Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

WELLFLEET INSURANCE COMPANY

To get information or file a complaint with your insurance company or HMO:

Call: Wellfleet Group, LLC at
Toll-free: 877-657-5030
Online:
https://wellfleetstudent.com/contact/
Email: appeals@wellfleetinsurance.com
Mail: P.O. Box 15369
Springfield, MA 01115-5369

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

WELLFLEET INSURANCE COMPANY

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Wellfleet Group, LLC at al

Teléfono gratuito: 877-657-5030

En línea: https://wellfleetstudent.com/contact/
Correo electrónico: appeals@wellfleetinsurance.com
Dirección postal: P.O. Box 15369
Springfield, MA 01115-5369

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

STUDENT HEALTH CERTIFICATE OF COVERAGE

POLICYHOLDER:	University of St. Thomas International (Policyholder)
POLICY NUMBER:	WI2223TXSHIP16
POLICY EFFECTIVE DATE:	August 11, 2022
POLICY TERMINATION DATE:	August 10, 2023
STATE OF ISSUE:	Texas

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 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.

Term of the Certificate
This Certificate terminates 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
One Year Term Insurance

Andrew M. DiGiorgio, President **Angela Adams, Secretary**

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

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

Texas Department of Insurance Notice

You have the right to an adequate network of preferred providers (also known as "network providers). If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

You have the right, in most cases, to obtain estimates:

- from out-of-network providers of what they will charge for their services; and
- from your insurer of what it will pay for the services.

You may obtain a current directory of preferred providers at the following website: www.wellfleetstudent.com or by calling 877-657-5030 for assistance in finding available preferred providers.

If you are treated by a provider or facility that is not a preferred provider, you may be billed for anything not paid by the insurer, unless prohibited by law.

If directory information is materially inaccurate and you rely on it, you may be entitled to have an out- of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

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SCHEDULE OF BENEFITS

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: Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through an Out-of-Network Provider. Benefits are paid at 60% of the Usual and Customary Rate. Immunizations required under Federal and State Law are paid at no charge to the Insured Person.

Medical Deductible*

In-Network Provider:	Individual:	$500
	Family:	$1,500
Out-of-Network Provider	Individual:	$1,000
	Family:	$3,000

*Medical **Deductible** is waived if Covered Medical Expenses are incurred at the Student Health Center

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	$6,350
	Family	$12,700
Out-of-Network Provider	Individual	$12,700
	Family	$25,400

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.

Coinsurance Amounts:

In-Network Provider:	80% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below.
Out-of-Network Provider:	60% of the Usual and Customary Rate (U&C) for Covered Medical Expenses unless otherwise stated below.

Medical Benefit Payments for In-Network Providers and Out-of-Network Providers
This Certificate provides benefits based on the type of health care provider You and Your 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 certain non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, 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 generally defined either as an amount set by state law or the lesser of the billed charges 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.

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.
If You incurred Covered Medical Expenses from an Out-of-Network Provider but 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), You may be eligible for cost sharing that would 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.

Preferred Provider Organization:
To locate an In-Network Provider in Your area, consult Your Provider Directory or call toll free 877-657-5030 or visit Our website at www.wellfleetstudent.com.

If You incurred Covered Medical Expenses from an Out-of-Network Provider but 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), You may be eligible for cost sharing that would 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.

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 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 & board expenses and miscellaneous services and supplies. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Preadmission Testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Physician's Visits while Confined	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Maximum days per Policy Year	25	25

Inpatient Rehabilitation Facility Expense Benefit Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Registered Nurse Services for private duty nursing while Confined	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER BENEFITS In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-certification requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.		
Inpatient Mental Health Disorder and Substance Use Disorder Benefit Pre-Authorization Required In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-Authorization requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Outpatient Mental Health Disorder and Substance Use Disorder Benefit Pre-Authorization Required except for office visits		
Physician's Office Visits	$20 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
All Other Outpatient Services except Emergency Services and Prescription Drugs	80% of the Negotiated Charge after Deductible for Covered Medical Expenses Deductible Waived	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses

PROFESSIONAL AND OUTPATIENT SERVICES		
Surgical Expenses		
Inpatient and Outpatient Surgery includes: Pre-Authorization Required Surgeon Services Anesthetist Assistant Surgeon	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate 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	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate 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-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Reconstructive Surgery Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Other Professional Services		
Gender Transition Benefit Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Home Health Care Expenses Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Hospice Care Coverage	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Office Visits		
Physician's Office Visits including Specialists/Consultants	$20 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Telemedicine or Telehealth Services	Payable the same as any other Physician or Specialist Office Visit	
Allergy Testing and Treatment including injections	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses

Chiropractic Care Benefit Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Shots and Injections unless considered Preventive Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Tuberculosis screening, Titers, QuantiFERON B tests including shots (other than covered under preventive services)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Emergency Services, Ambulance And Non-Emergency Services		
Emergency Care Services in an emergency department for Emergency Medical Conditions.	$150 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Rate.
Urgent Care Centers for non-life-threatening conditions	$30 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	100% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Rate.
Non-Emergency Ambulance Service ground and/or air, water transportation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Diagnostic Laboratory, Testing and Imaging Services		
Diagnostic Imaging Services Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses

Rehabilitation and Habilitation Therapies		
Cardiac Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Maximum per Policy Year for Physical Therapy, and Occupational Therapy and Speech Therapy Combined	35	35
Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
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.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Dialysis Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Durable Medical Equipment Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Enteral Formulas and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Hearing Aids and Cochlear Implants Limited to 1 hearing aid per ear per 3-year period; and one cochlear implant in each ear with internal	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses

replacement as medically or audiologically necessary		
Maternity Benefit	Same as any other Covered Sickness	
Prosthetic and Orthotic Devices Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Student Health Center/Infirmary Expense Benefit	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived Copayment Waived	
Non-emergency Care While Traveling Outside of the United States	60% of Actual Charge after Deductible for Covered Medical Expenses Subject to $10,000 maximum per Policy Year	
Pediatric Dental and Vision Care		
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)	See the Pediatric Dental Care Benefit description in the Certificate for further information.	
Type A services; Diagnostic and Preventive Dental Care Limited to 2 dental exams every 12 months	100% of Usual and Customary Rate for Covered Medical Expenses	
The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care:		
Type B services: Basic Restorative Care	50% of Usual and Customary Rate for Covered Medical Expenses	
Type C services: Major Restorative care	50% of Usual and Customary Rate for Covered Medical Expenses	
Medically Necessary Orthodontic Care	50% of Usual and Customary Rate 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	
Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19) Limited to1 visit(s) per Policy Year and1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year	100% of Usual and Customary Rate after Deductible 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.		
Miscellaneous Dental Services		
Accidental Injury Dental Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Sickness Dental Expense Benefit	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Oral Surgery and Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Rate 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. You will not be required to pay more for a prescription drug than the lesser of the applicable copayment, the allowable claim amount or the amount You would pay if purchasing without health benefits or discounts. 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.		
TIER 1 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. 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 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	60% of Actual charge after Deductible for Covered Medical Expenses
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	60% of Actual charge after Deductible for Covered Medical Expenses

