WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

STUDENT HEALTH CERTIFICATE OF COVERAGE

POLICYHOLDER:	OHIO WESLEYAN UNIVERSITY (Policyholder)
POLICY NUMBER:	WI2223OHSHIP98
POLICY EFFECTIVE DATE:	August 1, 2022
POLICY TERMINATION DATE:	July 31, 2023
STATE OF ISSUE:	Ohio

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 in accordance with the Termination Dates provisions. Coverage renewal is guaranteed as long as the Policy remains in force and You continue to meet the eligibility requirements of this Certificate and premiums are paid.

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.

NOTICE: IF THE INSURED PERSON OR HIS OR HER FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, THEY MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE THE INSURED PERSON TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS THE INSURED PERSON OR THEIR FAMILY.

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

TABLE OF CONTENTS

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 80% of the Usual and Customary Charge.

Medical Deductible*

In-Network Provider:	Individual:	$250
Out-of-Network Provider	Individual:	$500

*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	$5,000
Out-of-Network Provider	Individual	$10,000

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 Charge (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 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.

Ohio's House Bill 388 and the Federal No Surprises Act establish patient protections including from Out-of-Network Providers' surprise bills ("balance billing") for Emergency Care and other specified items or services. We will comply with these new state and federal requirements including how we process claims from certain Out-of-Network Providers. In accordance with these requirements, when You receive Emergency Services, or Out-of-Network Ambulance services (ground and/or air, water, fixed wing and rotary wing air transportation), or non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center without Your consent, You are protected from Surprise Billing. In these situations, Your cost sharing responsibility will be calculated as if the total amount that would be charged for the services by an In-Network Provider or facility were equal to the Recognized Amount for the services, which is the lesser of the Actual amount billed by the provider or facility and the Qualifying Payment Amount. Refer to the Preferred Provider Organization provision in the How The Plan Works And Description Of Benefits section for additional information.

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, TTY 711 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.

This plan provides patient protections from Out-of-Network Provider surprise bills ("balance billing") for Emergency Services and other specified items or services. The Company complies with these patient protections as established under Ohio Revised Code Sections 3902.50 through 3902.54, Ohio Administrative Code Section 3901-8-17, and the Federal No Surprises Act.

