covered Injury or Covered Sickness, then
2. We will pay the benefits stated in the Schedule of Benefits for the services, Treatments, and supplies described in the Covered Medical Expenses provision below.

Payment will be made, subject to the Coinsurance, Deductible, Copayment, maximums, and limits as stated in the Schedule of Benefits:
1. For the Negotiated Charge at an In-Network Provider or the Usual and Customary Charge at an Out-of-Network Provider for Covered Medical Expenses that are incurred as the result of a Covered Injury or Covered Sickness; and
2. Subject to the Exclusions and Limitations provision.

Medical Benefit Payments for In-Network Provider and Out-of-Network Providers
This Certificate provides benefits based on the type of health care provider the Insured Student and the Insured Student's covered Dependent select. This Certificate 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.

Dental and Vision Benefit Payments
For dental and vision benefits, You may choose any dental or vision provider.
For dental, different benefits may be payable based on type of service, as shown in the Schedule of Benefits.

Preferred Provider Organization
If You use an In-Network Provider, this Certificate will pay the Coinsurance percentage of the Negotiated Charge for Covered Medical Expenses shown in the Schedule of Benefits.

If an Out-of-Network Provider is used, this Certificate will pay the Coinsurance percentage of the Usual and Customary Charge for Covered Medical Expenses shown in the Schedule of Benefits. The difference between the provider fee and the Coinsurance amount paid by Us will be Your responsibility.

Note, however, that We 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 in 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 stablecondition, 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 thedate 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.

You should be aware that In-Network Hospitals may be staffed with Out-of-Network Providers. Receiving services from an In-Network Hospital does not guarantee that all charges will be paid at the In-Network Provider level of benefits. It is important that You verify that Your Physicians are In-Network Providers each time You call for an appointment or at the time of service.

Timely Access to Care

In-network Providers agree to provide timely access to care. You will see Your provider when You call for an appointment within the following timeframes:

- Urgent care appointments: within 48 hours of the request.
- Non-urgent appointments with primary Physician: within 10 business days of the request.
- Non-urgent appointments with Specialist: within 15 business days of the request.
- Non-urgent appointments with a non-Physician for Mental Health or Substance Use Disorder provider: within 10 business days of the request.
- Non-urgent follow-up appointments with a non-Physician for Mental Health or Substance Use Disorder provider: within 10 business days of the prior appointment for those undergoing a course of Treatment for an ongoing Mental Health or Substance Use Disorder condition.
- Non-urgent appointments with or ancillary services for the diagnosis or Treatment of Injury, Sickness, or other health condition: within 15 business days of the request.

- Telephone triage or screening services: not to exceed 30 minutes of the request.

Standards for timely access to pediatric oral or vision Essential Health Benefits include:
- Urgent care appointments: within 72 hours of the request.
- Non-urgent appointments: within 36 business days of the request for appointment.
- Preventive care appointments: within 40 days of the request for appointment.

We provide free language assistance services to people whose primary language is not English, such as:
- Qualified interpreters.
- Information written in other languages.

If, at the time of Your appointment, You need language assistance services, please contact:
Wellfleet Group, LLC dba Wellfleet Administrators, LLC
P.O. Box 15369
Springfield, MA 01115-5369
877-657-5030

Continuity of Care

If You are undergoing an active course of Treatment with an In-Network Provider, You may request continuation of Treatment by such In-Network Provider in the event the In-Network Provider's contract has terminated with the Preferred Provider Organization. We shall notify You of the termination of the In-Network Provider's contract at least 60 days in advance. When circumstances related to the termination render such notice impossible, We shall provide affected enrollees as much notice as is reasonably possible. The notice given must include instructions on obtaining an alternate provider and must offer Our assistance with obtaining an alternate provider and ensuring that there is no inappropriate disruption in Your ongoing Treatment. We shall permit You to continue to be covered, with respect to the course of Treatment with the provider, as set forth below.

Treatment will be continued to completion of service for the following conditions:
1. *An acute condition* – for the duration of the acute condition, not to exceed 90 days from the date of the notice to You of the termination;
2. *Serious chronic condition* – for the period of time necessary to complete a course of Treatment and to arrange for a safe transfer to another provider, not to exceed 12 months from the contract termination or 12 months from the Effective Date of coverage for a newly Insured Person;
3. *A pregnancy* - for the duration of the pregnancy. *A pregnancy is the three trimesters of pregnancy and the immediate postpartum period*;
4. *Maternal mental health condition* – until completion of covered services for the mental health condition, which must not exceed 12 months from the diagnosis or from the end of the pregnancy, whichever occurs later;
5. *A terminal illness* – for the duration of the terminal illness, which may not exceed 12 months from the contract termination date or 12 months from the Effective Date of coverage for a newly Insured Person;
6. *Care of a newborn born child - between birth and 36 months of age, not to exceed* 12 months from the contract termination date or 12 months from the Effective Date of coverage for a newly Insured Person;
7. *Surgery or other procedure that is recommended and documented by the provider* - to take place within 180 days of the contract's termination date or within 180 days of the Effective Date of coverage for a newly Insured Person;
8. *Institutional or inpatient care* – for the duration of an undergoing course of institutional or inpatient care from the provider or facility, not to exceed 90 days from the date of the notice to You of the termination.

Pre-Certification Process

In-Network - Your In-Network Provider is responsible for obtaining any necessary Pre-Certification before You receive the care. If Your In-Network Provider does not obtain the required Pre-Certification You will not be penalized. Please read below regarding review and notification.

Out-of-Network – You or Your Out-of-Network Provider are responsible for calling Us at the phone number found on the back of Your ID card and starting the Pre-Certification process. For Inpatient services the call must be made at least 5 working days prior to Hospital Confinement. For Outpatient services, the call must be made at least 5 working days prior to the start of the Outpatient service. In the case of an emergency, the call must take place as soon as reasonably possible. Failure to obtain the necessary Pre-Certification may result in a Retrospective review which may result in a possible denial however, this does not apply to Emergency Services.

For a list of services or supplies requiring Pre-Certification please refer to the Schedule of Benefits.

When Pre-Certification is approved, Your Physician will be notified of Our decision as follows:

1. For elective (non-emergency) admissions to a health care facility, We will notify the Physician and the health care facility by telephone and/or in writing of the number of inpatient days, if any, approved;
2. For Confinement in a health care facility longer than the originally approved number of days, the treating Physician or the health care facility must contact Us before the last approved day. We will review the request for continued stay to determine Medical Necessity and notify the Physician or the health care facility of Our decision by telephone and in writing;
3. For any other covered services requiring Pre-Certification, We will contact the Provider in writing or by telephone regarding Our decision.

For newly Insured Persons with a previously approved Pre-Certification, We will accept the approved Pre-Certification with documentation from the health care provider for at least 60 days.

If Pre-Certification is not approved, notification of Our decision will be provided by telephone, by fax to a verified number, or by electronic mail to a secure electronic mailbox to the attending health care professional and Hospital or Physician's office as applicable. Written notification will also be sent if notification occurred by telephone.

The Insured Person will be notified in writing regarding Our decision.

Our agent will make this determination within 72 hours for an urgent request and 4 business days for non-urgent requests following receipt of all necessary information for review. Notice of an Adverse Benefit Determination made by Our agent will be in writing and will include:

1. The reasons for the Adverse Benefit Determination including the clinical rationale, if any.
2. Instructions on how to initiate an appeal.
3. Notice of the availability, upon Your request or Your Authorized Representative, of the clinical review criteria relied upon to make the Adverse Benefit Determination. This notice will specify what, if any additional necessary information must be provided to, or obtained by, Our agent in order to render a decision on any requested appeal.

Failure by Our agent to make a determination within the time periods prescribed shall be deemed to be an Adverse Benefit Determination subject to an appeal.

If You have any questions about Your Pre-Certification status, You should contact Your Provider.

Covered Medical Expenses

We will pay for the following Covered Medical Expenses when they are incurred as the result of a Covered Injury or Covered Sickness or for Preventive Services.

Preventive Services

The following services shall be covered without regard to any Deductible, Coinsurance, or Copayment requirement

that would otherwise apply when provided by an In-Network Provider:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. Immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
4. With respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
5. Routine physical maintenance examinations (including routine vision and hearing screenings given as part of the examination) and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating in the current recommendations of the USPSTF);
6. Outpatient/office contraceptive services are covered, provided that the services are related to the use of FDA approved contraceptives. Examples of covered contraceptive services are: office visits, consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referral, counseling, and services related to the use of federal legend oral contraception or IUD insertion, diaphragm fitting, vasectomy (not subject to prior authorization) or contraceptive injections. Please note that prescription and nonprescription contraceptive drugs and devices (such as oral contraceptives, IUDs, diaphragms, and contraceptive injections) are covered under the Prescription Drug Benefit. See Prescription Drugs for information on those services and devices.

PREVENTIVE SERVICES

Preventive Care Services for Adults:

Covered services include:

1. Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked
2. Alcohol misuse screening and counseling
3. Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk
4. Blood pressure screening
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal cancer screening for adults 45 to 75 (including required colonoscopy following a positive result on a screening test or procedure other than a colonoscopy)
7. Depression screening
8. Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese
9. Diet counseling for adults at higher risk for chronic disease
10. Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting
11. Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
12. Hepatitis C screening for adults age 18 to 79 years
13. HIV screening for everyone ages 15 to 65, and other ages at increased risk Coverage includes home test kits for sexually transmitted diseases (STD), including any laboratory costs of processing the kit, that are deemed Medically Necessary or appropriate and ordered directly by a clinician, or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs. For purposes of this provision, home test kit means a product used for a test recommended by the federal Centers for Disease Control and Prevention guidelines or the United States Preventive Services Task Force that has been CLIA-waived, FDA-cleared or -approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside

of a clinical setting

14. PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV negative adults at high risk for getting HIV through sex or injection drug use
15. Immunizations for adults-doses, recommended ages, and recommended populations vary:
    - Chickenpox (Varicella)
    - Diphtheria
    - Flu (influenza)
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus (HPV)
    - Measles
    - Meningococcal
    - Mumps
    - Whooping Cough (Pertussis)
    - Pneumococcal
    - Rubella
    - Shingles
    - Tetanus
16. Lung cancer screening for adults 50 to 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
17. Obesity screening and counseling
18. Sexually transmitted infection (STI) prevention counseling for adults at higher risk
19. Statin preventive medication for adults 40 to 75 at high risk
20. Syphilis screening for adults at higher risk
21. Tobacco use screening for all adults and cessation interventions for tobacco users (including both prescription and over-the-counter medications) when prescribed by a Physician. For recommendations on tobacco cessation behavioral counseling interventions visit: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions
22. Tuberculosis screening for certain adults without symptoms at high risk
23. Annual routine eye exam for refraction to determine the need for vision correction
24. Hearing exam to determine the need for hearing correction (diagnostic audiometry)
25. Preventive screening and counseling services for stress management and chronic conditions
26. Prostate specific antigen tests

Preventive Care Services for Women or women who may become pregnant:

Covered services include:

1. Bone density screening for all women over age 65 or women age 64 and younger that have gone through menopause
2. Breast cancer genetic test counseling (BRCA) for women at higher risk
3. Breast cancer screening mammogram, with our without clinical breast examination, every 1-2 years for women 40 and older, upon referral by a participating nurse practitioner, participating certified nurse-midwife, participating Physician's Assistant, or participating Physician, providing care to the Insured Person and operating within the scope of practice provided under existing law
4. Breast cancer chemoprevention counseling for women at higher risk
5. Breastfeeding support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
6. Cervical cancer screening:
    - Pap test (including HPV testing) (also called a Pap smear) for women age 21 to 65

7. Chlamydia infection screening for younger women and other women at higher risk
8. Birth control: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs).
9. Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before
10. Domestic and interpersonal violence screening and counseling for all women
11. Donor Human Breast Milk when clinically-indicated for the purpose of optimizing the successful initiation and maintenance of breastfeeding
12. Folic acid supplements for women who may become pregnant
13. Gestational diabetes screening for women 24 weeks pregnant (or later) and those at high risk of developing gestational diabetes
14. Gonorrhea screening for all women at higher risk
15. Hepatitis B screening for pregnant women at their first prenatal visit
16. HIV screening and counseling for everyone age 15 to 65, and other ages at increased risk. Coverage includes home test kits for sexually transmitted diseases (STD), including any laboratory costs of processing the kit, that are deemed Medically Necessary or appropriate and ordered directly by a clinician, or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs. For purposes of this provision, home test kit means a product used for a test recommended by the federal Centers for Disease Control and Prevention guidelines or the United States Preventive Services Task Force that has been CLIA-waived, FDA-cleared or -approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting
17. Maternal depression screening for mothers at well-baby visits
18. Preeclampsia prevention and screening for pregnant women with high blood pressure
19. PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative women at high risk for getting HIV through sex or injection drug use
20. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
21. Sexually transmitted infections counseling for sexually active women
22. Syphilis screening
23. Tobacco Use screening and interventions (including both prescription and over-the-counter medications) when prescribed by a Physician. For recommendations on tobacco cessation behavioral counseling interventions visit: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions
24. Expanded tobacco intervention and counseling for pregnant tobacco users (including both prescription and over-the-counter medications) when prescribed by a Physician. For recommendations on tobacco cessation behavioral counseling interventions visit: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions
25. Urinary tract or other infection screening
26. Urinary incontinence screening for women yearly
27. Well-woman visits to get recommended services for all women

Preventive Care Services for Children:

Covered services include:

1. Alcohol, tobacco, and drug use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children
4. Bilirubin concentration screening for newborns
5. Blood pressure screening for children

6. Blood screening for newborns
7. Depression screening for adolescents beginning routinely at age 12
8. Developmental screening for children under age 3
9. Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders
10. Fluoride supplements for children without fluoride in their water source
11. Fluoride varnish for all infants and children as soon as teeth are present
12. Gonorrhea preventive medication for the eyes of all newborns
13. Hearing screening for all newborns; and regular screenings for children and adolescents as recommended by their provider
14. Height, weight and body mass index (BMI) measurements taken regularly for all children
15. Hematocrit, or hemoglobin screening for all children
16. Hemoglobinopathies or sickle cell screening for newborns
17. Hepatitis B screening for adolescents at high risk
18. HIV screening for adolescents at higher risk. Coverage includes home test kits for sexually transmitted diseases (STD), including any laboratory costs of processing the kit, that are deemed Medically Necessary or appropriate and ordered directly by a clinician, or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs. For purposes of this provision, home test kit means a product used for a test recommended by the federal Centers for Disease Control and Prevention guidelines or the United States Preventive Services Task Force that has been CLIA-waived, FDA-cleared or -approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting
19. Hypothyroidism screening for newborns
20. PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use
21. Immunization vaccines for children from birth to age 18 - doses, recommended ages, and recommended populations vary:
    - Chickenpox (Varicella)
    - Diphtheria, tetanus, and pertussis (DTap)
    - Haemophilus influenzae type b
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus (HPV)
    - Inactivated Poliovirus
    - Influenza (flu shot)
    - Measles
    - Meningococcal
    - Mumps
    - Pneumococcal
    - Rotavirus
    - Rubella
22. Lead screening for children at risk of exposure
23. Obesity screening and counseling
24. Oral health risk assessment for young children from 6 months to 6 years
25. Phenylketonuria (PKU) screening for newborns
26. Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
27. Tuberculin testing for children at higher risk of tuberculosis
28. Vision screening for all children
29. Well-baby and well-child visits
30. Annual routine eye exam for refraction to determine the need for vision correction

31. Hearing exam to determine the need for hearing correction (diagnostic audiometry)
32. Preventive screening and counseling services for stress management and chronic conditions

If the covered Preventive Service is provided during a Physician's Office Visit and it is billed separately from the office visit, You may be responsible for any Deductible, Coinsurance and/or Copayment applicable to the Physician's Office Visit only. If the Physician's Office Visit and the covered Preventive Service are billed together and the primary purpose of the visit was not the Preventive Service, You may be responsible for any Deductible, Coinsurance and/or Copayment applicable to the Physician's Office Visit, including the covered Preventive Service.

Preventive Services recommendations and guidelines can be found on the HealthCare.gov website at the following links:

- For all adults: https://www.healthcare.gov/preventive-care-adults/
- For woman: https://www.healthcare.gov/preventive-care-women/
- For children: https://www.healthcare.gov/preventive-care-children/

Important Notes:

1. These Preventive Services recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this plan. The updates will be effective on the first day of the calendar year, one year after the updated recommendation or guideline is issued.
2. Diagnostic testing for the Treatment or diagnosis of a Covered Injury or Covered Sickness will not be covered under the Preventive Services. For those types of tests and Treatment, You will pay the cost sharing specific to Covered Medical Expense for diagnostic testing and Treatment.
3. This plan will not limit gender-specific Preventive Services based on Your gender at birth, Your identity, or according to other records.

To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact Your Physician or contact Us by calling the number on Your ID card. This information can also be found at the https://www.healthcare.gov/ website.

We may use reasonable medical management techniques to determine the frequency, method, Treatment, or setting of Preventive Services benefits when not specified in the recommendations and guidelines of the:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP)
- United States Preventive Services Task Force (USPSTF)
- Health Resources and Services Administration (HRSA)
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

Inpatient Services

1. **Hospital Care** - Covered Medical Expenses include the following:
   - Room and Board Expenses**,** including general nursing care. Benefits may not exceed the daily semi-private room rate unless intensive care unit is required.
   - Intensive Care Unit**,** including 24-hour nursing care.
   - Hospital Miscellaneous Expenses, while Hospital Confined or as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as:
     a. The cost for use of an operating room;
     b. Prescribed medicines (excluding take-home drugs);
     c. Laboratory tests;
     d. Therapeutic services;
     e. X-ray examinations;

f. Casts and temporary surgical appliances;
g. Oxygen, oxygen tent; and
h. Blood and blood plasma.

2. **Preadmission Testing** for routine tests performed as a preliminary to Your being admitted to a Hospital. These tests must be performed within 5 working days prior to admission. This benefit is limited to routine tests such as complete blood count, urinalysis, and chest x-rays. Unless otherwise payable under this Certificate, We will pay for major diagnostic procedures under the Hospital Miscellaneous Expenses benefit. This includes tests such as CAT scans, cardiac catheterization, MRI's, NMR's, and blood chemistries.

3. **Physician's Visits while Confined**. Physician's visits will be paid for either inpatient or outpatient visits when incurred on the same day, but not both. Surgeon's fees are not payable under this benefit.

4. **Skilled Nursing Facility Benefit** for services received in a licensed Skilled Nursing Facility. Services must be Medically Necessary. Confinement for Custodial Care or residential care is not covered.

5. **Inpatient Rehabilitation Facility Expense Benefit** for the services, supplies and Treatments rendered to You in an Inpatient Rehabilitation Facility. You must enter an Inpatient Rehabilitation Facility:
   a. After being discharged from a Hospital Confinement for a Covered Sickness or Coverage Injury; and
   b. The services, supplies and Treatments rendered at the Inpatient Rehabilitation Facility must be related to the same Covered Sickness or Covered Injury.