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	60% of Actual charge after Deductible for Covered Medical Expenses
TIER 2 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. 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 Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$25 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual charge after Deductible for Covered Medical Expenses
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual charge after Deductible for Covered Medical Expenses
More than a 60 day supply filled at a Retail pharmacy	$75 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual charge after Deductible for Covered Medical Expenses
TIER 3 Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail Pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. 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 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	60% of Actual charge after Deductible for Covered Medical Expenses

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	60% of Actual charge after Deductible for Covered Medical Expenses
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	60% of Actual charge after Deductible for Covered Medical Expenses
Specialty Prescription Drugs		
For each fill up to a 30 day supply. Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual charge after Deductible for Covered Medical Expenses
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	60% of Actual charge after Deductible for Covered Medical Expenses
More than a 60 day supply	$150 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual charge after Deductible for Covered Medical Expenses
Zero Cost Medications		
Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	100% of Actual charge for Covered Medical Expenses Deductible Waived
Orally administered anti-cancer prescription drugs (including specialty drugs)		
Benefit	Greater of: Chemotherapy Benefit; or Infusion Therapy Benefit	
Diabetic Supplies (for Prescription supplies purchased at a pharmacy)		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill except, that the Insured Person's out-of-pocket costs for covered prescription insulin drugs will not exceed $25 per 30-day supply regardless of the amount or type of insulin that is needed to fill the Insured Person's prescription	

Mandated Benefits	
Acquired Brain Injury	Same as any other Covered Sickness
Autism Spectrum Disorder	Same as any other Mental Health Disorder
Cervical and Ovarian Cancer Screening	An initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal are covered as Preventive Service otherwise, covered same as any other Covered Sickness
Colorectal Cancer Screening	Same as any other Covered Sickness, unless considered a Preventive Service
Contraceptive Drugs and Devices and Related Services	Same as any other Covered Sickness, unless considered a Preventive Service
Early Detection of Cardiovascular Disease	Same as any other Covered Sickness, subject to the limitations described in the Benefit
Mammography and Other Breast Imaging	Same as any other Covered Sickness, unless considered a Preventive Service
Minimum Stay for Mastectomy and Lymph Node Dissection	Same as any other Covered Sickness, subject to the limitations described in the Benefit
Osteoporosis Detection and Prevention	Same as any other Covered Sickness
Prostate Cancer Screening	Same as any other Preventive Service

SECTION I - ELIGIBILITY

An Eligible Student must attend classes at the Policyholder's School 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 allowed.

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 You or Your Dependent has performed an act that constitutes fraud; or You have made an intentional misrepresentation of material fact during Your 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 You and/or Your Dependent, as applicable. If termination is a result of Your action, coverage will terminate for You and Your Dependents. If termination is a result of Your Dependent's action, coverage will terminate for Your Dependent.

Who is Eligible

Class	Description of Class(es)
1	All registered International students of the Policyholder taking 1 or more credit hours.

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 and the premium will be added to the student's tuition fees unless proof of comparable coverage is provided by completing the waiver.

Dependents are eligible for coverage under this plan.

Your Dependent may become eligible for coverage under this Certificate only when You become eligible; or within 60 days of a Qualifying Life Event.

SECTION II – EFFECTIVE AND TERMINATION DATES

Effective Dates: Your 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, 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 Your coverage becomes effective; or
2. The date Your Dependent is enrolled for coverage, provided premium is paid when due.
3. The day after the date of postmark when the Enrollment Form is mailed; or
4. The beginning date of the term 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 Your enrollment in the School's insurance plan; or
6. The Policy Effective Date.

Special Enrollment – Qualifying Life Event

You, and Your Spouse or Child can also enroll for coverage within 60 days of the loss of coverage in a health plan if coverage was terminated because You, Your 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.

You, Your Spouse or Child can also enroll 60 days from exhaustion of Your COBRA or continuation coverage or if You gain a Dependent or become 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 Your coverage will depend on when We receive proof of Your loss of coverage under another health plan and appropriate premium payment. Your coverage shall take effect on the latest of the following dates: (1) this Policy Effective Date; (2) the day after the date for which You lose Your coverage providing premium for Your coverage has been paid; (3) the date the Policyholder's term of coverage begins; or (4) the date You become a member of an eligible class of persons.

In addition, You, and Your Spouse or Child can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. You or Your Spouse or Child loses eligibility for Medicaid or a state child health plan.
2. You or Your Spouse or Child become eligible for Medicaid or a state child health plan.

We must receive notice and Premium payment within 60 days of the loss of 1 of these events. The Effective Date of Your coverage will depend on the date We receive Your completed enrollment information and required premium.

Termination Dates: Your insurance will terminate on the earliest of:

1. The date this Certificate terminates; or
2. The end of the period of coverage for which premium has been paid; or
3. The date You cease to be eligible for the insurance; or
4. The date You enter military service; or
5. For International Students, the date they cease to meet Visa requirements; or
6. For International Students, the date they depart 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 You except as the result of an inadvertent error and subject to any Grace Period provision.

Your Dependent's insurance will terminate on the earliest of:

1. The date Your insurance ends; or
2. The date Your Dependent cease to be eligible for the insurance; or
3. The end of the period of coverage for which premium has been paid.

Dependent Child Coverage:

Newly Born Children – A newly born child of Yours will be covered from the moment of birth. Such newborn child will be covered for Covered Injury or Covered Sickness 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, You 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, or any Child when you become a party in a suit to adopt the child.

We must receive:

1. Notification of an adoption within 31 days; and
2. Any premium required for the child.

We will provide coverage for the child as long as:

1. Your coverage under this Certificate remains in effect; and
2. 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 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.

Handicapped 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 disability or physical handicap; and
2. Chiefly dependent upon You 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 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; or
2. If You are Totally Disabled due to Covered Injury or Covered Sickness, the coverage for that condition will be extended for up to 90 days from the Termination Date of Your insurance coverage while such Total Disability 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 Your insurance or an eligible Dependent's insurance ends due to Your being called or ordered to active duty, such insurance will be reinstated without any waiting period when You return to School and satisfy the eligibility requirements defined by the School or College.

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 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 directly and from no other cause, results in an Injury.

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

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;
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 the Deductible and 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 voluntary 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 due to an unforeseeable, external event which results independently of disease, bodily infirmity or any other cause. 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 Rate 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 Your Certificate is in force, except with respect to any expenses payable under the Extension of Benefits Provision.

Covered 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 Disorders 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 pay 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 biological child, adopted child or child pending adoption, child under a medical or dental support order under an order issued under Chapter 154, Family Code, or enforceable by a court in this state, or stepchild under age 26; and
3. Your grandchild who is a dependent of Yours for federal income tax purposes at the time the application for coverage of the grandchild is made; and
4. 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 intellectual disability, mental illness or disorder or physical handicap.

   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.

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 routinely used in a Hospital but can be used effectively in a non-medical facility;
4. Can be expected to make a meaningful contribution to treating Your Sickness or Injury; and
5. 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. Equipment that can be used by Immediate Family Members other than You;
3. Health exercise equipment; and
4. 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 a Covered Injury or Covered 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 Covered 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) 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 mean 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 Disorder 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/Investigative means the service or supply has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication. For further explanation, see definition of Medically Necessary/Medical Necessity provision.