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-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Physician's Visits while Confined Limited to 1 visit per day of Confinement per provider	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Maximum days per Policy Year	90	90
Inpatient Rehabilitation Facility Expense Benefit including Physical Medicine and Day Rehabilitation Therapy services Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge 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 Charge after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient) Maximum Visits per Policy Year	60	60
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. You can obtain information on opioid over-use, prevention programs, and case management tools available for high risk individuals by calling the toll free customer service number 877-657-5030 listed on the back of Your ID card.		
Inpatient Mental Health Disorder and Substance Use Disorder Benefit, including Behavioral Health Services Including residential treatment facilities Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Outpatient Mental Health Disorder and Substance Use Disorder Benefit, including Behavioral Health Services Pre-Certification Required except for office visits		
Physician's Office Visits including, but not limited to, Physician visits; individual and group therapy; medication management	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
All Other Outpatient Services including, but not limited to, Intensive Outpatient Programs (IOP); partial hospitalization; Electronic Convulsive Therapy (ECT); Repetitive Transcranial Magnetic Stimulation (rTMS); Psychiatric and Neuro Psychiatric testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
PROFESSIONAL AND OUTPATIENT SERVICES		
Surgical Expenses		
Inpatient and Outpatient Surgery includes: Pre-Certification Required		
Surgeon Services Anesthetist Assistant Surgeon	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Surgical Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Organ Transplant Surgery Donor's search for bone marrow/stem cell transplants limited to $30,000 per Transplant Maximum benefit payable for travel and lodging expenses for any one transplant $10,000 Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Reconstructive Surgery Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Other Professional Services		
Home Health Care Expenses Pre-Certification required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Maximum visits per Policy Year	100	100
Hospice Care Coverage	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Office Visits		
Physician's Office Visits including Specialists/Consultants	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telehealth Services	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Allergy Testing and Treatment including injections	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Chiropractic Care Benefit Maximum visits per Policy Year	12	12
Emergency Services, Ambulance And Non-Emergency Services		
Emergency Services in an emergency department for Emergency Medical Conditions.	$200 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	The cost-share is the same as In-network Provider; however the benefit will be based on the Recognized Amount.
Urgent Care Centers for non-life-threatening conditions	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water, fixed wing and rotary wing air transportation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Non-Emergency Ambulance Service ground and/or air, water, fixed wing and rotary wing air transportation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diagnostic Laboratory, Testing and Imaging Services		
Diagnostic Imaging Services Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge 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 Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Including orally administered cancer drugs Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Infusion Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge 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 Charge after Deductible for Covered Medical Expenses
Cardiac Rehabilitation Maximum Visits per Policy Year	36	36
Pulmonary Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation Maximum Visits per Policy Year	20	20
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy and Inhalation Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maximum Visits for each therapy per Policy Year for Physical Therapy, Occupational Therapy and Speech Therapy and Inhalation Therapy	20	20
Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required Habilitative Services are covered to the extent that they are Medically Necessary – including services for children (up to age 21) with a medical diagnosis of Autism Spectrum Disorder. Clinical Therapeutic intervention, including but not limited to Applied Behavior Analysis, limited to 20 hours per week. These are separate limits and are not combined with therapy limits for other conditions.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Habilitation Services Maximum Visits for each therapy per Policy Year for Physical Therapy, Occupational Therapy and Speech Therapy These limits do not apply to the above limits for the condition of Autism.	20	20
OTHER SERVICES AND SUPPLIES		
Covered Cancer 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 Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Durable Medical Equipment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Enteral Formulas and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
Prosthetic and Orthotic Devices Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Private Duty Nursing Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Private Duty Nursing	90	90

Child Health Supervision Services, when Dependent Coverage is part of this Certificate.	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
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 care	100% of Usual and Customary Charge	
Type B services: Basic Restorative Care	100% of Usual and Customary	
Type C services: Major Restorative care	100% of Usual and Customary	
Medically Necessary Orthodontic services	50% of Usual and Customary	
Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.		

PREVENTIVE AND DIAGNOSTIC SERVICES (TYPE A)	
Diagnostic and Treatment Services:	
Periodic oral evaluation- Limited to 1 every 6 months	
Limited oral evaluation- problem focused- Limited to 1 every 6 months	
Comprehensive oral evaluation- Limited to 1 every 6 months	
Comprehensive periodontal evaluation- Limited to 1 every 6 months	
Intraoral-complete series (including bitewings) 1 every 60 (sixty) months film	
Intraoral- periapical first	
Intraoral- periapical - each additional film	
Intraoral- occlusal film	
Bitewing- single film 1 set every 6 months	
Bitewings -two films 1 set every 6 months	
Bitewings - four films 1 set every 6 months	
Vertical bitewings-7 to 8 films 1 set every 6 months	
Panoramic film-1 film every 60 (sixty) months	
Cephalometric x-ray	
Oral/ Facial Photographic Images	
Diagnostic Models	
Preventative Services:	
Prophylaxis-Child- Limited to 1 every 6 months	
Topical application of fluoride (excluding prophylaxis)--Limited to 2 every 12 months	
Topical application of fluoride (excluding prophylaxis)- 2 every 12 months	
Topical fluoride varnish- 2 in 12 months	
Sealant- per tooth- unrestored permanent molars - 1 sealant per tooth every 36 months	
Preventative resin restorations in a moderate to high caries risk patient- permanent tooth- 1 sealant per tooth every 36 months	
Space maintainer-fixed -unilateral	
Space maintainer-fixed- bilateral	
Space maintainer-removable-unilateral	