   Services, supplies and Treatments by an Inpatient Rehabilitation Facility include:
   a. Charges for room, board, and general nursing services;
   b. Charges for physical, occupational, or speech therapy;
   c. Charges for drugs, biologicals, supplies, appliances, and equipment for use in such facility, which are ordinarily furnished by the Inpatient Rehabilitation Facility for the care and Treatment of a Confined person; and
   d. Charges for medical services of interns, in training, under a teaching program of a Hospital with which the facility has an agreement for such services

6. **Physical Therapy while Confined** when prescribed by the attending Physician.

Mental Health and Substance Use Disorder Benefits

Mental Health and Substance Use Disorder Benefits for Medically Necessary Treatment of Mental Health and Substance Use Disorders, under the same terms and conditions applied to other medical conditions under this Certificate. Covered Medical Expenses include but are not limited to the following:

1. **Inpatient Benefits**:
   a. Diagnostic evaluation;
   b. Medication evaluation and management (pharmacotherapy);
   c. Treatment and counseling (including individual or group visits);
   d. Inpatient professional fees;
   e. Psychiatric and Neuro Psychiatric testing; and
   f. Inpatient Hospital and inpatient residential Treatment centers services, which includes:
      - Room and Board Expense, including general nursing care. Benefit may not exceed the daily semi-private room rate unless intensive care unit is required.
      - Intensive Care Unit, including 24-hour nursing care.
      - Hospital Miscellaneous Expenses, while Hospital Confined or as a precondition for being Hospital Confined.

2. **Outpatient Benefits - Outpatient Services, other than office visits**:
   a. Intensive Outpatient Programs;
   b. Partial Hospitalization;
   c. Electronic Convulsive Therapy;
   d. Psychiatric and Neuro Psychiatric testing;
   e. Repetitive Transcranial Magnetic Stimulation (rTMS);
   f. Gender Affirming surgery;
   g. Emergency Services in an emergency department; and
   h. Prescription Drugs.

   Outpatient Office Visits:
   a. Physician visits;
   b. Medication evaluation and management (pharmacotherapy);
   c. Treatment and counseling (including individual or group visits); and
   d. Psychological testing when necessary, to evaluate a mental health disorder.

   Coverage also includes Behavioral Health Treatment for Pervasive Developmental Disorder or Autism for Behavioral Health Treatment, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore to the maximum extent practicable, the functioning of an Insured Person diagnosed with the pervasive developmental disorder or autism.

3. **Community Based Care Program (CARE) -** We will cover Medically Necessary Covered Medical Expenses for the Treatment of an Insured Person suffering from certain mental illnesses who participates in community based treatment programs as outlined in a court ordered CARE Plan.

   For purposes of this section:
   A "CARE Plan" means an individualized, appropriate range of community-based services and support, which include clinically appropriate behavioral health care and other supportive services.

4. **Mobile Crisis Services/988 Center -** We will cover Medically Necessary Treatment for a Mental Health or Substance Use Disorder including Behavioral Health Crisis Services provided to an Insured Person by a 988 center or mobile crisis team.

   For purposes of this section:
   "Behavioral Health Crisis Services" means the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a Mental Health or Substance Use Disorder crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, mobile crisis teams, and crisis receiving and stabilization services.

Professional and Outpatient Services

SURGICAL EXPENSES

1. **Inpatient and Outpatient Surgery including Surgeon, Anesthetist, and Assistant Surgeon Services** (including pre- and post-operative visits) as specified in the Schedule of Benefits. Covered surgical expenses will be paid under either the Inpatient Surgery benefit or the Outpatient Surgery benefit. They will not be paid under both. This benefit is not payable in addition to Physician's Visits.

Sometimes 2 or more surgical procedures can be performed during the same operation.

a. **Through the Same Incision.** If covered multiple surgical procedures are performed through the same incision, We will pay for the procedure with the highest allowed amount and 50% of the amount We would otherwise pay under this Certificate for the secondary procedures, except for secondary procedures that, according to nationally-recognized coding rules, are exempt from multiple surgical procedure reductions. We will not pay anything for a secondary procedure that is billed with a primary procedure when that secondary procedure is incidental to the primary procedure.

b. **Through Different Incisions.** If covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
   - For the procedure with the highest allowed amount; and
   - 50% of the amount We would otherwise pay for the other procedures.

2. **Outpatient Surgical Facility and Miscellaneous** expenses benefit. Benefits will be paid for services and supplies, including:
   a. Operating room;
   b. Therapeutic services;
   c. Oxygen, oxygen tent; and
   d. Blood and blood plasma.

3. **Abortion Expense** for Covered Medical Expenses incurred for abortion and abortion-related services.

   As used in this benefit:
   Abortion means any medical Treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth.

4. **Bariatric Surgery** when it is Medically Necessary. This benefit requires prior approval.

5. **Organ Transplant Surgery**
   Recipient Surgery for Medically Necessary, non-Experimental and non-Investigational solid organ, bone marrow, stem-cell or tissue transplants or replacement and includes the cost of solid organ or other tissue transplantation services . We will provide benefits for the Hospital and other Covered Medical Expenses when You are the recipient of an Organ Transplant. If You are infected with HIV, eligibility for this benefit is not affected.

   Donor's Surgery for Medically Necessary transplant services required by the Insured Person who serves as an organ donor only if the recipient is also an Insured Person. We will not cover the transplant services of a non-Insured Person acting as a donor for an Insured Person if the non-Insured Person's expenses will be covered under another health plan or program.

   Services include harvesting the organ, blood evaluations and transfusions. Donor is covered for up to 90 days following the harvest and evaluation services.

   Treatment of donor complications related to stem cell donations, blood screening for stem cell donations and any issues caused by the donor's non-compliance with Physician's orders and/or Treatment plan.

   Travel Expenses when the facility performing the Medically Necessary transplant is located more than 200 miles from Your residence, coverage will be provided for lodging, meals and transportation expenses (coach class only) subject to the maximum benefits shown on the Schedule of Benefits.

   Non-Covered Services for transportation and lodging include, but are not limited to:

a. Child care;
b. Mileage within the medical transplant facility city;
c. Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us;
d. Frequent Flyer miles;
e. Coupons, Vouchers, or Travel tickets;
f. Prepayments or deposits;
g. Services for a condition that is not directly related or a direct result of the transplant;
h. Telephone calls;
i. Laundry;
j. Postage;
k. Entertainment;
l. Interim visits to a medical care facility while waiting for the actual transplant procedure;
m. Travel expenses for donor companion/caregiver;
n. Return visits for the donor for a Treatment of condition found during the evaluation.

6. **Reconstructive Surgery** covers all stages of reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and Treatment of physical complications for all stages of mastectomy, including lymphedemas. This benefit also covers cosmetic surgery specifically and solely for: Reconstruction due to bodily Injury, infection or other disease of the involved part; or for a congenital anomaly, including cleft palate, which resulted in a functional impairment.

OTHER PROFESSIONAL SERVICES

1. **Gender Affirming Services Benefit** for Medically Necessary expenses incurred for services and supplies provided in connection with gender affirming Treatment when You have been diagnosed with gender identity disorder or gender dysphoria. Covered Medical Expenses include the following:
   a. Counseling by qualified mental health professional;
   b. Hormone therapy, including monitoring of such therapy;
   c. Electrolysis/laser hair removal;
   d. Gender affirming surgery and procedures.

   Benefits will be paid the same as for Mental Health and Substance Use Disorders.

2. **Home Health Care Expenses** for Your Home Health Care when, otherwise, hospitalization or Confinement in a Skilled Nursing Facility would have been necessary. This does not include Private Duty Nursing.

3. **Hospice Care Coverage** when, as the result of a Covered Injury or Covered Sickness, You require Hospice Care, We will pay the Covered Medical Expenses incurred for such care. You must have been diagnosed with a terminal illness by a licensed Physician. You must have elected to receive palliative rather than curative care. Any required documentation will be no greater than that required for the same services under Medicare.

OFFICE VISITS

1. **Physician's Office Visits**. Physician's Visits include second surgical opinions, specialists, and consultant services. Benefits will be paid for either outpatient or inpatient visits on the same day, but not both. Surgeon fees are NOT payable under this benefit. Coverage includes adverse childhood experience screenings.

   For purposes of this section:
   Adverse childhood experience screenings means an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse

effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

2. **Standard Telemedicine or Telehealth Services Benefit** for health care delivery, diagnosis, consultation, or Treatment provided to You by a Physician.

3. **Third Party Telemedicine or Telehealth Services Program**
   In addition to providing Telemedicine or Telehealth Services when You use an In-Network or Out-of-Network Provider, We will cover Telemedicine or Telehealth visits between You and a contracted provider who participate in Our Telemedicine or Telehealth Services Program for behavioral health and musculoskeletal conditions that are not an Emergency Medical Condition.

   For non-Emergency Medical Conditions, the program allows Insured Persons to have a video or phone visit with a provider. To access the Telemedicine or Telehealth Services Program, You can set up an account online at https://www.teladoc.com/wellfleetstudent/. For the musculoskeletal program You can set up an account online at https://hinge.health/wellfleet. Refer to the Schedule of Benefits for applicable cost share.

4. **Acupuncture Services** that are Medically Necessary and provided by a Physician licensed to perform such services.

5. **Allergy Testing and Treatment, including injections.** This includes tests that You need such as PRIST, RAST, and scratch tests. Also, includes Treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications and asthma not responding to usual Treatments. This also includes the administration of allergy therapy, injections, allergy serum, and supplies used for allergy therapy.

6. **Chiropractic Care Benefit** for Treatment of a Covered Injury or Covered Sickness and performed by a Physician.

7. **Tuberculosis (TB) screening**, **Titers, QuantiFERON B tests including shots** (other than covered under Preventive Services) when required by the School for high risk Insured Persons.

Emergency Services, Ambulance and Non-Emergency Services

1. **Emergency Services** only in connection with care for an Emergency Medical Condition as defined. Benefits will be paid for the use of a Hospital emergency department or independent freestanding emergency department, a medical screening examination that is within the capability of the emergency department, including ancillary services routinely available to the emergency department, pre-stabilization services and supplies after You are moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after You are Stabilized as part of Observation Services or an inpatient or outpatient stay with respect to the visit in which the other Emergency Services are furnished. Refer to the Emergency Ambulance Service provision for transportation coverage.

   If You 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. The Post-Stabilization services will no longer qualify as Emergency Services once 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.

   Payment of this benefit will not be denied based on the final diagnosis following Stabilization or Post-Stabilization services.

   In case of a medical emergency:
   When You experience an Emergency Medical Condition, You should go to the nearest emergency room. You can also dial 911 or Your local emergency response service for medical and Ambulance assistance. If possible,

call Your Physician but only if a delay will not harm Your health.

2. **Urgent Care Centers (non-life-threatening conditions)** for services provided at an Urgent Care Center, as shown in the Schedule of Benefits. In the case of a life-threatening condition, You should go to the nearest emergency room.

3. **Emergency Ambulance Service,** with respect to an Emergency Medical Condition, for transportation provided as a result of a 911 emergency response system request for assistance to a Hospital by a licensed Ambulance, whether ground, air or water Ambulance. Transportation from a facility to Your home is not covered.

4. **Non-Emergency Ambulance Expenses** for transportation by a licensed Ambulance, whether by ground or air Ambulance (fixed wing) (as appropriate), or psychiatric transport van when the transportation is approved by Us and is:

   - From an Out-of-Network Hospital to an In-Network Hospital;
   - To a Hospital that provides a higher level of care that was not available at the original Hospital;
   - To a more cost-effective acute care Hospital/facility;
   - From an acute care Hospital/facility to a sub-acute setting; or
   - Determined by Your Physician that Your condition requires the use of services that only a licensed Ambulance or psychiatric transport van can provide and the use of other means of transportation would endanger Your health.

   Transportation from a facility to Your home is not covered.

Diagnostic Laboratory, Radiology, Testing and Imaging Services

1. **Diagnostic Complex Imaging Services**
   Covered Medical Expenses include complex imaging services provided by a provider, including but not limited to:

   - Computed tomography (CT) scans
   - Magnetic resonance imaging (MRI) including Magnetic resonance spectroscopy (MRS), Magnetic resonance venography (MRV) and Magnetic resonance angiogram (MRA)
   - Nuclear medicine imaging including positron emission tomography (PET) scans

2. **Diagnostic Laboratory, Radiological Services and Testing (Outpatient)**
   Covered Medical Expenses include diagnostic radiological services (other than diagnostic complex imaging), laboratory services, and pathology services and other tests. This includes Breast Tomosynthesis testing, including digital breast related tomography and ultrasound studies. Genetic and Biomarker testing are also included.

   Coverage includes Medically Necessary biomarker testing for the purposes of diagnosis, Treatment, appropriate management, or ongoing monitoring of Your disease or condition. Coverage includes biomarker tests meeting any of the following:
   a. A labeled indication for a test that has been approved or cleared by the United States Food and Drug Administration ("FDA") or is an indicated test for an FDA-approved drug.
   b. A national coverage determination made by the federal Centers for Medicare and Medicaid Services.
   c. A local coverage determination made by a Medicare Administrative Contractor for California.
   d. Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication in medical journals meeting nationally recognized requirements for scientific manuscripts.

e. Standards set by the National Academy of Medicine.

Coverage will be provided in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples.

For purposes of this coverage:

Biomarker means a characteristic objectively measured and evaluated as indicating normal biological processes, pathogenic processes, or pharmacological responses to specific therapeutic invention. A biomarker includes, but is not limited to, gene mutations or protein expression.

Biomarker testing means the analysis of an individual's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes, but is not limited to, single-analyte tests, multiplex panel tests, and whole genome sequencing.

3. **Chemotherapy and Radiation Therapy** for chemotherapy, oral chemotherapy drugs, and radiation therapy to treat or control a serious illness.

4. **Infusion Therapy** for the administration of antibiotics, nutrients, or other therapeutic agents by direct infusion.

Rehabilitation and Habilitation Therapies

1. **Cardiac Rehabilitation.** Benefits are available for Outpatient cardiac Rehabilitation programs. Covered Medical Expenses include exercise and education under the direct supervision of skilled program personnel in the intensive Rehabilitation phase of the program.

   No benefits are available for portions of a cardiac Rehabilitation program extending beyond the intensive Rehabilitation phase. On-going or life-long exercise and education maintenance programs intended to maintain fitness or to reinforce permanent lifestyle changes are not covered.

2. **Pulmonary Rehabilitation.** Benefits are available for pulmonary Rehabilitation services as part of an inpatient Hospital stay if it is part of a treatment plan ordered by a Physician. A course of outpatient pulmonary Rehabilitation may also be eligible for coverage if it is performed at a Hospital, Skilled Nursing Facility, or Physician's office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by a Physician.

3. **Rehabilitation Therapy** when prescribed by the attending Physician, limited to 1 visit per day.

4. **Habilitation Services** when prescribed by the attending Physician, limited to 1 visit per day.

Other Services and Supplies

1. **Covered Clinical Trials** includes coverage for costs associated with Your participation in a controlled clinical trial approved by specified institutions. A covered clinical trial means a phase I, phase II, phase III, or phase IV clinical trial conducted for the prevention, detection, or Treatment of cancer or another life-threatening disease or condition that meets at least one of the following:
   (a) Federally funded trials – the study or investigation is approved or funded (which may include funding through in-kind contributions) by one of the following:
      (1) The National Institutes of Health (NIH);
      (2) The Centers for Disease Control and Prevention;

(3) The Agency for Health Care Research and Quality;
(4) The Centers for Medicare & Medicaid Services;
(5) Cooperative group or center of any of the entities described in items (1) through (4) above or the Department of Defense or the United States Department of Veterans Affairs;
(6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; and
(7) Any of the following if:
    a) the Secretary of the United States Department of Health and Human Services (HHS) deemed that its system of peer review is comparable to that of National Institutes of Health (NIH); and
    b) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
        i. The United States Department of Veterans Affairs;
        ii. The United States Department of Defense; and
        iii. The United States Department of Energy.

(b) the study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
(c) the study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration; and
(d) the facility and personnel providing the treatment are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise.

Life-threatening disease or condition means a disease or condition from which the likelihood of death is probable, unless the course of the disease or condition is interrupted.

Coverage for routine patient care costs include drugs, items, devices and services furnished in connection with Your participation in the trial. Coverage for routine patient care costs does not include investigational drug , item, device, or service itself, the studied device or equipment, data collection services and any service not associated with direct clinical care to You.

As used in this benefit:
Controlled clinical trial means a Treatment that is:
(a) Approved by an institutional review board;
(b) Conducted for the primary purpose of determining whether or not a particular Treatment is safe and efficacious; and
(c) Approved by:
    (i) An institute or center of the National Institutes of Health;
    (ii) The United States Food and Drug Administration;
    (iii) The United States Department of Veteran's Affairs; or
    (iv) The United States Department of Defense.

2. **Diabetic Services and Supplies (including equipment and training)** includes coverage for the cost associated with equipment, supplies, and self-management training and education for the Treatment of all types of diabetes mellitus when prescribed by a Physician.

Benefits include, but are not limited to, the following services and supplies:
- Insulin preparations
- Foot care to minimize the risk of infection
- Injection aids for the blind
- Diabetic test agents
- Prescribed oral medications whose primary purpose is to control blood sugar

- Injectable glucagon
- Glucagon emergency kits

Equipment

- External insulin pumps
- Blood glucose monitors without special features, unless required for the legally blind
- Podiatric appliances for the prevention of complications associated with diabetes

Training

- Self-management training
- Patient management materials that provide essential diabetes self-management information

"Self-management training" is a day care program of educational services and self-care designed to instruct You in the self-management of diabetes (including medical nutritional therapy). The training must be provided by an American Diabetes Association Recognized Diabetes Self-Management Education Program or Physician whose scope of practice includes diabetic education or management.

This coverage includes the Treatment of insulin (type I) and non-insulin dependent (type II) diabetes and the Treatment of elevated blood glucose levels during pregnancy.

Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.

3. **Dialysis Treatment** of an acute or chronic kidney ailment, provided in an Outpatient facility of a Hospital, a free-standing renal Dialysis facility or in Your home. Covered Medical Expenses for home Treatment will include equipment, training and medical supplies. Private Duty Nursing is not covered.