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 Your country of citizenship. If You have dual citizenship, Your Home Country is the country of the passport You used to enter the United States. Your Home Country is considered the Home Country for any International Dependent of Yours 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 Rehabilitation facilities 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 You and Your Spouse or the parent, child, brother or sister of You or Your Spouses.

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** 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 convenience of an Insured Person, Physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or Treatment of an Insured Person's illness, injury or disease.

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.

Mental Health Disorder means a condition or disorder that substantially limits the life activities of an Insured Person with the disorder. Mental Health Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization.

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 pay during a Policy Year before Your Coverage begins to pay 100% of the allowed amount. 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 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.

Recognized Amount means:
1. an amount determined by an All-Payer Model Agreement under the Social Security Act, if adopted by Your state;
2. if there is no applicable All-Payer Model Agreement, an amount determined by a specified state law; or
3. if neither of the above apply, the lesser of:
   a. the Actual Amount billed by the provider or facility; or
   b. 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 or College 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 an illness or injury;
2. Provides care supervised by a Physician;
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.

Student Health Center or Student Infirmary means an on-campus facility or a designated facility by the Policyholder that provides:
1. Medical care and Treatment to Sick or Injured students; and
2. Nursing services.

A Student Health Center or Student Infirmary does not include:
1. Medical, diagnostic and Treatment facilities with major surgical facilities on its premises or available on a pre-arranged basis; or
2. Inpatient care.

Substance Use Disorder means any condition or disorder that substantially limits the life activities of an Insured Person with the disorder. Substance Use Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization.

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.

Telehealth Services means a health service, other than a telemedicine medical service or a teledentistry dental service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of his or her license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine Medical Services a health care service delivered by a Physician licensed in this state, or a health professional acting under the delegation and supervision of a Physician licensed in this state, and acting within the scope of his or her professional license to a patient at a different physical location than the Physician or health professional using telecommunications or information technology.

Teledentistry Dental Services means a health care service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient at a different physical location that the dentist or heal professional using telecommunications or information technology.

Total Disability or Totally Disabled, as it applies to the Extension of Benefits provision, means:
1) Your complete inability to engage in the everyday duties involved in the daily activities You performed prior to Your Covered Injury or Covered Sickness (work, school, housekeeping, etc.);
2) With care and Treatment by a Physician for the Covered Injury or Covered Sickness causing the disability.

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. Urgent Care Centers can also provide a variety of routine services like exams, physicals, vaccines, and lab services.

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

Service or Supply	**Usual and Customary Rate**
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, and certain non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, 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 Rate. 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 Rates.

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
Deductible
The Deductible amount (if any) is shown in the Schedule of Benefits. This dollar amount is what You have to incur in Covered Medical Expenses before benefits are payable under this Certificate. This amount will apply on an individual or family basis. The Deductible applies to all Covered Medical Expenses, unless specifically noted. Any expenses that You incur that are not Covered Medical Expenses are not applied toward Your Deductible.

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

Individual
The 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 Deductible applies separately to You and each of Your covered Dependents. After the amount of Covered Medical Expenses You incur reaches the 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 You and Your Covered Dependents must incur for In-Network Provider and Out-of-Network Provider Covered Medical Expenses. After the amount of Covered Medical Expenses You and Your Covered Dependents incur reach this Family 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 Deductible limit for the rest of the Policy Year, the following must happen:

- The combined Covered Medical Expenses that You and each of Your Covered Dependents incur towards the individual Deductibles must reach this Family Deductible limit in a Policy Year.

When this occurs in a Policy Year, the individual Deductibles for You and Your 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 the Deductible and 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 provides is the amount of Covered Medical Expenses You have to incur before Covered Medical Expense will be paid at 100% for the reminder 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(s) 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 You 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 of You must meet Your Out-of-Pocket Maximum separately.

Individual
Once the amount of the Copayments, Coinsurance and Deductibles You and Your 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 Rate 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 You and Your 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 You are responsible to incur during the Policy Year. This plan has an individual and family Out-of-Pocket Maximum.

The Out-of-Pocket Maximum may not apply to certain Covered Medical Expenses. If the Out-of-Pocket Maximum does not apply to a covered benefit, Your Copayment and Coinsurance for that medical expense will not count toward satisfying the 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 Usual and Customary Rate or the Negotiated Charge 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 You and Your 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 Rate 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 reimburse at the In-Network percentage for Treatment by an Out-of-Network Provider, and will calculate Your cost sharing amount at the usual and customary charge, 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 reasonably available to provide a Preventive Service or treat You for a specific Covered Injury or Covered Sickness; or

2. You have an Emergency Medical Condition and receive Emergency Services from an Out-of-Network Provider or facility. The most the Out-of-Network Provider or facility may bill You is the In-Network cost sharing amount (such as Deductibles, Copayments and Coinsurance). You can't be balance billed for these Emergency Services. This includes services You may get after You're in stable condition, unless the Out-of-Network Provider or facility determines that You can travel using non-medical or non-emergency transportation, the Out-of-Network Provider satisfies the consent and notice requirements, 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 is the In-Network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, Assistant Surgeon, hospitalist, or intensivist services. These Out-of-Network Providers can't balance bill You and may not ask You to give up Your protections not to be balance billed.

However, if You received notice from the Out-of-Network Provider of their non-network status at least 72 hours in advance, or if You make an appointment within 72 hours of the services being delivered and notice and consent is given on the date of 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. This notice and consent exception does not apply to ancillary services, which include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an Out-of-Network Provider in circumstances where there is no In-Network Provider who can furnish the item or service at the relevant facility.

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.

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, for a transitional period of at least 90 days from the date of the termination except that if You are in the second trimester of pregnancy at the time of the termination and the provider is treating You during the pregnancy. The transitional period must extend through delivery of the Child, immediate postpartum care, and follow-up checkup within the 6 week period after delivery for care directly related to the pregnancy. We shall also allow You to continue to coverage, with respect to the course of Treatment with the provider for up to 9 months after the Policy termination date if you have been diagnosed with a terminal illness on or before the termination date.

Pre-Authorization Process

In-Network – Your In-Network Provider is responsible for obtaining any necessary Pre-Authorization before You receive the care. If Your In-Network Provider does not obtain the required Pre-Authorization 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-Authorization process. For Inpatient services, it is recommended that the call be made at least 5 working days prior to Hospital Confinement. For Outpatient services, it is recommended that the call 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.

The following Inpatient and Outpatient services or supplies require Pre-Authorization:

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;
2. All Inpatient maternity care after the initial 48/96 hours;
3. All partial hospitalization in a Hospital, residential Treatment facility, or facility established primarily for the Treatment of a Substance Use Disorder;
4. Home Health Care;
5. Durable Medical Equipment over $500;
6. Surgery;

7. Transplant Services;
8. Diagnostic testing/radiology;
9. Chemotherapy/radiation;
10. Infusions/injectables;
11. Botox Injections;
12. Orthognathic Surgery;
13. Genetic Testing, except for BRCA;
14. Orthotics/prosthetics;
15. Transcranial Magnetic Stimulation (TMS);
16. Physical Therapy (Outpatient) Pre-Authorization required after the 12th visit;
17. Occupational Therapy (Outpatient) Pre-Authorization required after the 12th visit;
18. Chiropractic Services (Outpatient) Pre-Authorization required after the 12th visit.