Space maintainer-removable-bilateral	
Re-cementation of space maintainer	
Additional Procedures covered as Preventive and Diagnostic:	
Palliative treatment of dental pain- minor procedure	
BASIC RESTORATIVE SERVICES (TYPE B)	
Minor Restorative Services:	
Amalgam- one surface, primary or permanent	
Amalgam- two surfaces, primary or permanent	
Amalgam- three surfaces, primary or permanent	
Amalgam- four or more surfaces, primary or permanent	
Resin-based composite - one surface, anterior	
Resin-based composite -two surfaces, anterior	
Resin-based composite -three surfaces, anterior	
Resin-based composite- four or more surfaces or involving incisal angle (anterior)	
Re-cement inlay	
Re-cement crown	
Prefabricated stainless steel crown· primary tooth - Limited to I per tooth in 60 months	
Prefabricated stainless steel crown - permanent tooth - Limited to I per tooth in 60 months	
Protective Restoration	
Pin retention per tooth, in addition to restoration	
Endodontic Services:	
Therapeutic pulpotomy (excluding final restoration)- *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.*	
Partial pulpotomy for apexogenesis- permanent tooth with incomplete root development *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.*	
Pulpal therapy (resorbable filling)- anterior, primary tooth (excluding final restoration)	
Pulpal therapy (resorbable filling)- posterior, primary tooth (excluding final restoration). Incomplete endodontic treatment when treatment is discontinued.	
Periodontal Services:	
Periodontal scaling and root planing-four or more teeth per quadrant- Limited to 1 every 24 months	
Periodontal scaling and root planing-one to three teeth, per quadrant- Limited to 1 every 24 months	
Periodontal maintenance- 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy.	
Prosthodontic Services:	
Adjust complete denture-maxillary	
Adjust complete denture-mandibular	
Adjust partial denture-maxillary	
Adjust partial denture-mandibular	
Repair broken complete denture base	
Replace missing or broken teeth complete denture (each tooth)	
Repair resin denture base	
Repair cast framework	
Repair or replace broken clasp	
Replace broken teeth- per tooth	
Add tooth to existing partial denture	
Add clasp to existing partial denture	
Rebase complete maxillary denture- Limited to 1 in a 36-month period 6 months after the initial installation	
Rebase maxillary partial denture- Limited to 1 in a 36-month period 6 months after the initial installation	
Rebase mandibular partial denture- Limited to 1 in a 36-month period 6 months after the initial installation	
Reline complete maxillary denture -Limited to 1 in a 36-month Period 6 months after the initial installation	
Reline complete mandibular denture -Limited to l in a 36-month period 6 months after the initial installation	
Reline maxillary partial denture- Limited to 1 in a 36-month period 6 months after the initial installation	
Reline mandibular partial denture- Limited to 1 in a 36-month period 6 months after the initial installation	
Reline complete maxillary denture (laboratory) -Limited to 1 in a 36-month period 6 months after the initial	
Reline complete mandibular denture (laboratory)- Limited to 1 in a 36-month period 6 months after the initial	