4. **Durable Medical Equipment** for home use and Prosthetic and Orthotic Devices for rental or purchase, the fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and services to determine whether You need a device, including, but not limited to:
   - Diabetic shoes and inserts;
   - Glucose monitors, infusion pumps, and related supplies;
   - Respiratory drug delivery devices and supplies;
   - Tracheostomy equipment;.
   - Standard curved handle or quad cane and replacement supplies;
   - Standard or forearm crutches and replacement supplies;
   - Dry pressure pad for a mattress;
   - Cervical traction equipment (over door);
   - Bone stimulator;
   - Enteral pump and supplies;
   - Hospital grade breast pump and double breast pump kit;
   - IV pole;
   - Phototherapy blankets for Treatment of jaundice in newborns;
   - Compression burn garment; lymphedema gradient compression stocking; light compression bandage; manual compression garment; moderate compression bandage;
   - Non-segmental home model pneumatic compressor for the lower extremities;
   - Prosthetic devices incident to Mastectomy: including custom-made prostheses when Medically Necessary; adhesive skin support attachment for use with external breast prosthesis; and brassieres for breast prostheses;
   - Prosthetic devices to replace all or part of an external facial body part that has been removed or impaired as a result of disease, Injury, or congenital defect; and
   - Hospital beds, wheel chairs, and walkers.

   We will pay the lesser of either the rental or purchase charges, but not both. Such equipment must be prescribed by a Physician and a copy of the written prescription must accompany the claim.

Durable Medical Equipment must:

a. Be primarily and customarily used to serve a medical, Rehabilitative purpose;
b. Be able to withstand repeated use; and
c. Generally, not be useful to a person in the absence of Injury or Sickness.

5. **Enteral Formulas and Nutritional Supplements** Covered Medical Expenses prescribed by a Physician used to treat malabsorption of food caused by:
   - Crohn's Disease
   - Ulcerative colitis
   - Gastroesophageal reflux
   - Gastrointestinal motility;
   - Chronic intestinal pseudo-obstruction
   - Phenylketonuria
   - Eosinophilic gastrointestinal disorders
   - Inherited diseases of amino acids and organic acids
   - Multiple severe food allergies
   - Branded-chain ketonuria,
   - Galactosemia
   - Homocystinuria

   Covered benefits also include food products modified to be low in protein for inherited diseases of amino acids and organic acids. For purposes of this benefit, "low protein modified food product" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary Treatment of any inherited metabolic illness. Low protein modified food products do not include foods that are naturally low in protein.

6. **Infertility Treatment Benefit** for the Diagnosis and Treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease or dysfunction or a correctable medical condition otherwise covered under this Certificate.

   In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, and the American Society for Reproductive Medicine. All services must be provided by Physicians who are qualified to provide such infertility services in accordance with these guidelines.
   Infertility services provided to an Insured Person who is an appropriate candidate for infertility Treatment include, but are not limited to:

   - Initial evaluation;
   - Semen analysis;
   - Evaluation of ovulatory function;
   - Postcoital test;
   - Endometrial biopsy;
   - Pelvic ultrasound;
   - Hysterosalpingogram;
   - Sonohysterogram;
   - Testis biopsy;
   - Hormone level testing;
   - Laparoscopy;
   - Hysteroscopy;

- Vesiculography;
- Epididymography;
- Gamete intrafallopian tube transfer;
- Treatment of ovulatory dysfunction;
- Ovulation induction and monitoring;
- Artificial insemination;
- Salpingectomy (complete or partial, unilateral or bilateral)

7. **Fertility Preservation Benefit**
   Fertility preservation is covered for iatrogenic causes. Fertility preservation involves the retrieval of mature eggs/sperm with or without the creation of embryos that are frozen for future use. Covered Medical Expenses include services for fertility preservation provided when You:
   - are believed to be fertile, with or without a same sex partner; and.
   - have planned services or treatment that are proven to result in infertility such as:
     - Surgery, Chemotherapy or radiation therapy that is established in medical literature to result in infertility
     - Other gonadotoxic therapies
     - Removal of the uterus
     - Removal of both ovaries or testicles

   Fertility preservation means procedures to preserve fertility that are consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology.

8. **Maternity Benefit** for maternity charges as follows:
   a. **Routine prenatal** care

   b. **Hospital stays** for mother and newly born child will be provided for up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the caesarean section delivery Services of a licensed midwife are covered when rendered in a Hospital or licensed outpatient facility rendering maternity services.

      Home Births are also covered when services are rendered by a licensed Nurse midwife.

      Services covered as inpatient care will include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

   c. **Inpatient Physician charges or Surgeon charges** will be covered the same as for any other Covered Sickness for both mother and newborn child.

   d. **Physician-directed Follow-up Care** including:
      1. Physician assessment of the mother and newborn;
      2. Parent education;
      3. Assistance and training in breast or bottle feeding;
      4. Assessment of the home support system;
      5. Performance of any prescribed clinical tests; and
      6. Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric obstetrical and nursing professionals.

This benefit will apply to services provided in a medical setting or through Home Health Care visits. Any Home Health Care visit must be provided by an individual knowledgeable and experienced in maternity and newborn care. All Home Health Care visits that are made necessary by early discharge from the Hospital must be performed within 72 hours after discharge when prescribed by the treating Physician. When a mother or a newborn receives at least the number of hours of inpatient care shown in item "b", the Home Health Care visit benefit will apply to follow-up care that is determined to be necessary by the health care professionals responsible for discharging the mother or newborn.

e. **Outpatient Physician's visits** will be covered the same as for any other Covered Sickness.

f. **California Prenatal Screening Program** for participation in the statewide prenatal testing program administered by the State Department of Health Services will be covered the same as for any other Preventive Service.

g. **Prenatal Diagnosis of Genetic Disorders of Fetus** by means of diagnostic procedures in cases of high-risk pregnancy.

h. **Pasteurized Donor Human Breast Milk** when Medically Necessary and obtained from a tissue bank will be covered the same as for any other Covered Sickness, unless considered a Preventive Service. Refer to the Preventive Services section under this Certificate.

i. **Maternal Mental Health Program** for one maternal mental health screening to be conducted during pregnancy, at least one additional screening to be conducted during the first six weeks of the postpartum period, and additional postpartum screenings, if determined to be Medically Necessary and clinically appropriate in the judgment of the treating provider.

j. **Doula Services** will be covered the same as for any other Covered Sickness. Doulas are trained nonclinical professionals who provide emotional, educational, and practical support during pregnancy, delivery, and the postpartum period to improve outcomes for mothers and their infants.

9. **Prosthetic and Orthotic Devices** to replace all or part of a body organ, or replace all or part of the function of a permanently inoperative, absent, or malfunctioning body part when Medically Necessary and prescribed by a Physician.

   Coverage includes:
   - The prosthetic device including post laryngectomy;
   - Repairing or replacing the original device You outgrow or that is no longer appropriate because Your physical condition changed;
   - The fitting, instruction and other services (such as attachment or insertion) so You can properly use the device.

   Refer to the Durable Medical Equipment for home use and Prosthetic and Orthotic Devices provision for prosthetic and orthotic devices covered under the Durable Medical Equipment for home use and Prosthetic and Orthotic Devices benefit.

10. **Student Health Center/Infirmary Expense Benefit** if an Insured Person incurs Covered Medical Expenses as the result of Treatment at a Student Health Center/Infirmary, We will pay the Covered Medical Expenses incurred. Benefits will not exceed the amount shown in the Schedule of Benefits.

11. **Non-emergency Care While Traveling Outside of the United States** for Medically Necessary Treatment when You are traveling outside of the United States.

12. **Medical Evacuation Expense**
    The maximum benefit for Medical Evacuation, if any, is shown in the Schedule of Benefits.

    If You are unable to continue Your academic program as the result of a Covered Injury or Covered Sickness that occurs while You are covered under this Certificate, We will pay the necessary Actual Charges for evacuation to another medical facility or Your Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

    Payment of this benefit is subject to the following conditions:
    a. You must have been in a Hospital due to a Covered Injury or Covered Sickness for a Confinement of 5 or more consecutive days immediately prior to medical evacuation;
    b. Prior to the medical evacuation occurring, the attending Physician must have recommended, and We must have approved, the medical evacuation;
    c. We must approve the expenses incurred prior to the medical evacuation occurring, if applicable;
    d. No benefits are payable for expenses after the date Your insurance terminates. However, if on the date of termination, You are in the Hospital, this benefit continues in force until the earlier of the date the Confinement ends or 31 days after the date of termination;
    e. Evacuation to Your Home Country terminates any further insurance coverage under this Certificate for You; and
    f. Transportation must be by the most direct and economical route.

13. **Repatriation Expense**
    The maximum benefit for Repatriation, if any, is shown in the Schedule of Benefits.

    If You die while You are traveling 100 or more miles from Your place of residence and/or outside Your Home Country, We will pay a benefit. The benefit will be the necessary charges for preparation, including cremation, and transportation of the remains to Your place of residence or Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

Dental Benefits

1. **Pediatric Dental Care Benefit** Please refer to the Schedule of Benefits section of this Certificate for cost-sharing requirements. We cover diagnostic and preventive, basic restorative, major restorative and Medically Necessary orthodontic care services. Coverage is limited to Insured Persons through the end of the month in which the Insured Person turns 19.

Vision Benefits

1. **Pediatric Vision Care Benefit** for Insured Persons to the last day of the month following their 19th birthday. Coverage includes:
    a. Vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We cover one vision examination per Policy Year, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:
        1) Case history;
        2) External examination of the eye or internal examination of the eye;
        3) Opthalmoscopic exam;
        4) Low vision exam every five (5) years, and four (4) follow-up visits in any five (5) year period. This includes low vision aids such as high-power spectacles, magnifiers, and telescopes;

5) Determination of refractive status;
6) Binocular distance;
7) Tonometry tests for glaucoma;
8) Gross visual fields and color vision testing; and
9) Summary findings and recommendation for corrective lenses.

b. Eyeglass frames, prescription lenses, including glass or plastic lenses, all lenses power (single, bifocal, trifocal, lenticular), fashion and gradient tinting, ultraviolet protective coating, oversized and glass grey #3 prescription sunglass lenses – limited to one set per Policy Year; or

c. Prescription contact lenses (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery), limited as follows:
1) Daily disposables: Up to 1-year supply
2) Extended Wear disposable: Up to 1-year supply
3) Non-disposable – Up to 1 set per Policy Year

We will cover either prescription lenses for eyeglass frames or prescription contact lenses but not both.

2. **Adult Vision Care** for Insured Persons age 19 and older. We will provide benefits for a routine eye examination once every 12 months.

Miscellaneous Dental Services

1. **Accidental Injury Dental Treatment** as the result of Injury to Sound, Natural Teeth. Routine dental care and Treatment are not payable under this benefit. Damage to teeth due to chewing or biting is not deemed an accidental Injury and is not covered.

2. **Sickness Dental Expense Benefit** when, by reason of Sickness, You require Treatment for impacted wisdom teeth or dental abscesses, We will pay the Covered Medical Expenses incurred for the Treatment.

3. **Treatment for Temporomandibular Joint (TMJ) Disorders** for Treatment provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

4. **Surgical Services Directly Affecting the Upper or Lower Jawbone Benefit** for surgical procedures to correct abnormally positioned or improperly developed bones of the upper or lower jawbone, or associated bone joints of an Insured Person. This benefit does not include the provision of dental services.

5. **Dental Anesthesia** for general anesthesia and associated facility charges for dental procedures rendered in a Hospital or Ambulatory Surgical Center setting, when the clinical status or underlying medical condition requires dental procedures that ordinarily would not require general anesthesia to be rendered in a Hospital or Ambulatory Surgical Center, for: (a) Insured Persons below the age of 7 years, (b) Insured Persons who are developmentally disabled, regardless of age, and (c) Insured Persons whose health is compromised and for whom general anesthesia is Medically Necessary, regardless of age. Charges for the dental procedure itself (including the professional fee of the dentist) are not covered.

Prescription Drugs

1. **Prescription Drugs** are medications filled in an outpatient pharmacy for which a Physician's written prescription is required. This benefit is limited to medication necessary for the Treatment of the Covered Injury or Covered Sickness for which a claim is made. Some outpatient Prescription Drugs are subject to pre-certification. Some preventive drugs are available at $0 if pre-certification is approved. These prescription requirements help Your prescriber and pharmacists check that Your outpatient Prescription Drug is clinically appropriate using evidence-

based criteria.

At least one FDA-approved medication in each of the following categories will be covered without pre-certification, step therapy, or utilization review:

- Medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist.
- Medication for the detoxification or maintenance treatment of a substance use disorder, including a daily oral buprenorphine product.
- A long-acting buprenorphine product.
- A long-acting injectable naltrexone product.

a. **Off-Label Drug Treatments** – When Prescription Drugs are provided as a benefit under this Certificate, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
   (1) The drug is approved for marketing by the FDA for at least one diagnosis;
   (2) The drug has been recognized for Treatment of that condition by a nationally recognized drug database or in a major peer reviewed medical journals/clinical practice guidelines.

   When this portion of the prescription benefit is used, it will be the responsibility of the prescriber to submit to Us documentation supporting compliance with the requirements of this benefit.

b. **Dispense as Written (DAW)** – 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 Prescription 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.

c. **Investigational Drugs and Medical Devices** – The Prescription Drug benefit includes a drug or device that is Investigational if the intended use of the drug or device is included in the labeling authorized by the FDA or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature.

d. **Specialty Prescription Drugs** are limited to no more than a 30 day supply. However, if the Specialty Prescription Drug dispensed is the smallest package size available and exceeds a 30 day supply, You are responsible for the cost sharing defined for the day supply as shown in the Schedule of Benefits.

   Specialty Drugs – are Prescription Drugs which:
   (1) Are used in the management of chronic, orphan, or rare diseases;
   (2) Require specialized storage, distribution, and/or handling;
   (3) Have frequent dosing adjustments and clinical monitoring to decrease potential for drug toxicity and improve clinical outcomes;
   (4) Involve additional patient education, adherence, and/or support;
   (5) May include generic or biosimilar products; and/or
   (6) May have limited or exclusive drug distribution restrictions.

   Specialty Prescription Drugs are identified in the Formulary posted on Our website at www.wellfleetrx.com.

e. **Self-Administered Prescription Drugs** – Certain self-administered Prescription Drugs are only covered under the Prescription Drug benefit and are excluded from the medical benefits. Self-administered Prescription Drugs will not be covered when dispensed through a Physician's office or outpatient Hospital, except in emergency situations. While Insured Persons may self-administer these medications, they can still obtain these medications at the pharmacy and have them administered at an office visit. Coverage exceptions may be granted if self-administered Prescription Drugs are required as part of a hospitalization or emergency room visit. The list of self-administered Prescription Drugs only covered under the Prescription Drug benefit and excluded from the medical benefit can be found here: www.wellfleetrx.com.

f. **Retail Pharmacy Supply Limits** – We will pay for no more than a 30 day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for 1 cost sharing amount for up to a 30 day supply. However, if the Prescription Drug dispensed is the smallest package size available and exceeds a 30 day supply, You are responsible for the cost sharing defined for the day supply as shown in the Schedule of Benefits.

g. **Step Therapy** – When medications for the Treatment of any medical condition are restricted for use by a step therapy or fail-first protocol, the prescribing practitioner shall have access to a clear and convenient process to request an override of the restriction from Us. An override of that restriction will be granted by Us upon completion of the review if all necessary information to perform the override review has been provided, under the following documented circumstances:
   (1) The prescribing practitioner can demonstrate, based on sound clinical evidence, that the preferred Treatment required under step therapy or fail-first protocol has been ineffective in the Treatment of Your disease or medical condition; or
   (2) Based on sound clinical evidence or medical and scientific evidence:
      (a) The prescribing practitioner can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the Insured Person and known characteristics of the drug regimen; or
      (b) The prescribing practitioner can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to You.

h. **Quantity Limits** – Some Outpatient Prescription Drugs are subject to quantity limits. The quantity limits help the prescriber and pharmacist check that the Outpatient Prescription Drug is used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by Us to set these quantity limits.

i. **Tier Status** – The tier status of a Prescription Drug may change periodically. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Prescription Drug that becomes available as a Generic Prescription Drug) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website at www.wellfleetrx.com or by calling the number on Your ID card.

j. **Compounded Prescription Drugs** will be covered only when they contain at least 1 ingredient that is a covered legend Prescription Drug, do not contain bulk chemicals, and are obtained from a pharmacy that is approved for compounding. Compounded Prescription Drugs may require Your Provider to obtain Preauthorization. Compounded Prescription Drugs will be covered as the tier associated with the highest tier ingredient.

k. **Formulary Exception Process** – If a Prescription Drug is not on Our Formulary, You, Your Authorized Representative or Your prescribing Physician may request a Formulary exception for clinically appropriate Prescription Drug in writing, electronically or telephonically. If coverage is denied under Our standard or

expedited Formulary exception process, the Insured Person is entitled to an external appeal as outlined in the External Appeal section of this Certificate. Refer to the Formulary posted on Our website at www.wellfleetrx.com or call the number on Your ID card to find out more about this process.

Standard Review of a Formulary Exception – We will make a decision and notify You or Your Authorized Representative and the prescribing Health Care Professional no later than 72 hours after Our receipt of the Insured Person's request. If We approve the request, We will cover the Prescription Drug while You are taking the Prescription Drug, including any refills. This approval authorization requires renewal at least every 12 months.

Expedited Review of Formulary Exception – If You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain maximum function or if You are undergoing a current course of Treatment using a Non-Formulary Prescription Drug, You may request an expedited review of a Formulary exception. These requests should include a statement from Your prescribing Physician that harm could reasonably come to You if the requested drug is not provided within the timeframes for Our standard Formulary exception process. We will make a decision and notify You or Your Authorized Representative and the prescribing Physician no later than 24 hours after Our receipt of Your request. If We approve the request, We will cover the Prescription Drug. This approval authorization requires renewal at least every 12 months. Refer to the Formulary posted on Our website at www.wellfleetrx.com or call the number on Your ID card to find out more about this non-Formulary drug exception process.

l. **Tobacco cessation prescription and over-the-counter drugs** – Tobacco cessation Prescription Drugs and OTC drugs will be covered for two treatment regimens only. Any additional prescription drug treatment regimens will be subject to the cost sharing as shown in the Schedule of Benefits. For details on the current list of tobacco cessation Prescription Drugs and OTC drugs covered with no cost sharing during the two treatment regimens allowed, refer to the Formulary posted on Our website www.wellfleetrx.com or call the toll-free number on Your ID card.

m. **Zero Cost Drugs** – In addition to ACA Preventive Care medications, certain Prescription Drugs are covered at no cost to You. These zero cost drugs can be identified in the Formulary posted on Our website at www.wellfleetrx.com.

n. **Preventive contraceptives -** Your Outpatient Prescription Drug benefits cover certain Prescription drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a Physician and the prescription is submitted to the pharmacist for processing. Your outpatient Prescription Drug benefits also cover related services and supplies needed to administer covered devices. At least 1 form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive prescription drugs and applicable supply limits by referring to the Formulary posted on Our website at www.wellfleetrx.com or calling the toll-free number on Your ID card.

Coverage is provided for FDA-approved over-the-counter (OTC) contraceptive drugs, devices, and products without a prescription. Benefits includes point-of-sale coverage for OTC contraceptives (including but not limited to male condoms) at a participating pharmacy without a prescription, cost sharing, or medical management restrictions, including prior authorization and quantity limits. Point-of-sale coverage means that the claim will be processed by the participating pharmacy without cost sharing. You will not be required to pay upfront and submit a claim for reimbursement.