Pre-Authorization is not required for an Emergency Medical Condition or for a Life Threatening Condition or Urgent Care or Hospital Confinement for the initial 48/96 hours of maternity care.

Additionally, no authorization requirement will apply to obstetrical or gynecological care provided by In-Network Providers.

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 in writing or by telephone;
3. For any other covered services requiring Pre-Authorization, We will contact the Provider in writing or by telephone regarding Our decision.

Our agent will make this determination within 72 hours for an urgent request, within 24 hours for concurrent hospitalization and three (3) calendar 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.

Your Physician or Provider may request a renewal preauthorization at least 60 days before the date the preauthorization expires. If we receive a renewal request before the existing preauthorization expires, if practicable, we will review the request and issue a determination before the existing preauthorization expires.

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

You can find information about Pre-Authorization on Our website at www.wellfleetstudent.com.

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.

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 that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the Insured Person involved.
3. Immunizations in accordance with state law for each covered child from birth through the date of the child's sixth birthday for the following: Diptheria; Haemophilus influenzae type b; Hepatitis B; Measles; Mumps; Pertussis; Polio; Rubella; Tetanus; Varicella; and any other immunization that is required for the child by law.
4. 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.
5. 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.
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 and services related to the use of federal legend oral contraception or IUD insertion, diaphragm fitting, vasectomy 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.
7. For covered newborns, the administration of the newborn screening tests as required by applicable Texas law including the cost of a newborn screening test kit in the amount provided by the Department of State Health Services.

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 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. 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 Expense 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. Within 7 days after Your discharge from a Hospital Confinement;
   b. Such Confinement must be of at least 3 consecutive days; and
   c. Was for the same or related Sickness or Accident.

   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 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. **Registered Nurse Services while confined**, when private duty nursing care is prescribed by the attending Physician. General nursing care provided by the Hospital is not covered under this benefit.

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

MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER BENEFITS

1. **Inpatient and Outpatient Mental Health Disorder Benefit** for Treatment of Mental Health Disorders as specified on the Schedule of Benefits.

2. **Inpatient and Outpatient Substance Use Disorder Benefit** for Treatment of Substance Use Disorders as specified on the Schedule of Benefits.

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** expense 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. **Organ Transplant Surgery**
   Recipient Surgery for Medically Necessary, non-Experimental and non-investigative solid organ, bone marrow, stem-cell or tissue transplants. We will provide benefits for the Hospital and medical expenses of when You are the recipient of an Organ Transplant.

   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.

   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.

4. **Reconstructive Surgery** covers all stages of reconstruction of the breast on which the 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 craniofacial abnormalities to improve the functions of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, or tumors.

OTHER PROFESSIONAL SERVICES

1. **Gender Transition Benefit** for Medically Necessary expenses incurred for services and supplies provided in connection with gender transition when You have been diagnosed with gender identity disorder or gender dysphoria. Covered services include the following:
   a. Counseling by qualified mental health professional;
   b. Hormone therapy, including monitoring of such therapy;
   c. Gender transition surgery and procedures covered by Your plan.

2. **Home Health Care Expenses** for Home Health Care for You 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 expenses incurred for such care. You must have been diagnosed with a terminal illness by a licensed Physician. Their medical prognosis must be death within 6 months. 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.

2. **Telemedicine, Teledentistry or Telehealth Services** for 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) 2-way transfer of medical data and information.

3. **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.

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

5. **Shots and Injections** unless considered Preventive Services administered in an emergency room or Physician's office and charged on the emergency room or Physician's statement. This includes HPV vaccines for Insured Persons over age 26.

6. **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 satisfies the consent and notice requirements, 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 ground transportation to a Hospital by a licensed Ambulance. Transportation from a facility to Your home is not covered.

   Your plan also covers transportation to a Hospital by professional air or water Ambulance when:
   - Professional ground Ambulance transportation is not available;
   - Your condition is unstable, and requires medical supervision and rapid transport;
   - You are travelling from one Hospital to another; and
   - The first Hospital cannot provide the Emergency Services You need; and
   - The two (2) conditions above are met.

4. **Non-Emergency Ambulance Service** for Medically Necessary transportation by a licensed Ambulance, whether by ground or air Ambulance (as appropriate), when the Medically Necessary transportation 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; or
   - From an acute care Hospital/facility to a sub-acute setting.

   Transportation from a facility to Your home is not covered.

DIAGNOSTIC LABORATORY, TESTING AND IMAGING SERVICES

1. **Diagnostic Imaging Services** for diagnostic X-ray services as shown in the Schedule of Benefits when prescribed by a Physician.

2. **CT Scan, MRI and/or PET Scans** for diagnostic services when prescribed by a Physician.

3. **Laboratory Procedures (Outpatient)** for laboratory procedures as shown in the Schedule of Benefits when prescribed by a Physician.

4. **Chemotherapy and Radiation Therapy** for chemotherapy, oral chemotherapy drugs, and radiation therapy to treat or control a serious illness, as shown in the Schedule of Benefits**.**

5. **Infusion Therapy** for the administration of antibiotic, 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 are: exercise and education under the direct supervision of skilled program personnel in the intensive Rehabilitation phase of the program. The program must start within 3 months after a cardiac condition is diagnosed or a cardiac procedure is completed. The program must be completed within 6 months of the cardiac diagnosis or procedure.

   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.

4. **Habilitation Services** when prescribed by the attending Physician.

OTHER SERVICES AND SUPPLIES

1. **Covered Clinical Trials** includes coverage for routine costs associated with Your participation in a clinical trial. Coverage does not include the studied device, equipment or drug, data collection services and any service not associated with direct clinical care to You.

2. **Diabetic services and supplies (including equipment and training)** Benefits will be paid the same as any other Sickness 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 includes services and supplies:
   - Insulin preparations
   - Foot care to minimize the risk of infection
   - Injection aids, including devices used to assist with insulin injection and needleless systems
   - Diabetic test agents
   - Prescribed oral medications whose primary purpose is to control blood sugar
   - Injectable glucagon
   - Glucagon emergency kits
   - Biohazard disposal containers;
   - Non-prescription medications for the purpose of controlling blood sugar

   Equipment
   - External and implantable insulin pumps and associated appurtenances

- Repair and necessary maintenance of insulin pumps not otherwise covered under a manufacturer's warranty or purchase agreement
- Rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump
- Blood glucose monitors without special features, unless required for the legally blind
- Podiatric appliances, including therapeutic shoes, 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 or Your caretaker 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.

Covered expenses also include new or improved diabetic treatment, equipment and supplies that become available. They must be:

- Approved by the United States Food and Drug Administration
- Prescribed by Your provider
- Sent to us in writing by Your provider

Coverage will be provided for emergency refills of diabetes equipment or diabetes supplies in the same manner as for a nonemergency refill of diabetes equipment or diabetes supplies.

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 the home. Covered services for home Treatment will include equipment, training and medical supplies. Private Duty Nursing is not covered.