We cover over-the-counter (OTC) and Generic Prescription Drugs and devices for each of the methods identified by the FDA at no cost share. If a Generic Prescription Drug or device is not available for a certain

method, You may obtain a certain Brand-Name Prescription Drug for that method at no cost share. Up to a 12-month supply of contraceptives may be dispensed with a single prescription order.

o. **Orally administered anti-cancer drugs, including chemotherapy drugs** - Covered Medical Expenses include any drug prescribed for the Treatment of cancer if it is recognized for Treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication.

p. **Diabetic supplies -** The following diabetic supplies may be obtained under Your Prescription Drug benefit upon prescription by a Physician:
- Insulin
- Insulin syringes and needles
- Blood glucose and urine test strips
- Lancets
- Alcohol swabs
- Blood glucose monitors and continuous glucose meters

You can identify covered diabetic supplies by referring to the Formulary posted on Our website at www.wellfleetrx.com or by calling the toll-free number on Your ID card. Refer to the Diabetic Services and Supplies (including equipment and training) provision for diabetic services and supplies covered under the Diabetic Services and Supplies (including equipment and training) benefit.

q. **Preventive Care drugs and Supplements-** Covered Medical Expenses include preventive care drugs and supplements (including over the counter drug and supplements as required by the Affordable Care Act (ACA) guidelines when prescribed by a Physician and the prescription is submitted to the pharmacist for processing.

r. **Partial Fill of Schedule II Controlled Substances** – We will allow a partial fill of prescriptions for a Schedule II controlled substance if requested by You or Your prescribing Physician. Your out of pocket expenses will be prorated accordingly. The pharmacist will retain the original prescription with a notation of the amount filled until the full prescription has been dispensed. The total quantity dispensed will not exceed the total quantity prescribed.

s. **Pain Management Medication for Terminally Ill** Insured Persons when Medically Necessary. We shall approve or deny the request by the Provider for authorization of coverage for an Insured Person who has been determined to be terminally ill in a timely fashion, appropriate for the nature of the Insured Person's condition, not to exceed 72 hours of Our receipt of the information requested to make the decision. If the request is denied or if additional information is required, We shall contact the Provider within one working day of the determination, with an explanation of the reason for the denial or the need for additional information. The requested Treatment shall be deemed authorized as of the expiration of the applicable timeframe. The Provider shall contact Us within one business day of proceeding with the deemed authorized Treatment, to do all of the following:
1. Confirm that the timeframe has expired.
1. Provide the Insured Person's identification.
3. Notify Us of the Provider or Providers performing the Treatment.
4. Notify Us of the facility or location where the Treatment was rendered.

This benefit does not apply to coverage for any drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA.

t. **PEP (post-exposure prophylaxis)** medication to prevent HIV after possible exposure.

Mandated Benefits for California

Mandate Disclaimer: If any Preventive Services Benefit is subject to the mandated benefits required by state law, they will be administered under the federal or state guideline, whichever is more favorable to the Insured Person.

1. **AIDS Vaccine** for acquired immune deficiency syndrome (AIDS) that is approved for marketing by the FDA and that is recommended by the United States Public Health Service.

2. **Alzheimer's Disease Coverage** is provided for home-based care for You if You are diagnosed as having any significant destruction of brain tissue with resultant loss of brain function, including, but not limited to, progressive, degenerative, and dementing illness. This includes, but is not limited to, Alzheimer's disease.

3. **Diethylstilbestrol (DES) Coverage** for conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol.

4. **Osteoporosis** for services related to diagnosis, treatment, and appropriate management of osteoporosis. The services may include, but need not be limited to, all FDA approved technologies, including bone mass measurement technologies as deemed medically appropriate.

5. **Special Shoe Benefit** for special footwear as needed by Insured Persons who suffer from foot disfigurement, including disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by Accident or development disability.

6. **Emergency Department Medical Care and Follow-Up Health Care Treatment Following Rape or Sexual Assault** will be provided as shown in the Schedule of Benefits for charges incurred by an Insured Person who is a victim of rape or sexual assault. Follow-up care Treatment includes medical or surgical services for the diagnosis, prevention, or Treatment of medical conditions arising from an instance of rape or sexual assault.

7. **Pediatric Autoimmune Neuropsychiatric Disorders Benefit** for the Medically Necessary prophylaxis, diagnosis, and Treatment of Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS). Covered Medical Expenses will include antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchanges, and intravenous immunoglobulin therapy.

SECTION V - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If, as the result of a covered Accident, You sustain any of the following losses, We will pay the benefit shown on the Schedule of Benefits.

Loss of Life	The Principal Sum
Loss of hand	One-Half the Principal Sum
Loss of Foot	One-Half the Principal Sum
Loss of either one hand, one foot or sight of one eye	One-half the Principal Sum
Loss of more than one of the above losses due to one Accident	The Principal Sum

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 (1) Accident.

SECTION VI - 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 Certificate does not cover Loss nor provide benefits for any of the following, except as otherwise provided by the benefits of the Certificate and as shown in the Schedule of Benefits.

General Exclusions

- **International Students Only –** Covered Medical Expenses received within Your Home Country or country of origin that are covered under Your governmental or national health plan.
- 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 Your attending Physician or dentist.
- 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.
- Professional services rendered by an Immediate Family Member or anyone who lives with You.
- 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.
- Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
- 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.
- Services that are duplicated when provided by both a licensed midwife and a Physician.
- Expenses payable under any prior policy which was in force for the person making the claim.
- Expenses paid by Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid or Medi-Cal.
- 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.
- Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
- You are:
    - committing or attempting to commit a felony,
    - engaged in an illegal occupation, or
    - participating in a riot.
- Custodial Care service and supplies.
- Charges for hot or cold packs for personal use.
- Services of private duty Nurse except as provided in the Certificate.
- Expenses that are not recommended and approved by a Physician.
- Experimental or Investigational drugs, devices, Treatments or procedures.
- 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.
- Modifications made to dwellings.
- General fitness, exercise programs.
- Hypnosis.
- Rolfing.
- Biofeedback.
- 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.

- Any routine services such as physical exams, vaccinations, or laboratory testing required for employment, school, camp, sports participation, travel, insurance enrollment, or licensing, as well as for joining a sport or recreational activity, except as specifically provided under Preventive Services, or otherwise specifically covered under the Certificate.

Activities Related

- Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.

Weight Management/Reduction

- 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 Certificate.
- Treatment for obesity except surgery for morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat.

Family Planning

- Infertility Treatment (male or female)-this includes but is not limited to:
  - Genetic counseling and genetic testing;
  - Impotence, organic or otherwise;
  - Costs for an ovum donor or donor sperm;
  - Sperm, Ova, Embryo, Non-medical storage costs, except as specifically provided under the Fertility Preservation Expense benefit;
  - Ovulation predictor kits;
  - Reversal of tubal ligations;
  - Reversal of vasectomies;
  - Costs for and relating to surrogate motherhood if the individual is not an Insured Person under the Certificate;
  - Cloning; or
  - Medical and surgical procedures that are Experimental or Investigational, unless Our denial is overturned by an External Appeal Agent.

Vision

- Expenses for radial keratotomy.
- Adult Vision unless specifically provided in the Certificate.
- Charges for office visit exam for the fitting of prescription contact lenses, duplicate spare eyeglasses, non-prescription lenses or contact lenses that are for cosmetic purposes.

Dental

- Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.

Hearing

- Charges for hearing screening, hearing aids and the fitting or repair or replacement of hearing aids or cochlear implants except as specifically provided in the Certificate.

Cosmetic

- Treatment of Acne unless Medically Necessary.
- Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
- 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 Services Benefit.

Prescription Drugs

- 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 this 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;
- 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 Certificate 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;
- Prescription digital therapeutics;
- Medical marijuana, cannabis, or other supplies and/or services rendered at a cannabis dispensary. This does not include synthetic pharmaceutical products approved by the FDA and included on the Formulary;
- Sexual enhancements drugs;
- Vision correction products.

Third Party Refund:

When:

1. You are injured through the negligent act or omission of another person (the "third party"); and
2. Benefits are paid under this Certificate as a result of that Injury,

We are entitled to a refund by You of all Certificate benefits paid as a result of the Injury.

The refund must be made to the extent that You receive payment for the Injury from the third party or that third party's insurance carrier. We may file a lien against that third-party payment. Reasonable pro rata charges, such as legal fees and court costs, may be deducted from the refund made to Us. You must complete and return the required forms to Us upon request.

Coordination Of Benefits

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one (1) Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the

Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

DEFINITIONS

1. A Plan is any of the following that provides benefits or services for medical or dental care or Treatment. If separate policies are used to provide coordinated coverage for members of a group, the separate policies are considered parts of the same plan and there is no COB among those separate policies.
   a. Plan includes: group and nongroup insurance policies, health insuring corporation ("HIC") policies, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care policies, such as skilled nursing care; medical benefits under group or individual automobile policies; and Medicare or any other federal governmental plan, as permitted by law.
   b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid, Medi-Cal policies; or coverage under other federal governmental plans, unless permitted by law.

Each Certificate for coverage under a. or b. is a separate Plan. If a Plan has 2 parts and COB rules apply only to 1 of the 2, each of the parts is treated as a separate Plan.

2. This plan means, in a COB provision, the part of the Certificate providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the Certificate providing health care benefits is separate from this plan. A Certificate may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

3. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than 1 Plan.

   When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

4. Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowable expense.

   The following are examples of expenses that are not Allowable expenses:
   a. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless 1 of the Plans provides coverage for private hospital room expenses.
   b. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of Usual and Customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

c. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
d. If a person is covered by 1 Plan that calculates its benefits or services on the basis of Usual and Customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's Policy permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
e. The amount of any benefit reduction by the Primary plan because You failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, Pre-Certification of admissions, and preferred provider arrangements.

5. Closed panel plan is a Plan that provides health care benefits to Insured Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

6. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by 2 or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the Policyholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network Provider benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:
1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, Policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two (2) Plans is reversed so that the Plan covering the person as an employee, member, Policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
2. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
a. For a dependent child whose parents are married or are living together, whether or not they have ever been

married:

i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), We will follow the rules of that plan.

b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   i. If a court decree states that one (1) of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
   iii. If a court decree states that the parents have joint custody without specifying that 1 parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
   iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
   • The Plan covering the custodial parent;
   • The Plan covering the spouse of the custodial parent;
   • The Plan covering the non-custodial parent; and then
   • The Plan covering the spouse of the non-custodial parent.

c. For a dependent child covered under more than one Plan of individuals who are <u>not</u> the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

d. a. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.
   b. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
4. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
5. Longer or shorter length of coverage. The Plan that covered the person as an employee, member, Policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

B. If an Insured Person is enrolled in 2 or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by 1 Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. Our Agent or We may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. Our Agent or We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give Our Agent or We any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, Our Agent or We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. Our Agent or We will not have to pay that amount again. The term payment made includes providing benefits in the form of services, in which case payment made means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Our Agent or We is more than it should have paid under this COB provision, it may recover the excess from one (1) or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Insured Person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

SECTION VII - GENERAL PROVISIONS

Entire Contract Changes

The Policy, this Certificate, including the application, endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in the Policy or Certificate will be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon. No agent has authority to change the Policy or Certificate or waive any of its provisions.

Notice of Claim
Written or electronic notice of a claim must be given to Us within 90 days after the date of Injury or commencement of Sickness covered by this Certificate, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to Our authorized agent, with information sufficient to identify You will be deemed notice to Us.

Claim Forms
We, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by Us for filing proofs of Loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of Loss requirements by giving Us a written statement of the nature and extent of the Loss within the time limits stated in the Proofs of Loss provision.

Proof of Loss
Written proof of Loss must be furnished to Us or to Our authorized agent within 90 days after the date of such Loss. If it was not reasonably possible to give written proof in the time required, We may not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. The proof required must be given no later than one (1) year from the time specified unless the claimant was legally incapacitated.

Time of Payment
Indemnities payable under this Certificate will be paid immediately upon receipt of due proof of such Loss.

Payment of Claims
Benefits will be paid to You. Loss of life benefits, if any, will be payable in accordance with the beneficiary designation in effect at the time of payment. If no such designation or provision is then effective, the benefits will be payable to Your estate. Any other accrued indemnities unpaid at the time of Your death may, at Our option, be paid either to such beneficiary or to such estate.

If benefits are payable to Your estate or to a beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity, up to an amount not exceeding $1,000.00, to any one relative by blood or connection by marriage to You who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment.

We may pay all or a portion of any indemnities provided for health care services to the provider, unless You direct otherwise, in writing, by the time proofs of Loss are filed. We cannot require that the services be rendered by a particular provider.

Assignment
You may assign Out-of-Network benefits payable under this Certificate. In-network benefits are billed directly by the provider. We are not bound by an assignment unless it is in writing and until a duplicate of the original assignment has been filed with Us. We assume no responsibility regarding the validity of any assignment or payment made without notice of a prior assignment.

Physical Examination and Autopsy
We, at Our own expense, will have the right and opportunity to examine the person of an individual whose Injury or Sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder. In the case of Your death, We may have an autopsy performed unless prohibited by law.

Legal Actions
No action at law or in equity will be brought to recover on this Certificate prior to the expiration of 60 days after written proof of Loss has been furnished in accordance with the requirements of this Certificate. No such action will

be brought after the expiration of three years after the time written proof of Loss is required to be furnished.

Conformity with State Statutes
Any provision of this Certificate which, on its Effective Date, is in conflict with the statutes of the state in which this Certificate was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statutes.

Dispute Resolution
Should a dispute arise concerning the Policy or the payment of a claim hereunder, the Insured Person should contact Us in writing at Wellfleet Group, LLC dba Wellfleet Administrators, LLC PO Box 15369 Springfield, Massachusetts 01115-5369 (877) 657-5030, TTY 711. If a dispute is not resolved to his or her satisfaction, he or she may contact the **Consumer Services Division of the California Department of Insurance at 300 S. Spring Street, Los Angeles, CA 90013 or by phone at 1-800-927-HELP (1-800-927-4357); TDD: 800-482-4TDD (4833), www.insurance.ca.gov.**

SECTION VIII - ADDITIONAL PROVISIONS

1. We do not assume any responsibility for the validity of assignment.

2. You will have free choice of a legally qualified Physician with the understanding that the Physician-patient relationship will be maintained.

3. Our acknowledgment of the receipt of notice given under this Certificate, or the furnishing of forms for filing proofs of Loss or acceptance of such proof, or the investigation of any claim hereunder will not operate as a waiver of any of Our rights in defense of any claim arising under this Certificate.

4. This Certificate is not in lieu of and does not affect any requirement of coverage by Workers' Compensation Insurance.

5. All new persons in the groups or classes eligible to and applying for this insurance will be added in the respective groups or classes in which they are eligible.

6. The insurance of any Insured Person will not be prejudiced by the failure on the part of the Policyholder to transmit reports, pay Premium or comply with any of the provisions of this Certificate when such failure is due to inadvertent error or clerical mistake.

7. All books and records of the Policyholder containing information pertinent to this insurance will be open to examination by Us during the Certificate term and within one year after the termination of this Certificate.

8. Benefits are payable under this Certificate only for those expenses incurred while You are covered. No benefits are payable for expenses incurred after the date Your insurance terminates, except as may be provided under an Extension of Benefits.

SECTION IX – APPEALS PROCEDURE

If You have a claim that is denied by Us, You have the right to appeal it. Your Authorized Representative may act on Your behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. A Final Adverse Benefit Determination will also provide You and each Dependent the option to request an Independent Medical Review (External Review) from the California Department of Insurance.

If You receive Emergency Services from an Out-of-Network Provider, or You incur non-emergency Covered Medical

Expenses from an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, and You believe those services should have been paid at the In-Network level, You have the right to appeal that claim. If Your appeal of a Surprise Billing claim is denied, You have a right to seek Independent Medical Review (IMR) as set out in the Standard External Review Expedited External Review, and IMR provisions appearing in this section.

For purposes of this Section, the following definitions apply:
Adverse Benefit Determination means:

- A determination by Us or Our designee Utilization review organization that, based upon the information provided, a request for a benefit under the Policy upon application of any utilization review technique does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be Experimental or Investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;
- The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by Us or Our designee Utilization review organization of Your eligibility under the Policy;
- Any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit; or
- A rescission of coverage.

Authorized Representative means:

- A person to whom have given express written consent to represent You;
- A person authorized by law to provide substituted consent for You;
- A family member of Yours or Your treating health care professional when You are unable to provide consent;
- A health care professional when the Policy requires that a request for a benefit under the Policy be initiated by the health care professional; or
- In the case of an Urgent Care claim, a health care professional with knowledge of Your medical condition.

Concurrent claim means a request for a plan benefit(s) by You that is for an ongoing course of treatment or services over a period of time or for the number of treatments.

Concurrent review means Utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting.

Final Adverse Benefit Determination: An Adverse Benefit Determination that has been upheld by Us at the exhaustion of the appeals process.

Health care professional means a Physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

Independent Medical Review (External Review): A review of an Adverse Benefit Determination or a Final Adverse Benefit Determination by the California State Insurance Commissioner (Commissioner) and made up of Physicians or other appropriate health care providers with appropriate expertise in the problem or question involved.

Pre-service claim means the request for a plan benefit(s) by You prior to a service being rendered and is not considered a concurrent claim.

Post-Service Claim means any claims for a plan benefit(s) that is not a Pre-Service Claim.

Prospective review means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with Our requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

Retrospective review means any review of a request for a benefit that is not a prospective review request. Retrospective review does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

Urgent Care request means a request for a health care service or course of Treatment with respect to which the time periods for making a non-urgent care request determination:

1.
   a. Could seriously jeopardize Your life or health or Your ability to regain maximum function; or
   b. In the opinion of a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the health care service or Treatment that is the subject of the request.

2.
   a. Except as provided in (b) of this paragraph, in determining whether a request is to be treated as an Urgent Care request, an individual acting on Our behalf shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
   b. Any request that a Physician with knowledge of Your medical condition determines is an Urgent Care Request shall be treated as an urgent care request.

Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the Medical Necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, Prospective review, second opinion, certification, Concurrent review, case management, discharge planning or Retrospective review.

Utilization review organization means an entity that conducts Utilization review, other than Us performing utilization review for Our own health benefit plans.

There are 3 types of claims: Pre-Service, Concurrent Care, and Post-Service Claims. In addition, certain Pre-Service or Concurrent Care Claims may involve Urgent Care. If the Company makes an Adverse Benefit Determination, then You may appeal according to the following steps.

Step 1:

If Your claim is denied, You will receive written notice from Us that Your claim is denied (in the case of Urgent Claims, notice may be oral). The period in which You will receive this notice will vary depending on the type of claim. In addition, We may take an extension of time in which to review Your claim for reasons beyond Our control. If the reason for the extension is that You need to provide additional information, You will be given a certain amount of time in which to obtain the requested information (it will vary depending on the type of claim). The period during which We must make a decision will be suspended until the earlier of the date that You provide the information or the end of the applicable information-gathering period.

Type of Claim	**You will be notified by Us that a claim is denied as soon as possible but no later than:**	**Extension period allowed for circumstances beyond Our control:**	**If additional information is needed, You must provide within:**
Pre-Service Claim	15 days from receipt of claim (whether adverse or not)	One extension of 15 days	45 days of date of extension notice

Pre-Service Claim involving Urgent Care	72 hours from receipt of claim (whether adverse or not) (24 hours after receipt of claim if additional information is needed from You)	None	48 hours (We must notify You of determination within 48 hours of receipt of Your information)
Concurrent: To end or reduce Treatment prematurely (other than by policy amendment or termination) Pending the outcome of an appeal, benefits for an ongoing course of Treatment will not be reduced or terminated.	Notification to end or reduce Treatment will allow sufficient time in advance to allow You to appeal and obtain a determination on the adverse benefit determination prior to the end or reduction of prescribed Treatment	N/A	N/A
Concurrent: To deny Your request to extend Treatment	30 days from receipt of claim for Pre-Service Claim; or 60 days from receipt of claim for Post-Service Claim	One extension of 15 days	45 days of the date of extension notice
Concurrent: Involving Urgent Care	72 hours from receipt of claim (whether adverse or not) (24 hours after receipt of claim if additional information is needed from You; or 24 hours after receipt of claim provided that any such claim is made at least 24 hours prior to the end or reduction of prescribed Treatment)	None	48 hours (We must notify You of determination within 48 hours of receipt of Your information)
Post-Service Claim	30 days from receipt of claim	One extension of 15 days	45 days of the date of extension notice

Once You have received notice from Us, You should review it carefully. The notice will contain:

1. The reason(s) for the denial and the Policy provisions on which the denial is based.
2. A description of any additional information necessary for You to perfect Your claim, why the information is necessary, and Your time limit for submitting the information.

3. A description of the Policy's appeal procedures and the time limits applicable to such procedures, including a statement of Your right to bring a civil action following a final denial of Your appeal.
4. A statement indicating whether an internal rule, guideline or protocol was relied upon in making the denial and a statement that a copy of that rule, guideline or protocol will be made available upon request free of charge.
5. If the denial is based on a Medical Necessity, Experimental Treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request; and
6. If the claim was an Urgent Care request, a description of the expedited appeals process. The notice may be provided to You orally within 72 hours; however, a written or electronic notification will be sent to You no later than 3 days after the oral notification. If the claim was/is an Urgent Care request, You may initiate an Internal Appeal and an External Review simultaneously.
7. Information sufficient to identify the claim (including the date of service, the health care provider, and the claim amount (if applicable).
8. An explanation of how to request diagnosis and treatment codes (and their corresponding meanings).
9. The contact information for all relevant review agency contacts and the office of health insurance consumer assistance to assist You with Your claims, appeals and external review.
10. Notification that culturally and linguistically appropriate services are available.

INTERNAL APPEAL

Step 2:

If You do not agree with Our decision and wish to appeal, You may file a written appeal with Us at the address below within 180 days after receipt of the Adverse Benefit Determination notification (or oral notice if an Urgent Care request) referenced in Step 1. If the claim involves Urgent Care, Your appeal may be made orally.

You should submit all information referenced in Step 1 with Your appeal. You should gather any additional information that is identified in the notice as necessary to perfect Your claim and any other information that You believe will support Your claim.

Appeals should be sent to:
Wellfleet Insurance Company
Attention: Appeals Unit
Wellfleet Group, LLC dba Wellfleet Administrators, LLC
P.O. Box 15369
Springfield, MA 01115-5369

Type of Claim	**You must file Your appeal within:**	**You will be notified of Our determination as soon as possible but no later than:**
Pre-Service Claim	180 days after receipt of Adverse Benefit Determination	30 days of receipt of appeal
Pre-Service Claim involving Urgent Care	180 days after receipt of Adverse Benefit Determination	72 hours of receipt of appeal
Concurrent: To end or reduce Treatment prematurely	180 days after receipt of Adverse Benefit Determination Pending the outcome of the appeal, benefits for an ongoing	15 days of receipt of appeal

	course of Treatment will not be reduced or terminated.	
Concurrent: To deny Your request to extend Treatment	180 days after receipt of Adverse Benefit Determination for Pre-Service or Post-Service Claim	15 days of receipt of appeal for Pre-Service Claim; or 30 days of receipt of appeal for Post-Service Claim
Concurrent: Involving Urgent Care	180 days after receipt of Adverse Benefit Determination	72 hours of receipt of appeal
Post-Service Claim	180 days after receipt of Adverse Benefit Determination	60 days of receipt of appeal

Step 3:

If Your appeal is denied based on medical judgement such as Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or Treatment and You wish to seek an Independent Medical Review (IMR), You must file a written request for external review of the Adverse Benefit Determination with the California Department of Insurance (CDI).

You may also seek an IMR for a denial of an Urgent Care request based on medical judgement provided that (1) You have also filed an internal appeal in accordance with the terms described herein; and (2) the time frames for completion of an Urgent Care appeal will seriously jeopardize Your life or health or would seriously jeopardize Your ability to regain maximum function.

You may also seek an external review for a rescission of coverage.

It is necessary in most situations to go through Our Internal Appeals process before applying for an IMR with the CDI. If We uphold Our decision or have not provided a ruling within 30 days of Your filing an appeal, then You can request an IMR from the CDI. Your request for an IMR must be made within 6 months of Our upholding Our decision within the Internal Appeals process. If special circumstances are present, the law allows the Commissioner to extend the filing deadline beyond the 6 months. The date may be extended by the Commissioner.

STANDARD EXTERNAL REVIEW

Within 6 months after the date of receipt of a notice of an Adverse Benefit Determination, You may file a request for an IMR or CDI.

You may request an IMR if You disagree with Our decision regarding a disputed health care service that has been determined not to be Medically Necessary or has been denied as Experimental or Investigative. We are required to send You an IMR application with Our denial letter. If You do not receive an application from Us, You can request one from the CDI by calling 1-800-927-HELP or by completing an Application for IMR form.

You must submit the IMR form to:

California Department of Insurance
Consumer Services Division
300 Spring Street South Tower
Los Angeles CA 90013
1-800-927-4357, TDD: 1-800-482-4TDD (4833)
Consumer & Provider Health Inquiries & Complaints (ca.gov)

You should include a copy of the notice from Us and all other important information that supports Your request.

Since making a request for an IMR is voluntary, You must give written consent indicating that You wish to participate in the IMR program. The application form includes a consent statement which when signed gives Your permission to obtain any necessary medical records in order to proceed with the IMR.

When Your completed application, with any additional information is received, the CDI will determine if Your request qualifies for the IMR program. If Your request does qualify, You will be notified. If Your request does not qualify for the IMR program, then Your claims review request will be referred to the complaint/mediation program within the CDI.

When Your request qualifies as an IMR, the case is then sent to the IMR organization designated by the CDI. The CDI notifies Us and requires Us to provide the IMR organization with copies of all documents necessary to conduct the IMR. In most cases, We must provide all relevant documents including medical records to the IMR organization within 3 business days. The IMR organization is required to complete its review in writing within 30 days.

Once the IMR organization has made its determination, the written determination will be provided to You, to Us, and to the Commissioner. The determination must contain Your medical condition, the important documents reviewed, and the findings that are relevant to Your request.

Upon receiving the IMR determination, the Commissioner adopts the recommendation from the IMR organization immediately. A written decision will be issued by the CDI to You and to Us explaining that the recommendation is binding on Us.

The cost of the IMR is paid completely by Us after it has been decided that Your request qualifies for an IMR by the CDI.

EXPEDITED EXTERNAL REVIEW

The IMR process allows for exceptions to be made when there is a serious or imminent threat to Your health. If Your provider or the CDI certifies in writing that an imminent and serious threat to Your health may exist, including but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of Your health, the IMR organization must make its determination within three days of receiving the proper case information. Moreover, We must deliver the necessary information and documents to the IMR organization within 24 hours of approval from the CDI of Your IMR request.

When the CDI reviews Your request for an IMR, the CDI may waive the requirement that You first go through Our Internal Appeals process when an extraordinary or compelling case exists.

IMPORTANT INFORMATION

- Each level of appeal will be independent from the previous level (i.e., the same person(s) involved in a prior level of appeal will not be involved in the appeal).
- The claims reviewer will review relevant information that You submit even if it is new information. In addition, You have the right to request documents or other records relevant to Your claim.

- If a claim involves medical judgement, then the claims reviewer will consult with an independent health care professional that has expertise in the specific area involving medical judgment.
- You may review the claim file and present evidence and testimony at each state of the appeals process.
- You may request, free of charge, any new or additional evidence considered, relied upon, or generated by Us in connection with Your claim.
- If a decision is made based on new or additional rationale, You will be provided with the rationale and be given a reasonable opportunity to respond before a final decision is made.
- If You wish to submit relevant documentation to be considered in reviewing Your claim for appeal, it must be submitted with Your claim and/or appeal.
- You should raise all issues that You wish to appeal during Our Internal Appeal process and during the External Review.

CONTACT INFORMATION
If You have any questions or concerns, You can contact Us at:
Wellfleet Insurance Company
Attention: Appeals Unit
Wellfleet Group, LLC dba Wellfleet Administrators, LLC
P.O. Box 15369
Springfield, MA 01115-5369

California Department of Insurance
Health Claims Bureau, IMR Unit
300 S. Spring Street, 11th Floor
Los Angeles, CA 90013
Inside State Toll-Free: 1-800-927-4357
Outside State: 1-213-897-8921
Fax: 1-213-897-9641
TDD: 1-800-482-4833
www.insurance.ca.gov

SECTION IX – SCHEDULE OF BENEFITS

STANFORD UNIVERSITY
SCHEDULE OF BENEFITS
Actuarial Value: 88.99%
Metal Tier: Platinum

Preventive Services:
In-Network Provider: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of the Negotiated Charge when services are provided through an In-Network Provider.

Out-of-Network Provider: The Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through an Out-of-Network Provider. Benefits are paid at 50% of the Usual and Customary Charge. No cost sharing shall apply to services provided by an Out-of-Network Provider for a vasectomy.

Medical Deductible:

In-Network Provider:	Individual:	$150
	Family:	$300
Out-of-Network Provider:	Individual:	$1,500
	Family:	$4,500

Cost sharing You incur for Covered Medical Expenses that is applied to the Out-of-Network Provider Deductible will not be applied to satisfy the In-Network Provider Deductible. Cost sharing You incur for Covered Medical Expenses that is applied to the In-Network Provider Deductible will not be applied to satisfy the Out-of-Network Provider Deductible.

Out-of-Pocket Maximum:

In-Network Provider:	Individual:	$3,000
	Family:	$6,000
Out-of-Network Provider:	Individual:	No maximum
	Family:	No maximum

Cost sharing You incur for Covered Medical Expenses that is applied to the Out-of-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the In-Network Provider Out-of-Pocket Maximum and cost sharing You incur for Covered Medical Expenses that is applied to the In-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the Out-of-Network Provider Out-of-Pocket Maximum.

Specialty Prescription Drug Copayment Assistance Program - Prior Authorization May Be Required.
Please note: Amounts You pay out-of-pocket for covered Specialty Prescription Drugs 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. 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.

Coinsurance Amounts:

In-Network Provider:	*100% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below. *Select benefits are paid at 90% refer to schedule below for benefit information.
Out-of-Network Provider:	50% of the Usual and Customary Charge (U&C) for Covered Medical Expenses unless otherwise stated below.

Pre-Certification Requirement:
What types of Inpatient and Outpatient services or supplies require Pre-Certification?
Pre-Certification is required for the following:

1. All Inpatient admissions, including length of stay, to a Hospital, Skilled Nursing Facility, a facility established primarily for the Treatment of a Substance Use Disorder, or a residential Treatment facility, surgical procedures;
2. All Inpatient maternity care after the initial 48 hours following vaginal delivery/96 hours following a cesarean section;
3. Home Health Care;
4. Durable Medical Equipment over $500 per item;
5. Outpatient Surgical Procedures;
6. Transplant Services;
7. Diagnostic Testing and Radiology services listed at www.wellfleetstudent.com/providers/. See Prior Authorization Requirements section;
8. Complex Imaging;
9. Chemotherapy/Radiation;
10. Fertility Preservation;
11. Infusion Therapy;
12. Botox Injections;
13. Genetic Testing, except for BRCA;
14. Orthotics/Prosthetics;
15. Non-emergency air Ambulance (fixed wing).

Pre-Certification is not required for an Emergency Medical Condition, or Urgent Care, or Hospital Confinement for the initial 48 hours following a normal vaginal delivery or 96 hours following a cesarean section of maternity care.

Pre-Certification is not a guarantee that benefits will be paid.

Student Health Center ("Vaden") Referral Parameters
When available, the Insured Student must first use the resources of the Student Health Center ("Vaden") where Treatment may be administered, or a referral is issued indicating the services were not available at Vaden. The Insured Student is then free to seek services outside Vaden. Covered Medical Expenses incurred for medical Treatment rendered outside of Vaden for which no prior approval or referral is obtained will be subject to the Referral Penalty shown below. A referral issued by Vaden must be made available to Us so that the claim can be processed accurately.

A Vaden referral for outside care is **un**necessary for the following conditions:
1. For an Emergency Medical Condition;
2. For medical care provided at Stanford Health Care's Express Care Clinic or Walk in Clinic;
3. For medical care received when the student is more than 25 miles from campus;
4. For maternity care;*
5. When service is rendered at another facility during breaks, holidays, or periods when Vaden is closed;
6. For medical care obtained by a student who is not eligible to use Vaden;
7. For mental health care, including Psychiatry;
8. For the routine annual eye exam;

*Additionally, no authorization or referral requirement will apply to obstetrical or gynecological care provided by In-Network Providers (including IUD services, colposcopy, and pregnancy termination).

The applicable Deductible(s); Coinsurance and Copayment(s) shall apply to all of the exceptions to the referral requirement shown above.

Dependents are not eligible to use Vaden and therefore are exempt from the above limitations and referral requirements**.**

Referral Penalty:
Unless an exception to the Student Health Center Referral applies, if an Insured Student does not obtain a Referral from the Student Health Center then, We will not pay for Covered Medical Expenses under this Certificate. The additional percentage or dollar amount which the Insured Student may pay as a penalty for failure to obtain a Referral is not a Covered Medical Expense and will not be applied towards the Deductible amount, if applicable or the Out-Of-Pocket Maximum.

Medical Benefit Payments for In-Network Providers and Out-of-Network Providers
This Certificate provides benefits based on the type of health care provider the Insured Student and the Insured Student's covered Dependent selects. This Certificate 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.

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 in the How The Plan Works And Description Of Benefits section 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 the toll-free phone number shown on Your ID card.

Dental and Vision Benefit Payments
For dental and vision benefits, You may choose any dental or vision provider. For dental, different benefits may be payable based on the type of service, as shown in the Schedule of Benefits.
Preferred Provider Organization:
To locate an In-Network Provider in Your area, consult Your Provider Directory or call toll-free 833-343-5338, TTY 711 or visit Our website at www.wellfleetstudent.com.

If You incurred Covered Medical Expenses from an Out-of-Network Provider because You were informed by Us prior to receipt of the Treatment that the provider was an In-Network Provider, either through the Provider Directory, or in Our

response to Your request for such information (via telephone, electronic communication, web-based or internet-based means), Your cost sharing will be no greater than if the service had been provided by an In-Network Provider. For additional information, contact Us at the number on Your ID card.

****Specialist**: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:

1. **THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
3. **DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY AN IN-NETWORK OR OUT-OF-NETWORK PROVIDER.**
4. **UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE WILL ALWAYS APPLY.**
5. **UNLESS SPECIFIED BELOW, ANY APPLICABLE COPAYMENTS ARE APPLIED AFTER DEDUCTIBLE IS MET.**
6. **UNLESS OTHERWISE SPECIFIED BELOW, ANY DAY OR VISIT LIMITS WILL BE APPLIED TO IN-NETWORK AND OUT-OF-NETWORK COMBINED.**

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK	OUT-OF-NETWORK
INPATIENT SERVICES		
Hospital Care Includes Hospital Room and Board Expenses and Hospital Miscellaneous Expenses. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Certification Required	$500 Copayment per admission after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Certification Required	$500 Copayment per admission after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses

MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, and any Pre-Certification requirements that apply to a Mental Health and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness. Day or visit limits do not apply to Mental Health and Substance Use Disorder Benefits.		
Inpatient Mental Health and Substance Use Disorder Benefits Pre-Certification Required Inpatient Treatment for Mental Health, including Gender Dysphoria and Behavioral Health Treatment for Pervasive Developmental Disorder or Autism and Substance Use Disorders. This includes inpatient Psychiatric and Residential Treatment Centers	$250 Copayment per admission after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Mental Health and Substance Use Disorder Benefits For the Treatment of Mental Health, including Gender Dysphoria and Behavioral Health Treatment for Pervasive Developmental Disorder or Autism and Substance Use Disorders.		
Outpatient Physician and **Specialists Office Visits (including but not limited to the following: Physician visits, individual and group therapy, hormone therapy, medication management)	$35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
All Other Outpatient Services (All Other Outpatient Services does not include Emergency Services in an emergency department, Urgent Care Centers, and Emergency Ambulance Service and Prescription Drugs. Refer to the Emergency Services, Ambulance and Non-Emergency Services, and Prescription Drugs sections of this Schedule of Benefits for benefit information.) Pre-Certification may be required for certain All Other Outpatient Services. To see if Pre-Certification is required, refer to	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses

the Pre-Certification Requirement listing and specific benefit listed in this Schedule of Benefits		
Community Based Care Program (CARE)	100% of the Negotiated Charge Deductible Waived	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Mobile Crisis Services/988 Center	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Charge.
PROFESSIONAL AND OUTPATIENT SERVICES		
Surgical Expenses		
Inpatient and Outpatient Surgery includes: Pre-Certification Required for Surgery only Surgeon Services Anesthetist Assistant Surgeon	 100% of the Negotiated Charge after Deductible for Covered Medical Expenses 100% of the Negotiated Charge after Deductible for Covered Medical Expenses 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Surgical Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	$250 Copayment per occurrence after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Abortion Expense	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived
Bariatric Surgery Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Organ Transplant Surgery Travel and lodging expenses a maximum of $2,000 per Policy Year or $250 per day, whichever is less while at the transplant facility. Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Reconstructive Surgery Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Other Professional Services		
Gender Affirming Services Benefit Pre-Certification Required for gender affirming surgery	Same as any other Mental Health Disorder	
Home Health Care Expenses Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Maximum visits per Policy Year	100	100
Hospice Care Coverage	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Office Visits		
Physician's Office Visits For Mental Health and Substance Use Disorder see the Mental Health and Substance Use Disorder Benefits section	$35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
**Specialists Visits For Mental Health and Substance Use Disorder see the Mental Health and Substance Use Disorder Benefits section	$50 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Standard Telemedicine or Telehealth Services Benefit	$35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Third Party Telemedicine or Telehealth Services Program Behavioral Health Musculoskeletal	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	

Acupuncture Services (Medically Necessary Treatment only)	$35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Acupuncture Services Maximum visits per Policy Year	30	30
Allergy Testing and Treatment, including injections	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit	$35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Maximum visits per Policy Year	30	30
Tuberculosis screening (TB), Titers, QuantiFERON B tests including shots (other than covered under Preventive Services)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
EMERGENCY SERVICES, AMBULANCE AND NON-EMERGENCY SERVICES		
Emergency Services in an emergency department for Emergency Medical Conditions.	$300 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived Copayment waived if admitted	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Urgent Care Centers for non-life-threatening conditions	$100 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$100 Copayment per visit then the plan pays 100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived
Emergency Ambulance Service ground and/or air, water transportation	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Non-Emergency Ambulance Expenses ground and/or air (fixed wing) transportation Pre-Certification Required for non-emergency air Ambulance (fixed wing)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	Ground Ambulance transportation: 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses Air Ambulance transportation: Paid the same as In-Network Provider subject to Usual and Customary Charge.