4. **Durable Medical Equipment** for the rental or purchase of Durable Medical Equipment, including, but not limited to, Hospital beds, wheel chairs, walkers, braces that stabilize an injured body part and braces to treat curvature of the spine. 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. **Hearing Aids and Cochlear Implants** and related services and supplies**.** Benefits are limited as shown in the Schedule of Benefits and includes the following related services and supplies:
   - fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of the hearing aid;
   - treatment related to hearing aids and cochlear implants, including cover for habilitation and rehabilitation as necessary for education gain.

7. **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 is the result of Complications of Pregnancy. If the delivery is the result of Complications of Pregnancy, the Hospital stay will be covered the same as for any other Covered Sickness. Services of a licensed Nurse 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 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.

8. **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. This includes:
   - the necessary repair and replacement of a prosthetic or orthotic device unless the repair or replacement is necessitated by misuse or loss by the Insured Person; and
   - coverage limited to the most appropriate model of prosthetic device or orthotic device that adequately meets the medical needs of the Insured as determined by the treating Physician or podiatrist and prosthetist or orthotist, as applicable.

9. **Student Health Center/Infirmary Expense Benefit** if an Insured Student 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.

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

PEDIATRIC DENTAL AND VISION BENEFITS

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

2. **Pediatric Vision Care Benefit** include a routine vision exam provided by an ophthalmologist, optometrist, or therapeutic optometrist. The exam will include refraction and glaucoma testing. Coverage is limited to covered persons through the end of the month in which they turn 19. Please refer to the Schedule of Benefits section of this Certificate for cost-sharing requirements.

   Vision care services and supplies include:
   a. Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
   b. Eyeglass frames, prescription lenses or prescription contact lenses
      i. Prescription lenses include glass or plastic lenses, all lens power (single, bifocal, trifocal, lenticular), fashion and gradient tinting, ultraviolet protective coating, oversized and glass-grey #3 prescription sunglass lenses
      ii. Polycarbonate lenses are covered in full for children, monocular patients and those with prescriptions > +/- 6.00 diopters
   c. Non-conventional prescription contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses
   d. Aphakic prescription lenses prescribed after cataract surgery has been performed
   e. Low vision services: a significant loss of vision, but not total blindness
      i. Providers specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the Insured Person's remaining usable vision
      ii. After Pre-Authorization eligible health services include one comprehensive low vision evaluation every 5 years; 4 follow-up visits in any 5-year period. Also included are prescription optical devices, such as high-power spectacles, magnifiers and telescopes
   f. Services and materials include:
      i. Vision exam
      ii. Single vision lenses
      iii. Bifocal, trifocal, and lenticular lenses
      iv. Medically necessary and elective contact lenses
      v. Frames
      vi. Scratch resistant coatings
   g. Optional lenses and treatments include:
      i. Ultraviolet protective coating

ii. Polycarbonate lenses (if not a child, monocular patients or prescription ≥+/-6.00 diopters)
iii. Blended segment lenses
iv. Intermediate vision lenses
v. Standard and premium progressives
vi. Photochromic glass lenses
vii. Plastic photosensitive lenses
viii. Polarized lenses
ix. Standard, premium, and ultra anti-reflective coating.

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 Percentage of the Covered Medical Expenses incurred for the Treatment.

3. **Oral Surgery and Treatment** – expenses incurred for the treatment of:
    1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
    2. Incision and drainage of facial abscess;
    3. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; and
    4. Reduction of a dislocation of, excision of, and injection of the temporomandibular joint, except as excluded under the Plan.

4. **Treatment for Temporomandibular Joint (TMJ) Disorders** for the diagnostic or surgical Treatment of conditions affecting the temporomandibular joint if the Treatment is Medically Necessary as a result of: an Accident; trauma; congenital defect; developmental defect; or pathology. Coverage may be subject to any provision that is generally applicable to surgical Treatment, including a requirement for Pre-Authorization of coverage.

PRESCRIPTION DRUGS

1. **Prescription Drugs** are medications filled in an outpatient pharmacy for which a Physician's written prescription is required up to the amount shown in the Schedule of Benefits. 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-Authorization. These prescription requirements help Your prescriber and pharmacists check that Your outpatient prescription drug is clinically appropriate using evidence-based criteria.

    a. **Off-Label Drug Treatments** – When prescription drugs are provided as a benefit of the issued 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 by the FDA;
        2. The drug is prescribed for the Treatment of a life-threatening condition, including cancer, HIV or AIDS;
        3. The drug has been recognized for Treatment of that condition by a nationally recognized drug database or two separate articles in major peer reviewed medical journals/clinical practice guidelines (cancer indications will only require evidence from ONE article or clinical practice guideline).

        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.

As it pertains to this benefit, life threatening means either or both of the following:

a. Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted; or
b. Disease or conditions with a potentially fatal outcome and where the end point of clinical intervention is survival.

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 the Member requests a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available, the Member 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 in as shown in the Schedule of Benefits.

Specialty Drugs – are Prescription Drugs which:

1. Are only approved to treat limited patient populations, indications, or conditions; or
2. Are normally injected, infused, or require close monitoring by a Physician or clinically trained individual; or
3. Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

Specialty prescription drugs are identified in the Formulary posted on Our website at www.wellfleetstudent.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 benefit. Self-administered Prescription Drugs will not be covered when dispensed through a Physician's office or outpatient Hospital, except in emergency situations. While members 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.wellfleetstudent.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, You and 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 within seventy-two (72) hours or twenty-four hours if the prescribing practitioner believes that denial of the request makes the death of or serious harm to You probable, 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.

If a request for an override is denied, it is considered an Adverse Determination subject to an Expedited Appeal as outlined in the Appeal section of this Certificate. Visit Our website http://studentinsurance.com/ or call the number on the Member's ID card to find out more about this process.

This provision for step therapy does not apply to prescription drugs when used for treatment for stage-four advanced, metastatic cancer, or associated conditions when You have met the following criteria and prescribed medication.

1. You meet one of the following criteria:
   a. You don't have to fail to respond successfully to a different drug; or
   b. You prove a history of failure on a different drug.

2. The medication meets the following criteria:
   a. The drug is consistent with best practices for the treatment of stage-four advanced, metastatic cancer, or an associated condition;
   b. Supported by peer-reviewed, evidence basted literature; and
   c. Approved by the United States Food and Drug Administration.

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. **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.

j. **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 of the Non-Formulary Prescription Drug is denied under Our standard or expedited Formulary exception process, You are entitled to an external review by an Independent Review Organization (IRO) as outlined in the Independent Review Of Denial Of Prescription Drug Exception Process provision below. Refer to the Formulary posted on Our website at www.wellfleetstudent.com or call the number on Your ID card to find out more about this process.

Standard Review of a Formulary Exception – If You request a Formulary exception, We will make a decision and notify You or Your Authorized Representative and the prescribing Health Care Professional of Our coverage determination no later than 72 hours after Our receipt of Your request. If We approve the request, We will cover the Non-Formulary Prescription Drug for the duration of the prescription , including any refills. This approval authorization requires renewal at least every 12 months.