DIAGNOSTIC LABORATORY, RADIOLOGY, TESTING AND IMAGING SERVICES		
Diagnostic Complex Imaging Services Pre-Certification Required When You are referred by the Student Health Center to a different medical facility for complex imaging services, benefits include reimbursement for ground travel up to $50 round trip.	$250 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diagnostic Laboratory, Radiological Services and Testing (Outpatient) Pre-Certification may be required. See Prior Authorization Requirements section listed at www.wellfleetstudent.com/providers/.	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
REHABILITATION AND HABILITATION THERAPIES		
Cardiac Rehabilitation	$35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	$35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy including Physical Therapy, and Occupational Therapy and Speech Therapy	$35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy Maximum Visits for each therapy per Policy Year for Physical Therapy, Occupational Therapy and Speech Therapy Combined with Habilitation Services Therapy	30	30

Habilitation Services including Physical Therapy, and Occupational Therapy and Speech Therapy	$35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitation Services Maximum Visits for each therapy per Policy Year for Physical Therapy, Occupational Therapy and Speech Therapy Combined with Rehabilitation Therapy	30	30
OTHER SERVICES AND SUPPLIES		
Covered Clinical Trials	Same as any other Covered Sickness	
Diabetic Services and Supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Durable Medical Equipment Pre-Certification Required	$25 Copayment per device after Deductible then the plan pays 90% of the Negotiated Charge for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Enteral Formulas and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infertility Treatment Benefit Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Fertility Preservation Benefit Pre-Certification Required	Same as any other Covered Sickness	
Maternity Benefit	Same as any other Covered Sickness	
Prosthetic and Orthotic Devices Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Non-emergency Care While Traveling Outside of the United States	50% of Actual Charge after Deductible for Covered Medical Expenses Subject to $10,000 maximum per Policy Year	

Medical Evacuation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $50,000 maximum per Policy Year
Repatriation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $25,000 maximum per Policy Year
DENTAL BENEFITS	
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)	See the Dental Care Schedule of Benefits below and Pediatric Dental Care Benefit description for further information.
Type A Services: Diagnostic and Preventive Dental Care Preventive Dental Care Limited to 2 dental exams every 12 months The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care:	100% of Usual and Customary Charge for Covered Medical Expenses
Type B Services: Basic Restorative Care	80% of Usual and Customary Charge for Covered Medical Expenses
Type C Services: Major Restorative Care	50% of Usual and Customary Charge for Covered Medical Expenses
Medically Necessary Orthodontic Care	50% of Usual and Customary Charge for Covered Medical Expenses
Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	Deductible Waived

Dental Care Schedule of Benefits

Type A Services: Diagnostic and Preventive Dental Care

- D0120 - Periodic oral exam
- D0140 - Limited oral evaluation - problem focused
- D0145 – Oral evaluation – child under 3
- D0150 - Comprehensive oral exam
- D0160 - Detailed and extensive oral evaluation - by report
- D0170 - Reevaluation - limited, problem focused
- D0180 - Comprehensive periodontal evaluation
- D0210 - Complete full mouth images
- D0220 - Periapical - first image
- D0230 – Periapical – each additional image
- D0240 - Occlusal film

- D0260 - Extraoral - each additional radiographic image
- D0270 – Bitewing – single image
- D0272 - Bitewing - two images
- D0273 - Bitewing – three images
- D0274 - Bitewing - four images
- D0277 - Vertical bitewings - 7 to 8 images
- D0290 - Posterior - anterior or lateral skull and facial bone survey radiographic image
- D0310 - Sialography
- D0320 - TMJ arthrogram, including injection
- D0322 - Tomographic survey
- D0330 - Panoramic image (once in a 36-month period per provider)
- D0340 - 2D cephalometric radiographic image – acquisition, measurement and analysis
- D0350 - 2D oral/facial photographic image obtained intra-orally or extra-orally
- D0502 – Other oral pathology procedures, by report
- D0601 - Caries risk assessment (CRA) and documentation, with a finding of low risk
- D0602 - Caries risk assessment (CRA) and documentation, with a finding of moderate risk
- D0603 - Caries risk assessment (CRA) and documentation, with a finding of high risk
- D0999 - Unspecified diagnostic procedure, by report
- D1110 - Prophylaxis - adult (2 per year)
- D1120 - Prophylaxis - child (2 per year)
- D1206 - Topical fluoride varnish (2 per year)
- D1208 - Topical application of fluoride - excluding varnish (2 per year)
- D1351 - Sealant - per tooth (for 1st, 2nd & 3rd, permanent molars - no limit)
- D1352 - Preventive resin restoration - permanent (for 1st, 2nd & 3rd, permanent molars - no limit)
- D1353 – Sealant repair – per tooth
- D1354 - Interim caries arresting medicament application (for 1st, 2nd & 3rd, permanent molars - no limit)
- D1510 – Space maintainer – fixed – unilateral
- D1515 - Space maintainer - fixed - bilateral
- D1520 - Space maintainer - removable - unilateral
- D1525 - Space maintainer - removable - bilateral
- D1550 - Re-cementation of space maintainer
- D1555 - Removal of fixed space maintainer
- D1575 - Distal shoe space maintainer – fixed – unilateral
- D2990 - Resin infiltration of lesion (once per tooth every 3 years, permanent molars only)
- D4346 - Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation
- D9110 - Palliative treatment of dental pain, minor

Type B Services: Basic Restorative Care

- D0250 - Extra-oral – 2D projection radiographic image
- D0251 - Extra-oral posterior dental radiographic image
- D2140 - Amalgam - 1 surface
- D2150 - Amalgam - 2 surfaces
- D2160 - Amalgam - 3 surfaces
- D2161 - Amalgam - 4 or more surfaces
- D2330 - Resin - 1 surface - anterior
- D2331 - Resin - 2 surfaces - anterior
- D2332 - Resin - 3 surfaces - anterior

- D2335 - Resin - 4 or more surfaces - anterior
- D2390 - Resin - based composite crown, anterior
- D2391 - Resin one surface - posterior D2392 Resin - two surfaces - posterior
- D2393 - Resin - three surfaces - posterior
- D2394 - Resin - four or more surfaces - posterior
- D2910 - Recement or re-bond inlay, onlay, veneer or partial coverage restoration
- D2915 - Recement or re-bond indirectly fabricated or prefabricated post and core
- D2920 - Recement crown
- D2921 - Reattachment of tooth fragment, incisal edge or cusp
- D2929 - Prefabricated porcelain/ceramic crown - primary tooth
- D2930 - Stainless steel crown - primary
- D2931 - Stainless steel crown - permanent
- D2932 - Prefabricated resin crown
- D2933 - Stainless steel crown with resin window
- D2934 - Prefabricated stainless crown - primary tooth
- D2940 - Protective restoration
- D2941 - Interim therapeutic restoration – primary dentition
- D2951 - Pin retention - per tooth in addition to restoration
- D2970 - Temporary crown (fractured tooth)
- D2999 - Unspecified restorative procedure, by report
- D3110 - Pulp cap - direct
- D3120 - Pulp cap - indirect
- D3220 - Pulpotomy (therapeutic)
- D3221 - Gross pulpal debridement primary and permanent
- D3222 - Partial pulpotomy for apexogenesis
- D3230 - Pulpal therapy - anterior primary tooth
- D3240 - Pulpal therapy - posterior primary tooth
- D3310 - Root canal - anterior excluding final restoration
- D3320 - Root canal - bicuspid excluding final restoration
- D3331 - Treatment of root canal obstruct-non surgical access
- D3332 - Incomplete endodontic therapy inoperable or fractured tooth
- D3333 - Internal root repair of perforation defects
- D3346 - Retreatment-root canal treatment - anterior
- D3347 - Retreatment-root canal treatment - bicuspid
- D3351 - Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
- D3352 - Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
- D3353 - Apexification/recalcification - final
- D3355 - Pulpal regeneration - initial visit
- D3356 - Pulpal regeneration – interim medication replacement
- D3357 - Pulpal regeneration – completion of treatment
- D3410 - Apicoectomy - anterior
- D3421 - Apicoectomy- bicuspid (first root)
- D3425 - Apicoectomy- molar (first root)
- D3426 - Apicoectomy- each additional root
- D3427 - Peri-radicular surgery without apicoectomy
- D3430 - Retrograde filling - per root

- D3450 - Root amputation - per root
- D3920 - Hemi-section - not including root canal therapy
- D4210 - Gingivectomy/gingivoplasty, 4+ teeth (1 per quadrant/tooth every 3 years)
- D4211 - Gingivectomy/gingivoplasty, 1 To 3 teeth (1 per quadrant/tooth every 3 years)
- D4212 - Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth (1 per quadrant/tooth every 3 years)
- D4240 - Gingival flap –with root planing, 4 or more contiguous teeth (1 per quadrant/tooth every 3 years)
- D4241 - Gingival flap - includes root planing, 1-3 teeth (1 per quadrant/tooth every 3 years)
- D4245 - Apically positioned flap
- D4268 - Surgical revision procedure per tooth
- D4341 - Periodontal scaling and root planing, 4 or more teeth per quadrant (1 per quadrant every 2 rolling years)
- D4342 - Periodontal scaling and root planing, 1-3 teeth (1 per separate quadrant every 2 rolling years)
- D4910 - Periodontal maintenance - procedures (2 per calendar year following active periodontal treatment)
- D4920 - Unscheduled dressing change (by someone other than treating dentist or their staff)
- D4999 - Unspecified periodontal procedure, by report
- D5731 - Reline complete mandibular denture (chairside)
- D5740 – Reline maxillary partial denture (chairside)
- D5860 - Overdenture – complete, by report
- D6053 - Implant/Abutment supported removable denture for completely edentulous arch By Report
- D6054 - Implant/Abutment supported removable denture for partially edentulous arch By Report
- D6078 - Implant/Abutment supported fixed denture for completely edentulous arch By Report
- D6079 - Implant/Abutment supported fixed denture for partially edentulous arch By Report
- D6092 - Recement implant/abutment supported crown
- D6093 - Recement implant/abutment supported partial
- D6930 - Recement or re-bond fixed partial denture retainers
- D7111 - Extract coronal remnants - deciduous tooth
- D7140 - Extraction - erupted tooth or exposed root
- D7210 - Surgical removal of erupted tooth
- D7220 - Removal of impacted tooth - soft tissue
- D7250 - Surgical removal of residual tooth roots
- D7260 - Oroantral fistula closure
- D7261 - Primary closure of a sinus perforation
- D7270 - Tooth re-implantation of accidental displaced tooth
- D7272 - Tooth transplantation
- D7280 - Surgical access of unerupted tooth
- D7282 - Mobilization of erupted or malpositioned tooth to aid eruption
- D7283 - Device to aid eruption of impacted tooth
- D7285 - Incisional biopsy of oral tissue-hard (bone/tooth)
- D7286 - Incisional biopsy of oral tissue-soft
- D7310 - Alveoloplasty in conjunction with extraction
- D7311 - Alveoloplasty in conjunction with extraction, 1-3 teeth
- D7320 - Alveoloplasty not in conjunction with extraction
- D7321 - Alveoloplasty not in conjunction with/extraction, 1-3 teeth
- D7450 - Removal of odontogenic cyst/tumor up to 1.25 cm
- D7451 - Removal of odontogenic cyst/tumor greater than 1.25 cm
- D7471 – Removal of lateral exostosis (maxilla or mandible)
- D7472 - Removal of torus palatinus
- D7473 - Removal of torus mandibularis

- D7485 - Surgical reduction of osseous tuberosity
- D7510 - Incision and drainage of abscess intraoral
- D7511 - Incision and drainage of abscess - intraoral soft tissue, complex
- D7520 - Incision and drainage of abscess - extraoral, soft tissue
- D7521 - Incision and drainage- extraoral complex
- D7530 - Removal foreign body, mucosa, skin, tissue
- D7540 - Removal of reaction producing foreign body
- D7550 - Partial ostectomy/sequestrectomy
- D7910 - Suture of recent small wound less than 5 cm
- D7960 - Frenectomy
- D7963 - Frenuloplasty
- D7970 - Excision of hyperplastic tissue - per arch
- D7971 - Excision of pericoronal gingiva
- D7972 - Surgical reduction of fibrous tuberosity
- D7999 - Unspecified oral surgery procedure
- D9410 - House call
- D9430 - Office visit for observation (during regular hours)
- D9440 - Office visit after hours
- D9930 - Treatment of complications post-surgical
- D9950 - Occlusion analysis
- D9951 - Occlusal adjustment - limited
- D9952 - Occlusal adjustment - complete
- D3999 - Unspecified endodontic procedure, by report
- D7911 - Complicated suture - up to 5 cm
- D7912 - Complicated suture - greater than 5 cm

Type C Services: Major Restorative Care

- D2510 - Inlay - metallic - 1 surface (1 per tooth every 5 years)
- D2520 - Inlay - metallic - 2 surfaces (1 per tooth every 5 years)
- D2530 - Inlay - metallic - 3 or more surfaces (1 per tooth every 5 years)
- D2542 - Onlay - metallic - 2 surfaces (1 per tooth every 5 years)
- D2543 - Onlay - metallic - 3 surfaces (1 per tooth every 5 years)
- D2544 - Onlay - metallic - 4 or more surfaces (1 per tooth every 5 years)
- D2610 - Inlay - porcelain/ceramic - 1 surface (1 per tooth every 5 years)
- D2620 - Inlay - porcelain/ceramic - 2 surfaces (1 per tooth every 5 years)
- D2630 - Inlay - porcelain/ceramic - 3 or more surfaces (1 per tooth every 5 years)
- D2642 - Onlay - porcelain/ceramic - 2 surfaces (1 per tooth every 5 years)
- D2643 - Onlay - porcelain/ceramic - 3 surfaces (1 per tooth every 5 years)
- D2644 - Onlay - porcelain/ceramic - in addition to inlay (1 per tooth every 5 years)
- D2650 - Inlay - composite/resin - 1 surface (1 per tooth every 5 years)
- D2651 - Inlay - composite/resin - 2 surfaces (1 per tooth every 5 years)
- D2652 - Inlay - composite/resin - 3 surfaces (1 per tooth every 5 years)
- D2662 - Onlay - composite/resin - 2 surfaces (1 per tooth every 5 years)
- D2663 - Onlay - composite/resin - 3 surface (1 per tooth every 5 years)
- D2664 - Onlay - composite/resin - 4 or more surfaces (1 per tooth every 5 years)
- D2710 - Crown - resin-based composite, indirect (1 per tooth every 5 years)
- D2712 - Crown – 3/4 resin-based composite, indirect (1 per tooth every 5 years)
- D2720 - Crown - resin with high noble metal (1 per tooth every 5 years)

- D2721 - Crown - resin with predominantly base metal (1 per tooth every 5 years)
- D2722 - Crown - resin with noble metal (1 per tooth every 5 years)
- D2740 - Crown - porcelain/ceramic substrate (1 per tooth every 5 years)
- D2750 - Crown - porcelain fused high noble metal (1 per tooth every 5 years)
- D2751 - Crown - porcelain fused predominantly base metal (1 per tooth every 5 years)
- D2752 - Crown - porcelain fused to noble metal (1 per tooth every 5 years)
- D2780 - Crown - 3/4 cast high noble metal (1 per tooth every 5 years)
- D2781 - Crown - 3/4 cast predominantly base metal (1 per tooth every 5 years)
- D2782 - Crown - 3/4 cast noble metal (1 per tooth every 5 years)
- D2783 - Crown - 3/4 porcelain/ceramic (1 per tooth every 5 years)
- D2790 - Crown - full cast high noble metal (1 per tooth every 5 years)
- D2791 - Crown - full cast predominantly based metal (1 per tooth every 5 years)
- D2792 - Crown - full cast noble metal (1 per tooth every 5 years)
- D2794 - Crown - titanium (1 per tooth every 5 years)
- D2950 - Core buildup, including any pins when required
- D2952 - Cast post and core in addition to crown
- D2953 - Cast post - each Additional - same tooth
- D2954 - Prefab post and core in addition to crown
- D2957 - Prefabricated post - each add - same tooth
- D2960 - Labial veneer – chairside (1 per tooth every 5 years)
- D2961 - Labial veneer -lab (1 per tooth every 5 years)
- D2962 - Labial veneer porcelain – lab (1 per tooth every 5 years)
- D2971 - Additional procedures - new crown under partial
- D2980 - Crown repair
- D2981 - Inlay repair - material failure
- D2982 - Onlay repair - material failure
- D2983 - Veneer repair - material failure
- D3330 - Root canal treatment - molar excluding final restoration
- D3348 - Retreatment - root canal treatment - molar
- D4249- - Clinical crown lengthening hard tissue
- D4260 - Osseous surgery, including elevation of a full thickness flap and closure – four or more contiguous teeth or tooth bounded spaces per quadrant (1 per quadrant/tooth every 3 years)
- D4261 - Osseous surgery, including elevation of a full thickness flap and closure – 1 to 3 contiguous teeth or tooth bounded spaces per quadrant (1 per quadrant/tooth every 3 years)
- D4270 - Pedicle soft tissue graft procedure
- D4273 - Connective tissue graft procedures, including donor and recipient surgical sites - first tooth, implant, or edentulous tooth position in graft
- D4275 - Non-autogenous connective tissue graft, including recipient site and donor material - first tooth, implant, or edentulous tooth position in graft
- D4276 - Connective tissue/pedicle graft - tooth
- D4277 - Free soft tissue graft procedure, including recipient and donor surgical site - first tooth, implant, or edentulous tooth position in graft
- D4278 - Free soft tissue graft procedure, including recipient and donor surgical sites - each additional contiguous tooth, implant or edentulous tooth position in same graft site
- D4283 - Autogenous connective tissue graft procedure, including donor and recipient surgical sites – each additional contiguous tooth, implant or edentulous tooth position in same graft site
- D4285 - Non-autogenous connective tissue graft procedure, including recipient surgical site and donor material – each additional contiguous tooth, implant or edentulous tooth position in same graft site

- D4355 - Full mouth debridement (1 per lifetime)
- D5110 - Complete denture - maxillary (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5120 - Complete denture - mandibular (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5130 - Immediate denture – maxillary (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5140 - Immediate denture – mandibular (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5211 - Maxillary partial denture - resin base (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5212 - Mandibular partial denture - resin base (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5213 - Maxillary partial denture - cast base (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5214 - Mandibular partial denture cast base (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5221 - Immediate maxillary partial denture – resin base, including any conventional clasps, rests and teeth (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5222 - Immediate mandibular partial denture – resin base, including any conventional clasps, rests and teeth (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5223 - Immediate maxillary partial denture – cast metal framework with resin denture bases, including any conventional clasps, rests and teeth. Includes limited follow-up care only; does not include future rebasing (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5224 - Immediate mandibular partial denture – cast metal framework with resin denture bases, including any conventional clasps, rests and teeth (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5225 - Maxillary partial denture – flexible base (1 every 5 years)
- D5226 - Mandibular partial denture – flexible base (1 every 5 years)
- D5281 - Removable unilateral partial denture (1 every 5 years)
- D5410 - Adjustments maxillary complete denture (not eligible within 6 months of denture placement, then no limit)
- D5411 - Adjustments mandibular complete denture (not eligible within 6 months of denture placement, then no limit)
- D5421 - Adjustments partial denture - maxillary (not eligible within 6 months of denture placement, then no limit)
- D5422 - Adjustments partial denture - mandibular (not eligible within 6 months of denture placement, then no limit)
- D5510 - Repair broken complete denture base
- D5520 - Replace missing or broken teeth, complete denture
- D5610 - Repair resin denture base
- D5620 - Repair cast framework
- D5630 - Repair or replace broken clasp – per tooth
- D5640 - Replace broken teeth - per tooth
- D5650 - Add tooth to existing partial denture
- D5660 - Add clasp to existing partial denture – per tooth
- D5670 - Replace all teeth - upper partial
- D5671 - Replace all teeth - lower partial
- D5710 - Rebase complete maxillary denture (not eligible within 6 months of denture placement, then no limit)

- D5711 - Rebase complete mandibular denture (not eligible within 6 months of denture placement, then no limit)
- D5720 - Rebase partial maxillary denture (not eligible within 6 months of denture placement, then no limit)
- D5721 - Rebase partial mandibular denture (not eligible within 6 months of denture placement, then no limit)
- D5730 - Reline complete maxillary denture, chairside (not eligible within 6 months of denture placement, then no limit)
- D5731 - Reline complete mandibular denture, chairside (not eligible within 6 months of denture placement, then no limit)
- D5740 - Reline complete maxillary denture, chairside (not eligible within 6 months of denture placement, then no limit)
- D5741 - Reline complete mandibular partial denture, chairside (not eligible within 6 months of denture placement, then no limit)
- D5750 - Reline complete maxillary denture, laboratory (not eligible within 6 months of denture placement, then no limit)
- D5751 - Reline complete mandibular denture, laboratory (not eligible within 6 months of denture placement, then no limit)
- D5760 - Reline maxillary partial denture, laboratory (not eligible within 6 months of denture placement, then no limit)
- D5761 - Reline mandibular partial denture, laboratory (not eligible within 6 months of denture placement, then no limit)
- D5761 - Reline mandibular partial denture, laboratory (not eligible within 6 months of denture placement, then no limit)
- D5820 - Interim partial denture - upper (maxillary)
- D5821 - Interim partial denture - lower (mandibular)
- D5850 - Tissue conditioning, upper
- D5851 - Tissue conditioning, lower
- D5863 - Overdenture – complete maxillary (1 every 5 years)
- D5864 - Overdenture - partial maxillary (1 every 5 years)
- D5865 - Overdenture -complete mandibular (1 every 5 years)
- D5866 - Overdenture – partial mandibular (1 every 5 years)
- D6010 - Surgical placement of implant body endosteal implant
- D6013 - Surgical placement of mini implant
- D6040 - Surgical placement eposteal implant
- D6050 - Surgical placement transosteal implant
- D6055 - Dental implant supported connecting bar
- D6056 - Prefabricated abutment
- D6057 - Custom abutment
- D6058 - Abutment supported porcelain/ceramic crown (1 every 5 years)
- D6059 - Abutment supported porcelain fused metal crown high (1 every 5 years)
- D6060 - Abutment supported porcelain fused metal crown base (1 every 5 years)
- D6061 - Abutment supported porcelain fused metal crown noble (1 every 5 years)
- D6062 - Abutment supported cast metal crown high noble (1 every 5 years)
- D6063 - Abutment supported cast metal crown base noble (1 every 5 years)
- D6064 - Abutment supported cast metal crown noble metal (1 every 5 years)
- D6065 - Implant supported porcelain/ceramic crown (1 every 5 years)
- D6066 - Implant supported porcelain fused metal crown high (1 every 5 years)
- D6067 - Implant supported metal crown high (1 every 5 years)
- D6068 - Abutment supported retainer for porcelain/ceramic (1 every 5 years)
- D6069 - Abutment supported retainer for porcelain fused metal high (1 every 5 years)

- D6070 - Abutment supported retainer for porcelain fused metal base (1 every 5 years)
- D6071 - Abutment supported retained for porcelain fused metal noble (1 every 5 years)
- D6072 - Abutment supported retained for cast metal full partial denture high (1 every 5 years)
- D6073 - Abutment supported retainer for cast metal full partial denture base (1 every 5 years)
- D6074 - Abutment supported retainer for cast metal full partial denture noble (1 every 5 years)
- D6075 - Implant supported retainer for ceramic full partial denture (1 every 5 years)
- D6076 - Implant supported retainer for porcelain fused metal high noble metal (1 every 5 years)
- D6077 - Implant supported retainer for cast metal high (1 every 5 years)
- D6080 - Implant maintenance procedures, when prostheses are removed and reinserted, including cleansing of prosthesis and abutments
- D6090 - Repair implant supported prosthesis
- D6091 - Replace precision attachment
- D6094 - Abutment supported crown – titanium (1 every 5 years)
- D6095 - Repair implant abutment prosthesis (1 every 5 years)
- D6100 - Implant removal, by report (1 every 5 years)
- D6110 - Implant/abutment supported removable denture for completely edentulous arch – maxillary (1 every 5 years)
- D6111 - Implant/abutment supported removable denture for completely edentulous arch – mandibular (1 every 5 years)
- D6112 - Implant/abutment supported removable denture for partially edentulous arch – maxillary (1 every 5 years)
- D6113 - Implant/abutment supported removable denture for partially edentulous arch – mandibular (1 every 5 years)
- D6114 - Implant/abutment supported fixed denture for completely edentulous arch – maxillary (1 every 5 years)
- D6115 - Implant/abutment supported fixed denture for completely edentulous arch – mandibular (1 every 5 years)
- D6116 - Implant/abutment supported fixed denture for partially edentulous arch – maxillary (1 every 5 years)
- D6117 - Implant/abutment supported fixed denture for partially edentulous arch – mandibular (1 every 5 years)
- D6194 - Abutment supported retainer crown for full partial denture (1 every 5 years)
- D6199 - Unspecified implant procedure, by report
- D6205 - Pontic - indirect resin based composite (1 every 5 years)
- D6210 - Pontic - cast high noble metal (1 every 5 years)
- D6211 - Pontic - cast predominantly base metal (1 every 5 years)
- D6212 - Pontic - cast noble metal (1 every 5 years)
- D6214 - Pontic – titanium (1 every 5 years)
- D6240 - Pontic - porcelain fused to high noble (1 every 5 years)
- D6241 - Pontic - porcelain fused to base metal (1 every 5 years)
- D6242 - Pontic - porcelain fused to noble metal (1 every 5 years)
- D6245 - Pontic - porcelain/ceramic (1 every 5 years)
- D6250 - Pontic - resin with high noble metal (1 every 5 years)
- D6251 - Pontic - resin with predominantly base metal (1 every 5 years)
- D6252 - Pontic - resin with noble metal (1 every 5 years)
- D6545 - Retainer - cast metal for resin bonded for fixed prosthesis (1 every 5 years)
- D6548 - Retainer - porcelain/ceramic resin bonded for fixed prosthesis (1 every 5 years)
- D6600 - Inlay – porcelain/ceramic, 2 surfaces (1 every 5 years)
- D6601 - Inlay – porcelain/ceramic, 3 or more surfaces (1 every 5 years)
- D6602 - Inlay - cast high noble metal, 2 surfaces major (1 every 5 years)
- D6603 - Inlay - cast high noble metal, 3 or more surfaces (1 every 5 years)
- D6604 - Inlay - cast predominately base metal 2 surfaces (1 every 5 years)

- D6605 - Inlay - cast predominately base metal 3 or more surfaces (1 every 5 years)D6606 Inlay - cast noble metal, 2 surfaces (1 every 5 years)
- D6607 - Retainer inlay - cast noble metal, three or more surfaces (1 every 5 years)
- D6608 - Retainer onlay - porcelain/ceramic, 2 surfaces (1 every 5 years)
- D6609 - Retainer onlay - porcelain/ceramic, 3 or more surfaces (1 every 5 years)
- D6610 - Retainer onlay - cast high noble metal, 2 surfaces (1 every 5 years)
- D6611 - Retainer onlay - cast high noble metal, 2 or more surfaces (1 every 5 years)
- D6612 - Retainer onlay - cast predominantly base metal, 2 surfaces (1 every 5 years)
- D6613 - Retainer onlay -cast predominantly base metal, 3 or more surfaces (1 every 5 years)
- D6614 - Retainer onlay - cast noble metal, 2 surfaces (1 every 5 years)
- D6615 - Retainer onlay - cast noble metal, 3 or more surfaces (1 every 5 years)
- D6624 - Retainer inlay – titanium (1 every 5 years)
- D6634 - Retainer onlay - titanium (1 every 5 years)
- D6710 - Retainer crown - indirect resin based composite (1 every 5 years)
- D6720 - Retainer crown - resin with high noble metal (1 every 5 years)
- D6721 - Retainer crown - resin with predominantly base metal (1 every 5 years)
- D6722 - Retainer crown - resin with noble metal (1 every 5 years)
- D6740 - Retainer crown - porcelain/ceramic (1 every 5 years)
- D6750 - Retainer crown - porcelain fused to high noble metal (1 every 5 years)
- D6751 - Retainer crown - porcelain fused to predominantly base metal (1 every 5 years)
- D6752 - Retainer crown - porcelain fused to noble metal (1 every 5 years)
- D6780 - Retainer crown - 3/4 cast high noble metal (1 every 5 years)
- D6781 - Retainer crown - 3/4 cast predominantly base metal (1 every 5 years)
- D6782 - Retainer crown - 3/4 cast noble metal (1 every 5 years)
- D6783 - Retainer crown - 3/4 porcelain/ceramic (1 every 5 years)
- D6790 - Retainer crown - full cast high noble metal (1 every 5 years)
- D6791 - Retainer crown - full cast predominantly base metal (1 every 5 years)
- D6792 - Retainer crown - full cast noble metal (1 every 5 years)
- D6794 - Retainer crown – titanium (1 every 5 years)
- D6940 - Stress breaker
- D6980 - Fixed partial denture repair
- D6985 - Pediatric partial denture, fixed
- D6999 - Unspecified fixed prosthodontic procedure, by report
- D7230 - Removal of impacted tooth - partial bony
- D7240 - Removal of impacted tooth - full bony
- D7241 - Removal of impacted tooth - complication
- D7251 - Coronectomy
- D7290 - Surgical repositioning of teeth
- D7291 - Transseptal fiberotomy, by report
- D7340 - Vestibuloplasty - ridge extension (1 every 5 years)
- D7350 - Vestibuloplasty - ridge extension including soft tissue grafts (once per arch)
- D7410 - Excision of benign lesion up to 1.25 cm
- D7411 - Excision of benign lesion more than 1.25 cm
- D7412 - Excision of benign lesion, complicated
- D7413 - Excision of malignant lesion up to 1.25 cm
- D7414 - Excision of malignant lesion more than 1.25 cm
- D7415 - Excision of malignant lesion complicated
- D7440 - Excision of malignant lesion up to 1.25 cm

- D7441 - Excision of malignant lesion greater than 1.25 cm
- D7460 - Removal non-odontogenic cyst/tumor up to 1.25 cm
- D7461 - Removal nonodontogenic cyst/tumor greater than 1.25 cm
- D7465 - Destruction of lesion(s) by physical or chemical methods
- D7490 - Radical resection of maxilla/mandible with bone graft
- D7560 - Maxillary sinusotomy for removal of tooth
- D7610 - Maxilla - open reduction
- D7620 - Maxilla - closed reduction
- D7630 - Mandible- open reduction
- D7640 - Mandible- closed reduction
- D7650 - Malar and/or zygomatic arch - open reduction
- D7660 - Malar and/or zygomatic arch - closed reduction
- D7670 - Alveolus - closed reduction
- D7671 - Alveolus - open reduction
- D7680 - Facial bones complicated reduction
- D7710 - Maxilla - open reduction
- D7720 - Maxilla - closed reduction
- D7730 - Mandible - open reduction
- D7740 - Mandible - closed reduction
- D7750 - Malar and/or zygomatic arch - open
- D7760 - Malar and/or zygomatic arch - closed
- D7770 - Alveolus - open reduction stabilization of teeth
- D7771 - Alveolus - closed reduction stabilization of teeth
- D7780 - Facial bones - complicated reduction
- D7810 - Open reduction of dislocation
- D7820 - Closed reduction of dislocation
- D7830 - Manipulation under anesthesia
- D7840 - Condylectomy
- D7850 - Surgical discectomy, with/without implant
- D7852 - Disc repair
- D7854 - Synovectomy
- D7856 - Myotomy
- D7858 - Joint reconstruction
- D7860 - Arthrotomy
- D7865 - Arthroplasty
- D7870 - Arthrocentesis
- D7872 - Arthroscopy - diagnosis with/without biopsy
- D7873 - Arthroscopy - surgical lavage
- D7874 - Arthroscopy - surgical disc reposition
- D7875 - Arthroscopy - surgical synovectomy
- D7876 - Arthroscopy - surgical discectomy
- D7877 - Arthroscopy - surgical debridement
- D7880 - Occlusal orthotic device, by report
- D7899 - Unspecified temporomandibular joint dysfunctions (TMD) therapy, by report
- D7920 - Skin graft
- D7940 - Osteoplasty for orthognathic deformities
- D7941 - Osteotomy - mandibular rami
- D7943 - Osteotomy - ramus, opened with bone graft

- D7944 - Osteotomy - segmented or subapical
- D7945 - Osteotomy - body of mandible
- D7946 - LeFort I - (maxilla -total)
- D7947 - LeFort I - (maxilla - segmented)
- D7948 - LeFort II/III - osteoplasty of facial bones without graft
- D7949 - LeFort II/LLL - with bone graft
- D7950 - Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report
- D7951 - Sinus augmentation
- D7952 - Sinus augmentation - vertical approach
- D7955 - Repair of maxillofacial soft/hard tissue
- D7980 - Sialolithotomy
- D7981 - Excision of salivary gland, by report
- D7982 - Sialodochoplasty
- D7983 - Closure of salivary fistula
- D7990 - Emergency tracheotomy
- D7991 - Coronoidectomy
- D7995 - Synthetic graft
- D7997 - Appliance removal including removal of arch bar
- D8210 - Removable appliance therapy
- D8220 - Fixed or cemented appliance therapy
- D9120 - Partial denture sectioning
- D9210 - Local anesthesia not in conjunction with operative or surgical procedures
- D9211 - Regional block anesthesia
- D9212 - Trigeminal division block anesthesia
- D9215 - Local anesthesia in conjunction with operative or surgical procedures
- D9219 - Evaluation - deep sedation or general anesthesia
- D9223 - Deep sedation/general anesthesia – each 15 minute increment
- D9230 - Analgesia
- D9243 - Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment
- D9248 - Non-intravenous conscious sedation (includes non-Iv minimal and moderate sedation)
- D9420 - Hospital or ambulatory surgical center
- D9610 - Therapeutic drug injection
- D9612 - Therapeutic parenteral drugs
- D9910 - Application of desensitizing medication
- D9932 - Cleaning and inspection of removable complete denture, maxillary
- D9933 - Cleaning and inspection of removable complete denture, mandibular
- D9934 - Cleaning and inspection of removable partial denture, maxillary
- D9935 - Cleaning and inspection of removable partial denture, mandibular
- D9940 - Occlusal guards
- D9942 - Repair and/or reline of occlusal guard
- D9943 - Occlusal guard adjustment (not eligible within first 6 months after placement of appliance)
- D9999 - Unspecified adjunctive procedure, by report
- D5899 - Unspecified removable prosthodontic procedure, by report
- D5911 - Facial moulage - sectional, by report
- D5912 - Facial moulage - complete, by report
- D5913 - Nasal prosthesis, by report
- D5914 - Auricular prosthesis, by report

- D5915 - Orbital prosthesis, by report
- D5916 - Ocular prosthesis, by report
- D5919 - Facial prosthesis, by report
- D5922 - Nasal septal prosthesis, by report
- D5923 - Ocular prosthesis, interim, by report
- D5924 - Cranial prosthesis, by report
- D5925 - Facial augmentation implant prosthesis, by report
- D5926 - Nasal prosthesis, replacement, by report
- D5927 - Auricular prosthesis, replacement, by report
- D5928 - Orbital prosthesis, replacement, by report
- D5929 - Facial prosthesis, replacement, by report
- D5931 - Obturator prosthesis, surgical, by report
- D5932 - Obturator prosthesis, definitive, by report
- D5933 - Obturator prosthesis, modification, by report
- D5934 - Mandibular resection prosthesis with flange, by report
- D5935 - Mandibular resection prosthesis without flange, by report
- D5936 - Obturator prosthesis, interim, by report
- D5937 - Trismus appliance (not for TMJ), by report
- D5951 - Feeding aid, by report
- D5952 - Speech aid prosthesis, pediatric, by report
- D5953 - Speech aid prosthesis, adult, by report
- D5954 - Palatal augmentation prosthesis, by report
- D5955 - Palatal lift prosthesis, definitive, by report
- D5958 - Palatal lift prosthesis, interim, by report
- D5959 - Palatal lift prosthesis, modification, by report
- D5960 - Speech aid prosthesis, modification, by report
- D5982 - Surgical stent, by report
- D5983 - Radiation carrier, by report
- D5984 - Radiation shield, by report
- D5985 - Radiation cone locator, by report
- D5986 - Fluoride gel carrier, by report
- D5987 - Commissure splint, by report
- D5988 - Surgical splint, by report
- D5991 - Topical vesiculobullous disease medicament carrier, by report
- D5992 - Adjust maxillofacial prosthetic appliance, by report
- D5993 - Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report
- D5999 - Unspecified maxillofacial prosthesis, by report