Expedited Review of Formulary Exception – If You request a Formulary exception due to exigent circumstance, 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. Exigent circumstances exist when 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. 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. If We approve the request, We will cover the Non-Formulary Prescription Drug for the duration of the exigent.. This approval authorization requires renewal at least every 12 months. Refer to the Formulary posted on Our website at www.wellfleetstudent.com or call the number on Your ID card to find out more about this non-Formulary drug exception process.

To request a Standard or Expedited Review of a Formulary Exception for a clinically appropriate Prescription Drug, You or Your Authorized Representative or the prescribing Physician may call Us at (877) 657-5030. You or Your Authorized Representative and Your prescribing Physician may also send a written request to:
Wellfleet Insurance Company
Attention: Wellfleet Group, LLC
P.O. Box 15369
Springfield, MA 01115-5369
Fax Number: (413) 733-4612

Independent Review Of Denial Of Prescription Drug Exception Process - If coverage of a Non-Formulary Prescription Drug is denied under the Standard Review of a Formulary Exception provision or the Expedited Review of a Formulary Exception provision, You or Your Authorized Representative or Your prescribing Physician are entitled to request that the original exception request and subsequent denial of such request be reviewed by an IRO.

The IRO will make its determination on the external exception request and notify You or Your Authorized Representative and the prescribing Physician of the IRO's coverage determination:

a. No later than 72 hours following Our receipt of the request, if the original request was a standard exception request under the Standard Review of a Formulary Exception provision. If the IRO grants an external exception review of a standard exception request, We will provide coverage of the Non-Formulary Prescription Drug for the duration of the prescription; or
b. No later than 24 hours following receipt of the request, if the original request was an expedited exception request under the Expedited Review of a Formulary Exception provision. If the IRO grants an external exception review of an expedited exception request, We will provide coverage of the Non-Formulary Prescription Drug for the duration of the exigency.

You or Your Authorized Representative or Your prescribing Physician have the right to request for an independent external organization to review Our final decision. To request the independent review, fill out the Request for a Review by an Independent Review Organization form (TDI Form LHL009) enclosed with the Notice of Adverse Benefit Determination. Requests should be sent to Express Scripts, who will forward the request the Texas IRO.

To request an independent external review, You or Your Authorized Representative or Your prescribing Physician should call Express Scripts at (877) 640-7938. You or Your Authorized Representative or Your prescribing Physician may also send a written request to:
Express Scripts Attention: External Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588

If the IRO grants an external exception review of a standard exception request, We will provide coverage of the Non-Formulary Prescription Drug for the duration of the prescription, including any refills.

If the IRO grants an external exception review of an expedited exception request, We will provide coverage of the Non-Formulary Prescription Drug for the duration of the exigency.

When an exception is approved, the Non-Formulary Prescription Drug is treated as an Essential Health Benefit, and any cost sharing will apply toward the Out-of-Pocket Maximum.

k. **Tobacco cessation prescription and over-the-counter drugs** – Tobacco cessation prescription drugs and OTC drugs will be covered for two 90-day treatment regimens only. Any additional prescription drug treatment regimens will be subject to the cost sharing in Your 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 90-day treatment regimens allowed, refer to the Formulary posted on Our website www.wellfleetstudent.com or call the toll free number on Your ID card.

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

m. **Preventive contraceptives -** Your Outpatient Prescription Drug plan covers 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 plan also covers 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 by referring to the Formulary posted on Our website at www.wellfleetstudent.com or calling the toll-free number on Your ID card.

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.

n. **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.

o. **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

You can access the list of diabetic supplies by referring to the Formulary posted on Our website at www.wellfleetstudent.com or by calling the toll-free number on Your ID card. See Your Diabetic services and supplies (including equipment and training) section for coverage of blood glucose monitors and external insulin pumps.

p. **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.

q. **Medication synchronization:** We may cover a prescription filled by a pharmacy early one time. This way the pharmacy can synchronize Your chronic medications. If You take multiple medications, We can help make sure you follow the prescribed course of treatment by dispensing them all at the same time and at the same pharmacy. We will do this if Your prescriber or pharmacist decides filling or refilling the prescription

that way is in Your best interest and You request less than a 30-day supply. This provision does not apply to:
1. A Schedule II controlled substance; or
2. A Schedule III controlled substance containing hydrocodone

r. **Early refill of Prescription eye drops:** We may cover a prescription refilled early by a pharmacy for liquid eye drops to treat a chronic eye disease or condition if:
1. the original prescription states that additional quantities of the eye drops are needed;
2. the refill does not exceed the total quantity of dosage unites authorized by the prescribing provider on the original prescription, including refills; and
3. the refill is dispensed on or before the last day of the prescription dosage and:
   i. Not earlier than the 21st day after the date a prescription for a 30-day supply of eye drops is dispensed; and, if applicable:
   ii. Not earlier than the 42nd day after the date a prescription for a 60-day supply of eye drops is dispensed; or
   iii. Not earlier than the 63rd day after the date a prescription for a 90-day supply of eye drops is dispensed.

Mandated Benefits for Texas

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 student.

1. Acquired Brain Injury for Medically Necessary Treatment of an acquired brain injury including:
   a. Cognitive rehabilitation therapy which includes services designed to address therapeutic cognitive activities, based on an assessment and understanding of the Insured Person's brain-behavioral deficits.
   b. Cognitive communication therapy which includes services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.
   c. Neurocognitive therapy which includes services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
   d. Neurocognitive rehabilitation which includes services designed to assist cognitively impaired Insured Persons to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
   e. Neurofeedback therapy including services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.
   f. Neurophysiological testing which is an evaluation of the functions of the nervous system.
   g. Neurophysiological Treatment which consists of interventions that focus on the functions of the nervous system.
   h. Neurophysiological testing which is the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous functioning.
   i. Neurophysiological Treatment which consists of interventions designed to improve or minimize deficits in behavioral and cognitive processes.
   j. Neurobehavioral Treatment which consists of interventions that focus on behavior and the variables that control behavior.
   k. Psychophysiological Treatment which includes interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
   l. Remediation which is the process(es) of restoring or improving specific function.
   m. Post-acute transition services which are services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
   n. Community reintegration services which are services that facilitate the continuum of care as an affected Insured Person transitions into the community.

2. Autism Spectrum Disorder for screening a child for autism spectrum disorder at the ages of 18 and 24 months. Coverage is provided for autism spectrum disorder from the date of diagnosis until the Insured Person completes 9 years of age. However, if a child who is being treated for autism spectrum disorder becomes 10 years of age or older and continues to need Treatment, the Treatment and services will continue. Coverage is provided for all Generally Recognized Services prescribed in relation to autism spectrum disorder by the primary care Physician in the Treatment plan recommended by that Physician. An individual providing Treatment prescribed must be a health care practitioner:
   a. Who is licensed, certified, or registered by an appropriate agency of this state;
   b. Whose professional credential is recognized and accepted by an appropriate agency of the United States;
   c. Who is certified as a Provider under the TRICARE military health system; or
   d. Who is an individual acting under the supervision of a health care practitioner as described above.