Medically Necessary Orthodontic Care

- D0470 - Diagnostic casts
- D8010 - Limited orthodontic treatment of primary dentition
- D8020 - Limited orthodontic treatment - transitional dentition
- D8030 - Limited orthodontic treatment - adolescent dentition
- D8040 - Limited orthodontic treatment - adult dentition
- D8050 - Interceptive treatment - primary dentition
- D8060 - Interceptive treatment - transitional dentition
- D8070 - Comprehensive treatment - transitional dentition

• D8080 - Comprehensive treatment - adolescent dentition • D8090 - Comprehensive treatment - adult dentition • D8660 - Pre-orthodontic treatment examination to monitor growth and development • D8670 - Periodic orthodontic treatment visit • D8680 - Orthodontic retention • D8681 - Removable orthodontic retainer adjustment • D8691 - Repair of orthodontic appliance • D8693 - Re-bonding or recementing and/or repair, as required, of fixed retainers • D8694 - Repair of fixed retainers, includes reattachment • D8999 - Unspecified orthodontic treatment, by report • D8692 - Replacement of lost or broken retainer (once per arch)		
VISION BENEFITS		
Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19) Limited to 1 vision examination per Policy Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	See the Pediatric Vision Care Benefit description for further information. 100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived	
Adult Vision Care (age 19 and older) Routine Eye Examination once every 12 months Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions Lenses, frames, and contact lenses (including fittings) are not covered. No referral requirement	$25 Copayment per visit then the plan pays 100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived	
MISCELLANEOUS DENTAL SERVICES		
Accidental Injury Dental Treatment	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Sickness Dental Expense Benefit	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Treatment for Temporomandibular Joint (TMJ) Disorders	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Surgical Services Directly Affecting the Upper or Lower Jawbone Benefit	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dental Anesthesia	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
PRESCRIPTION DRUGS		
Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy. Your benefit is limited to a 30 day supply. Coverage for more than a 30 day supply only applies if the smallest package size exceeds a 30 day supply. See "Retail Pharmacy Supply Limits" section for more information. Maintenance Prescription Drugs are limited to a 90-day supply subject to 3 times the applicable cost share for retail drugs		
TIER 1 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$10 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 60 day supply filled at a Retail pharmacy	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
TIER 2 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$35 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered

More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$70 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 60 day supply filled at a Retail pharmacy	$105 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
TIER 3 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail Pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$100 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 60 day supply filled at a Retail pharmacy	$150 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
Specialty Prescription Drugs		
For each fill up to a 30 day supply.	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 30 day supply but less than a 61 day supply	$100 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 60 day supply	$150 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered

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.wellfleetrx.com/students 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.		
For each fill up to a 30 day supply.	75% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
Zero Cost Drugs		
	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
Orally administered anti-cancer Prescription Drugs (including Specialty Drugs)		
Benefit	Same as any other Prescription Drug. The total amount of Copayments and Coinsurance an Insured Person must pay will not exceed $250 for an individual prescription of up to a 30-day supply.	
Diabetic Supplies (for prescription supplies purchased at a pharmacy)		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill.	
MANDATED BENEFITS		
AIDS Vaccine	Same as any other Preventive Service	
Alzheimer's Disease Coverage	Same as any other Covered Sickness	
Diethylstilbestrol (DES) Coverage	Same as any other Covered Sickness	
Osteoporosis	Same as any other Covered Sickness, unless considered a Preventive Service	
Special Shoe Benefit	Same as any other Covered Sickness	
Emergency Department Medical Care and Follow-Up Health Care Treatment Following Rape or Sexual Assault (first 9 months after the Insured Person initiates Treatment)	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived
Pediatric Autoimmune Neuropsychiatric Disorders Benefit	Same as any other Covered Sickness	
Accidental Death and Dismemberment		
Principal Sum	$10,000	
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 (1) Accident. This benefit is payable in addition to any other benefits payable under this Certificate.		

Wellfleet Insurance Company
5814 Reed Road
Fort Wayne, IN 46835
877-657-5030

Notice of Availability of Language Assistance Services

Wellfleet Insurance Company does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Wellfleet Insurance Company:

- Provides free language assistance services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

- Provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified interpreters
  - Information in other formats

If you need these services, please contact Wellfleet Insurance Company.

If you believe Wellfleet Insurance Company has failed to provide these services or discriminated in another way, you can file a complaint with:

- c/o Wellfleet Group, LLC dba Wellfleet Administrators, LLC
  877-657-5030
  413-244-7761
  appeals@wellfleetinsurance.com

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, our appeals unit is available to help you.

You can also submit a complaint to the Department of Insurance for review:

- Electronically, through the Department of Insurance Consumer Complaint Center at https://cdiapps.insurance.ca.gov/CP/login/; or
- By printing a complaint form to mail to:
    - California Department of Insurance
      Consumer Services Division
      300 S. Spring Street
      Los Angeles, CA 90013
      Inside State Toll-Free: 1-800-927-4357
      Outside State: 1-213-897-8921
      Fax: 1-213-897-9641
      TDD: 1-800-482-4833

- The complaint form is available at http://www.insurance.ca.gov/01-consumers/101-help/upload/CSD002RFAHealth20151224_092616.pdf.

You can also file a discrimination complaint with the U.S. Department of Health and Human Services, Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex:

- Electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf; or
- By mail or phone at:
    - U.S. Department of Health and Human Services
      200 Independence Avenue, SW
      Room 509F, HHH Building
      Washington, D.C. 20201
      Phone: 1-800-368-1019
      TDD: 800-537-7697

- Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

Effective: August 01, 2019

This Notice of Privacy Practices (" Notice") applies to **Wellfleet Insurance Company** and **Wellfleet New York Insurance Company**'s (together, " w e", **"**us" or " our") insured health benefits plans. We are required to provide you with this Notice.

Personal Information is information that identifies you as an individual, such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage.

Protected Health Information (your "Health Information") is information that identifies you as related to your physical or mental health, your health care, or payment for your healthcare.

Our Responsibilities

We are required by law to maintain the privacy of the Health Information we hold and to provide you with this Notice and to follow the duties and privacy practices described in this Notice. We are required to abide by the terms of this Notice currently in effect.

We utilize administrative, technical, and physical safeguards to protect your information against unauthorized access and against threats and hazards to its security and integrity. We comply with all applicable state and federal rules pertaining to the security and confidentiality of your information.

We will promptly inform you if a breach has occurred that may have compromised the privacy or security of your Health Information.

Overview of this Notice

This Notice describes how certain information about you may be used and disclosed and how you can get access to this information. This Notice addresses three primary areas:

- An overview of Your Health Information. This section addresses how we collect your information, how we use it to run our business, and the reasons we share it.
- Your Rights. This section gives an overview of the rights you have with respect to your information we have in our records.
- How to Contact Us. In case you have any questions, requests, or even if you feel you need to make a complaint, we want to make sure you are in contact with the right person.

YOUR HEALTH INFORMATION

How We Acquire Your Information

In order to provide you with insurance coverage, we need Personal Information about you. We gather this information from a variety of sources including your employer, your health care provider, your school, other insurers, and third party administrators (TPAs). This information is necessary to properly administer your health plan benefits.

How We use Your Health Information

Below are some examples of how we use and disclose your Health Information. Broadly, we will use and disclose your Health Information for Treatment, Payment and Health Care Operations.

Treatment refers to the health care treatment you receive. We do not provide treatment, but we may disclose certain information to doctors, dentists, pharmacies, hospitals, and other health care providers who will take care of you. For example, a doctor may send us information about your diagnosis and treatment so we can develop a health care plan and arrange additional services.

Payment refers to activities involving the collection of premiums, payment of claims, and determining covered services. For example, we may review your Health Information to determine if a particular treatment is medically necessary and what that payment for the services should be.

Health Care Operations refers to the business functions necessary for us to operate, such as audits, complaints responses and quality assurance activities. For example, we would use your Health Information (but not genetic information) for underwriting and calculating rates, or we may use your Health Information to detect and investigate fraud.

Additionally:

- We may **confirm enrollment** in the health plan with the appropriate party.
- If you are a **dependent** of someone on the plan, we may disclose certain information to the plan's subscriber, such as an explanation of benefits for a service you may have received.
- We may share enrollment information, payment information, or other Health Information in order to coordinate treatment or other services you may need.

We may disclose your information when instructed to do so, including:

- **Health oversight activities** may require that we disclose your information to governmental, licensing, auditing and accrediting agencies;
- **Legal proceedings** may require disclosure of your Health Information in response to a court order or administrative order, or in response to a subpoena, discovery request, warrant, summons, or other valid process;
- **Law enforcement activities** might require disclosure of certain Health Information to local, state or federal law enforcement, so long as the release is authorized or required by law;
- **As required by law** or to avert a serious threat to safety or health; and,
- To **certain government agencies**, such as the Department of health and Human Services or the Office of Civil Rights if they are conducting an investigation or audit.

Authorizations

Occasionally we may receive a request to share your information in a manner outside of how we normally use your Health Information, as described above. In those cases, we will ask you for your authorization before we share your Health Information.

YOUR RIGHTS

You have the **right to request restrictions** on certain uses and disclosures of your Health Information, including the uses and disclosures listed in this Notice and disclosures permitted by law. You also have the **right to request that we communicate with you in certain ways**.

- We will accommodate reasonable requests;
- We are not required to agree to a request to restrict a disclosure unless you have paid for the cost of the health care item or service in full (i.e., the entire sum for the procedure performed) and disclosure is not otherwise required by law; and,
- If you are a minor, depending on the state you reside in, you may have the right in certain circumstances to block parental access to your Health Information. For example, a minor may have the rights of an adult with respect to diagnosis and care of conditions such as STDs, drug dependency, and pregnancy.

You have the **right to inspect and copy your Health Information** in our records. Please note that there are exceptions to this, such as:

- Psychotherapy notes;
- Information complied in reasonable anticipation, or for use in, a civil, criminal or administrative action or proceeding;
- Health Information that is subject to a law prohibiting access to that information; or,
- If the Health Information was obtained from someone other than us under a promise of confidentiality and the access request would be reasonably likely to reveal the source of the information.

We may deny your request to inspect and copy your Health Information if:

- A licensed health care professional has determined your requested access is reasonably likely to endanger your life or physical safety of another;
- The Health Information makes reference to another person and a licensed health care professional has determined that access requested is reasonably likely to cause substantial harm to another; or,
- A licensed health care professional has determined that access requested by your personal representative is likely to cause substantial harm to you or another person.

You have the **right to request an amendment** to your Health Information if you believe the information we have on file is incomplete or inaccurate. Your request must be in writing and must include the reason for the request. If we deny your request, you may file a written statement of disagreement.

You have the right to know who we have provided your information to - - this is known as an **accounting of disclosures**. A request for an accounting of disclosures must be submitted in writing to the address below. The accounting will not include disclosures made for treatment, payment, health care operations, for law enforcement purposes, or as otherwise permitted or required by law. If you request an accounting of disclosures more than once in a twelve (12) month period we may charge a reasonable fee to process, compile and deliver the information to you this second time.

You have a **right to receive a paper copy of this Notice**. Simply call the customer service line indicated on your ID card and request a paper copy be mailed to you. You may also submit a written request to us at the address below.

You will receive a notice of a breach of your Health Information. You have the **right to be notified of a breach** of unsecure Health Information.

Finally, you have the **right to file a complaint** if you feel your privacy rights were violated. You may also file a complaint with the Secretary of Health and Human Services.

CONTACT

For all inquiries, requests and complaints, please contact:

Privacy and Security Officer
Wellfleet Insurance Company/
Wellfleet New York Insurance Company
c/o Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369

In California
c/o Wellfleet Group, LLC
dba Wellfleet Administrators, LLC
PO Box 15369
Springfield, MA 01115-5369

This Notice is Subject to Change

We may change the terms of this notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of your Health Information we maintain, as well as any information we may receive or maintain in the future.

Please note that we do not destroy your Health Information when you terminate your coverage with us. It may be necessary to use and disclose this information for the purposes described above even after our coverage terminates, although policies and procedures will remain in place to protect against inappropriate use and disclosure.

Gramm-Leach-Bliley ("GLB") Privacy Notice

We understand your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of *nonpublic personal information* ("NPI"). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

COLLECTING YOUR INFORMATION

We collect NPI about our customers to provide them with insurance products and services. This may include your name, Social Security number, telephone number, address, date of birth, gender, work/school enrollment history, and health history. We may receive NPI from your completing the following forms:

- Claims forms
- Enrollment forms
- Beneficiary designation/Assignment forms
- Any other forms necessary to effectuate coverage, administer coverage, or administer and pay your claims

We also collect information from others that is necessary for us to properly process a claim, underwrite coverage, or to otherwise complete a transaction requested by a customer, policyholder or contract holder.

SHARING YOUR INFORMATION

We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization such as a policyholder's or contract holder's broker, a third-party administrator, reinsurer, employer, school, or plan sponsor. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

HEALTH INFORMATION

We will not share any of your protected health information ("PHI") unless allowed by law, and/or you have provided us with the appropriate authorization. Additional information on how we protect your PHI can be found in the Notice of Privacy Practices.

SAFEGUARDING YOUR INFORMATION

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees or authorized individuals who need to know the NPI to provide insurance products or services to you. Our employees are continually trained on how to keep information safe.

ACCESSING YOUR INFORMATION

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our processing costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTING YOUR INFORMATION

If you believe the NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two (2) years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two (2) years.

CONTACTING US

If there are any questions concerning this notice, please feel free to write us at:

Privacy and Security Officer
Wellfleet Insurance Company
c/o Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369

In California
c/o Wellfleet Group, LLC
dba Wellfleet Administrators, LLC
PO Box 15369
Springfield, MA 01115-5369

NOTICE OF NON-DISCRIMINATION AND ACCESSIBIILITY REQUIREMENTS

The Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Company does not exclude people or treat them worse because of their race, color, national origin, age, disability, or sex.

The Company provides free aids and services to people with disabilities to communicate effectively with us, such as:

1. Qualified sign language interpreters
2. Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose first language is not English when needed to communicate effectively with us, such as:

1. Interpreters
2. information translated into other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Wellfleet Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator,
PO Box 15369
Springfield, MA 01115-5369
(413) 733-4540
civilcoordinator@wellfleetinsurance.com

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
800-868-1019; 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ADVISORY NOTICE TO POLICYHOLDERS

U.S. TREASURY DEPARTMENT'S OFFICE OF FOREIGN ASSETS CONTROL ("OFAC")

No coverage is provided by this Policyholder Notice nor can it be construed to replace any provisions of your policy. You should read your policy and review your Declarations page for complete information on the coverages you are provided.

This Policyholder Notice provides information concerning possible impact on your insurance coverage due to the directives issued by OFAC and possibly by the U.S. Department of State. **Please read this Policyholder Notice carefully.**

OFAC of the U.S. Department of Treasury administers and enforces economic and trade sanctions policy on Presidential declarations of "National Emergency". OFAC has identified and listed numerous:

- Foreign agents;
- Front organizations;
- Terrorists;
- Terrorist organizations; and
- Narcotics traffickers

as *Specially Designated Nationals* and *Blocked Persons.* This list can be found on the U.S. Department of Treasury's website (www.treas.gov/ofac)

In accordance with OFAC regulations, or any applicable regulation promulgated by the U.S. Department of State, if it is determined that you or another insured, or any person or entity claiming the benefits of this insurance has violated U.S. sanctions law or is identified by OFAC as a *Specially Designated National* or *Blocked Person*, this insurance will be considered a blocked or frozen contract and all provisions of this insurance will be immediately subject to OFAC. When an insurance policy is considered to be such a blocked or frozen contract, neither payments nor premium refunds may be made without authorization from OFAC. Other limitations on the premiums and payments also apply.

Women's Health & Cancer Rights Act

If you have had or are going to have a Mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). If you are receiving Mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient for:

a. Reconstruction of the breast on which the Mastectomy was performed;
b. Reconstruction of the other breast to produce a symmetrical appearance;
c. Prosthesis;
d. Treatment of physical complications from all stages of Mastectomy, including lymphedemas.

Coverage will be subject to the same plan limitations, copays, deductible and coinsurance provisions that currently apply to Mastectomy coverage and will be provided in consultation with you and your attending physician.

LANGUAGE ASSISTANCE PROGRAM

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call (877) 657-5030.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al (877) 657-5030.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電：(877) 657-5030.

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi (877) 657-5030.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. (877) 657-5030번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa (877) 657-5030.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру (877) 657-5030.

هيبنت: اذإ تنكتدحتت **ةيبرعلا (Arabic)**، نإف تامدخ ةدعاسملا ةيوغللا ةيناجملا ةحاتم كل. ءاجرلا لاصتلاأ بـ 657-5030 (877).

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan (877) 657-5030.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le (877) 657-5030.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer (877) 657-5030.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para (877) 657-5030.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero (877) 657-5030.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie (877) 657-5030 an.

注意事項：日本語 **(Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。(877) 657-5030 にお電話ください。

ىسراف (Farsi) هجوت :امشن ابز رگا دشاب ىم امش رايتخا رد نگيار روط هب ىنابز دادما تامدخ ،تسا.
(877) 657-5030 تمسا بيگريد.

कृपया ध्या द□: य□द आप □**हंद**□ **(Hindi)** भाषी ह□ तो आपके □लए भाषा सहायता सेवाएं□न:शुल् उपलब् ह□। कृपया पर काल कर□ (877) 657-5030

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau (877) 657-5030.

ប្រយ័ត្ន៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ**(Khmer)** សេវាកម្មភាសាជំនួយឥតគិតថ្លៃមានសម្រាប់អ្នក។

សូមទូរស័ព្ទមកលេខ (877) 657-5030 ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti (877) 657-5030.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' (877) 657-5030 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac (877) 657-5030

ગુજરાતી (Gujarati) ચુ ના: જો તમે જરાતી બોલતા હો, તો ન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો (877) 657-5030

λληνικά (Greek)ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (877) 657-5030

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (877) 657-5030

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ(877) 657-5030

ਪੰਜਾਬੀ (Punjabi) ਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ (877) 657-5030

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ,
ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (877) 657-5030

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, an individual is covered by the Association if the insurer was a member of the Association and the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payee or assignees, whether or not they live in California.

Amounts of Coverage

The basic coverage protections provided by the Association are as follows.

Life Insurance, Annuities and Structured Settlement Annuities

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

Life Insurance

80% of death benefits but not to exceed $300,000
80% of cash surrender or withdrawal values but not to exceed $100,000

Annuities and Structured Settlement Annuities

80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not exceed $250,000

The maximum amount of protection provided by the Association to an individual, for all life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

Health Insurance

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance Guarantee Association	California Department of Insurance Consumer Communications Bureau
P.O Box 16860, Beverly Hills, CA 90209-3319	300 South Spring Street Los Angeles, CA 90013
(323) 782-0182	(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.