   As used in this benefit:
   General Recognized Services includes services such as: evaluation and assessment services; applied behavior analysis; behavior training and behavior management; speech therapy; occupational therapy; Physical Therapy; or medications or nutritional supplements used to address symptoms of autism spectrum disorder.

3. Cervical and Ovarian Cancer Screening for an annual cervical cytological screening for women age 18 years or older for expenses for medically recognized diagnostic examination for the early detection of cervical and ovarian cancer. Coverage includes a CA 125 blood test; a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papilloma virus; and any other test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer.

   A screening test required under this selection must be performed in accordance with the guidelines adopted by:
   a. The American College of Obstetricians and Gynecologists; or
   b. Another similar national organization of medical professionals recognized by the commissioner.

4. Colorectal Cancer Screening for any Insured Person who is 45 years of age or older and at normal risk for developing colon cancer.

   As used in this benefit:
   a. All colorectal cancer examinations, preventive services, and laboratory tests assigned a grade of "A" or "B" by the United States Preventive Services Task Force (USPSTF) for average-risk individual, this includes services that may be assigned a grade of "A" or "AB" in the future; and
   b. an initial colonoscopy or other medical test or procedure for colorectal cancer screening;
   c. a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.

5. Contraceptive Drugs and Devices and Related Services including a consultation, examination, procedure, or medical service that is provided as an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy.

6. Early Detection of Cardiovascular Disease for screening medical procedures to each Insured Person who is:
   a. A male older than 45 years of age and younger than 76 years of age; or
   b. A female older than fifty-five (55) years of age and younger than seventy-six (76) years of age; and who:
   c. Is diabetic; or
   d. Has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary algorithm, that is intermediate or higher.

   Coverage is required to be provided under this section for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every 5 years, performed by a laboratory that is certified by a national organization recognized by the commissioner by rule for the purposes of this section:
   a. Computed tomography scanning measuring coronary artery calcification; or
   b. Ultrasonography measuring carotid intima-media thickness and plaque.

7. Mammography and Other Breast Imaging provided for women who are 35 years of age or older for an annual screening by low-dose mammography, including digital mammogram or breast tomosynthesis, for the presence of occult breast cancer.

   Benefits include diagnostic mammograms which will be paid no less favorable than for screening mammograms. Diagnostic mammograms are not subject to any age limitation.

   As used in this benefit:
   Low-dose mammography means:
   - the x-ray examination of the breast using equipment dedicated specifically for mammography, including an x-ray tube, filter, compression device, and screens, with an average radiation exposure delivery of less than one rad mid-breast and with two views for each breast;
   - digital mammography; or
   - breast tomosynthesis.

   Breast tomosynthesis means a radiologic mammography procedure that involves the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast from which applicable breast cancer screening diagnoses may be determined.

   Diagnostic imaging means an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate any of the following:
   - A subjective or objective abnormality detected by a physician or Insured Person in a breast;
   - An abnormality seen by a physician on a screening mammogram;
   - An abnormality previously identified by a physician as probably benign in a breast for which follow-up imaging is recommended by a physician; or
   - An Insured Person with a personal history of breast cancer or dense breast tissue.

8. Osteoporosis Detection and Prevention for medically accepted bone mass measurements for the detection of low bone mass and to determine the Qualified Enrollee's risk of osteoporosis and fractures associated with osteoporosis.

   As used in this benefit:
   Qualified Enrollee means an individual who is: A postmenopausal woman who is not receiving estrogen replacement therapy; has vertebral abnormalities, primary hyperparathyroidism, or a history of bone fractures; or an individual who is receiving long-term glucocorticoid therapy or being monitored to assess the response or to efficacy of an approved osteoporosis drug therapy.

9. Prostate Cancer Screening for an annual medically recognized diagnostic examination for the detection of prostate cancer and a prostate-specific antigen test used for the detection of prostate cancer for each male who is at least 50 years of age and is asymptomatic; or is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor.

SECTION V - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

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

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 -** Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible.
- Treatment, service or supply which is not Medically Necessary for the diagnosis, care or Treatment of the sickness or injury involved. This applies even if they are prescribed, recommended or approved by the Student Health Center or by Your attending Physician or dentist.
- Medical services rendered by a provider employed for or contracted with the Policyholder, including team Physicians or trainers[, except as specifically provided in the Schedule of Benefits or as part of the Student Health Center benefits provided by this plan.
- Professional services rendered by an Immediate Family Member or anyone who lives with You. This exclusion does not apply to Dental services.
- 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 Rates 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 certified Nurse midwife and a Physician.
- Expenses payable under any prior policy which was in force for the person making the claim.
- Loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority.
- Injury sustained as the result of Your operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle Accident takes place.
- Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
- 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 Investigative drugs, devices, Treatments or procedures unless otherwise covered under Covered Clinical Trials or covered under clinical trials (routine patient costs). See the Other Benefits section for more information.
- Routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue,

donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal.

- Loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
- Non-chemical addictions.
- Non-physical, occupational, speech therapies (art, dance, etc.).
- Modifications made to dwellings.
- General fitness, exercise programs.
- Hypnosis.
- Rolfing.
- Biofeedback.
- Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
- Sleep Disorders, except for the diagnosis and Treatment of obstructive sleep apnea.
- 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.

Activities Related:

- Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate or club sports for which benefits are paid under another Sports Accident policy issued to the Policyholder; or for which coverage is provided by the National Collegiate Athletic Association (NCAA), National Association of Intercollegiate Athletic (NAIA) or any other sports association per Intercollegiate or club sports Accident.
- Racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles) or other hazardous sport or hobby.

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. Surgery for removal of excess skin or fat.

Family Planning:

- Infertility Treatment (male or female)-this includes but is not limited to:
  - Procreative counseling;
  - Premarital examinations;
  - Genetic counseling and genetic testing;
  - Impotence, organic or otherwise;
  - Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
  - In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
  - Costs for an ovum donor or donor sperm;
  - Sperm storage costs;
  - Cryopreservation and storage of embryos;
  - Ovulation induction and monitoring;
  - Artificial insemination;
  - Hysteroscopy;
  - Laparoscopy;
  - Laparotomy;

- Ovulation predictor kits;
- Reversal of tubal ligations;
- Reversal of vasectomies;
- Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
- Cloning; or
- Medical and surgical procedures that are Experimental or Investigative, unless Our denial is overturned by an External Appeal Agent.

- Elective abortions.

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, lenses or frames, 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 exams, hearing screening 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.

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;
- Bulk chemicals;
- Non-insulin syringes, surgical supplies, Durable Medical Equipment/medical devices, except as specifically provided in the Prescription Drug Benefit section of the Certificate;
- Repackaged products;
- Blood components except factors;
- Any drug or medicine for the purpose of weight control;
- Fertility drugs;

- 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 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-Authorization of admissions, and preferred provider arrangements.

5. Allowed Amount is the amount of a billed charge that a carrier determines to be covered for services provided by a Non-Preferred Provider or Physician. The allowed amount includes both the carrier's payment and any applicable Deductible, Copayment, or Coinsurance amounts for which the Insured Person is responsible.

6. 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.

7. 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 this 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 this 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: The Insured Person 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.

Reimbursement to Texas Department of Health and Human Services Commission: We will repay the actual costs of medical expenses the Texas Department of Health and Human Services Commission pays through medical assistance for you or your dependent if you or your dependent are entitled to payment for medical expenses.

Repayment of these medical expenses for your dependent child will be paid to the Texas Department of Health and Human Services Commission if, you submit proof of loss, you notify us in writing that:

- Your dependent child is covered under the financial and medical assistance service program in Texas and you either:
  a. Have possession or access to the child through a court order; or
  b. Are not entitled to possession of or access to the child and are required by the court to pay child support.

You will need to ask us to make direct payment to the Texas Department of Health and Human Services Commission.

Payment to a managing or possessory conservator: When a court order gives another person certain rights and duties to act on behalf of your dependent child. Such a person is called a managing or possessory conservator. We may pay that person benefits on behalf of your dependent child. To receive, benefits, they must send us a written certified copy of the court order with the claim form. But they are not entitled to benefits if:

- We received a valid assignment of benefits on an unpaid medical bill
- You sent us a claim for benefits for a covered medical expense that you paid.

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.

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 an external review by an Independent Review Organization (IRO) as set out in the Standard External Review and Expedited External Review 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 health care services provided or proposed to be provided are not Medically Necessary or are Experimental or Investigative.

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.

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.

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.

In most cases, You should complete Our Internal Appeals process before You:
- File a complaint with the Texas Department of Insurance;
- File a request for an External Review;
- Pursue arbitration, litigation or other type of administrative proceedings.

However, in some cases, You do not have to exhaust the Internal Appeal process before You move on to an External Review. These situations are:
- You have a life-threatening situation;
- For the denial of prescription drugs or intravenous infusions;
- You have an Urgent Care situation or a claim that involves ongoing treatment. In these situations, You may have Your claim go through the External Review at the same time as the Internal Appeal process; and
- We did not follow all of the State or Federal claim determination and appeal requirements. However, You will not be able to proceed directly to an External Review if:
  - The rule violation was minor and not likely to influence a decision or harm You;
  - The violation was for a good cause or a matter beyond Our control;
  - The violation was part of an ongoing good faith exchange of information between You and Us.

Within 1 business day of making a determination, You will be notified if the external review request is denied and You will be provided with: (1) the reasons why the claim is initially ineligible for external review; or (2) the information or materials needed for a complete request. In the event Your request is denied due to lack of information or materials, You must perfect Your claim by the later of the end of the 4-month period following the final internal Adverse Benefit Determination or 48 hours following notification that Your request for external review was denied.

If initially eligible for an external review, We will assign the request to an IRO. The IRO will make a determination and provide You and Us with notice of its determination within 45 days of receiving the review request

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 of Our determination as soon as possible but no later than:**
Pre-Service Claim	3 business days, for non-urgent requests, of receipt of request or preauthorization request
Pre-Service Claim involving Urgent Care	1 business day of receipt of request or preauthorization request
Concurrent: Hospitalization To deny Your request to extend Treatment	24 hours of receipt of request for concurrent hospitalization

Concurrent: Involving Urgent Care or Emergency Care	1 business day of receipt of request
Post-Service Claim	30 days of receipt of claim
Life Threatening	No later than one (1) hour after the request
Acquired Brain Injury	No later than three (3) business days after the request
Step Therapy	72 hours after receiving the request or 24 hours if urgent or life threatening.
Prescription Drugs or Intravenous Infusions	No later than the 30th day before the date on which the prescription drug or intravenous infusions will be discontinued.

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.
11. You have the right to an immediate external appeal if the denial is for:
    a. prescription drugs or intravenous infusions; or
    b. a life-threatening situation.
12. You have the right to an internal expedited review if the denial is for:
    a. emergency care; or
    b. continued hospitalization; or
    c. a step-therapy exception request; or
    d. prescription drugs or intravenous infusion.

INTERNAL APPEAL

Step 2:

If You do not agree with Our decision and wish to appeal, You must file a written or oral appeal with Us at the address below within 180 days after receipt of the Adverse Benefit Determination notification referenced in Step 1. 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
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	15 calendar days of receipt of appeal
Pre-Service Claim involving Urgent Care	180 days after receipt of Adverse Benefit Determination	1 business day or 72 hours from the date all information to complete the review is received of receipt of appeal
Continued Hospitalization	180 days after receipt of Adverse Benefit Determination	1 business day or 72 hours from the date all information to complete the review is received of receipt of appeal
Emergency Care	180 days after receipt of Adverse Benefit Determination for Pre-Service or Post-Service Claim	1 business day or 72 hours from the date all information to complete the review is received
Post-Service Claim	180 days after receipt of Adverse Benefit Determination	30 days of receipt of appeal
Life Threatening	180 days after receipt of Adverse Benefit Determination	one (1) hour after the request
Acquired Brain Injury	180 days after receipt of Adverse Benefit Determination	three (3) business days after the request
Step Therapy	180 days after receipt of Adverse Benefit Determination	1 business day or 72 hours from the date all information to complete the review is received
Prescription Drugs or Intravenous Infusions	180 days after receipt of Adverse Benefit Determination	1 business day or 72 hours from the date all information to complete the review is received

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 external review from an Independent Review Organization (IRO), You must file a written request for external review.

You may also seek an external review by an IRO 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.

STANDARD EXTERNAL REVIEW

Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination, You may file a request for an external review with Us.

You must file Your written request for an external review with Us at the address below within 4 months of the date You received the applicable denial.

Within 5 business days of receiving Your request for an external review, We will complete a preliminary review of the request to determine whether You were covered under the Policy at the time the expense was incurred and whether You have exhausted the Internal Appeal process where required.

EXPEDITED EXTERNAL REVIEW

If, due to Your medical condition, the time frame for completion of the standard external review process would seriously jeopardize Your life or health or Your ability to regain maximum function, You may request an expedited external review, the preliminary review will be completed immediately. If determined to be initially eligible, We will assign the request to an IRO and the IRO will complete the review as expeditiously as Your medical condition requires, but in no event more than 72 hours after receiving the request. If the notice is provided to You orally, a written or electronic notification will be sent to You no later than 48 hours after the oral notification.

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 exhaust these appeals procedures before filing a complaint or appeal with Your state's Department of Insurance.
- 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
P.O. Box 15369
Springfield, MA 01115-5369

State of Texas
Office of the Commissioner of Insurance
P.O. Box 149104
Austin, TX 78714
1-800-578-4677
Tdi.texas.gov or www.tdi.texas.gov/consumer

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, " we", "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.

कृपा ध्या द□: य□द आप □**हंद**□ **(Hindi)** भाषी ह□ तो आपके □लए भाषा सहायता सेवाएं□न:शुल् उपलब् ह□। कृपा 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

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up tothese dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.
- **Life insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.
- **Individual annuities:** Up to $250,000 in the present value of benefits, including cash surrender andnet cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuitiesare in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies orcontracts. A limit of $500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the valueof variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life and Health Insurance Guaranty Association 1717 West 6th Street, Suite 230 Austin, TX 78703-4776 1-800-982-6362 or www.txlifega.org	**Texas Department of Insurance** P.O. Box 12030 Austin, TX 78711 1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summaryof your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.