Reline maxillary partial denture (laboratory)·Limited to 1 in a 36-month period 6 months after the initial installation	
Reline mandibular partial denture (laboratory) Rebase/Reline- Limited to 1 in a 36-month period 6 months after the initial installation	
Tissue conditioning (maxillary)	
Tissue conditioning (mandibular)	
Re-cement fixed partial denture	
Fixed partial denture repair, by report	
Oral Surgery:	
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
Removal of impacted tooth - soft tissue	
Removal of impacted tooth- partially bony	
Removal of impacted tooth - completely bony	
Removal of impacted tooth - completely bony with unusual surgical complications	
Surgical removal of residual tooth roots (cutting procedure)	
Coronectomy- intentional partial tooth removal	
Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
Surgical access of an unerupted tooth	
Alveoloplasty in conjunction with extractions - per quadrant	
Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant	
Alveoloplasty not in conjunction with extractions- per quadrant	
Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant	
Removal of exostosis	
Incision and drainage of abscess intraoral soft tissue	
Suture of recent small wounds up to *5* cm	
Excision of pericoronal gingiva	
MAJOR SERVICES (TYPE C)	
Major Restorative Services:	
Detailed and extensive oral evaluation- problem focused, by report	
Inlay- metallic- one surface- An alternate benefit will be provided	
Inlay- metallic- two surfaces -An alternate benefit will be provided	
Inlay- metallic-three surfaces -An alternate benefit will be provided	
Onlay- metallic- two surfaces- Limited to 1 per tooth every 60 months	
Onlay - metallic- three surfaces- Limited to 1 per tooth every 60 months	
Onlay - metallic- four or more surfaces- Limited to 1 per tooth every 60 months	
Crown- porcelain/ceramic substrate- Limited to 1 per tooth every 60 months	
Crown- porcelain fused to high noble metal- Limited to 1 per tooth every 60 months	
Crown- porcelain fused to predominately base metal-Limited to 1 per tooth every 60 months	
Crown- porcelain fused to noble metal-Limited to 1 per tooth every 60 months	
PREVENTIVE AND DIAGNOSTIC SERVICES (TYPE A)	
Diagnostic and Treatment Services:	
Periodic oral evaluation- Limited to 1 every 6 months	
Limited oral evaluation- problem focused- Limited to 1 every 6 months	
Comprehensive oral evaluation- Limited to 1 every 6 months	
Comprehensive periodontal evaluation- Limited to 1 every 6 months	
Intraoral-complete series (including bitewings) 1 every 60 (sixty) months film	
Intraoral- periapical first	
Intraoral- periapical - each additional film	
Intraoral- occlusal film	
Bitewing- single film 1 set every 6 months	
Bitewings -two films 1 set every 6 months	
Bitewings - four films 1 set every 6 months	
Vertical bitewings-7 to 8 films 1 set every 6 months	
Panoramic film-1 film every 60 (sixty) months	
Cephalometric x-ray	
Oral/ Facial Photographic Images	
Diagnostic Models	

Preventative Services:	
Prophylaxis-Child- Limited to 1 every 6 months	
Topical application of fluoride (excluding prophylaxis)--Limited to 2 every 12 months	
Topical application of fluoride (excluding prophylaxis)- 2 every 12 months	
Topical fluoride varnish- 2 in 12 months	
Sealant- per tooth- unrestored permanent molars - 1 sealant per tooth every 36 months	
Preventative resin restorations in a moderate to high caries risk patient- permanent tooth- 1 sealant per tooth every 36 months	
Space maintainer-fixed -unilateral	
Space maintainer-fixed- bilateral	
Space maintainer-removable-unilateral	
Space maintainer-removable-bilateral	
Re-cementation of space maintainer	
Additional Procedures covered as Preventive and Diagnostic:	
Palliative treatment of dental pain- minor procedure	
BASIC RESTORATIVE SERVICES (TYPE B)	
Minor Restorative Services:	
Amalgam- one surface, primary or permanent	
Amalgam- two surfaces, primary or permanent	
Amalgam- three surfaces, primary or permanent	
Amalgam- four or more surfaces, primary or permanent	
Resin-based composite - one surface, anterior	
Resin-based composite -two surfaces, anterior	
Resin-based composite -three surfaces, anterior	
Resin-based composite- four or more surfaces or involving incisal angle (anterior)	
Re-cement inlay	
Re-cement crown	
Prefabricated stainless steel crown· primary tooth - Limited to I per tooth in 60 months	
Prefabricated stainless steel crown - permanent tooth - Limited to I per tooth in 60 months	
Protective Restoration	
Pin retention per tooth, in addition to restoration	
Endodontic Services:	
Therapeutic pulpotomy (excluding final restoration)- *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.*	
Partial pulpotomy for apexogenesis- permanent tooth with incomplete root development *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.*	
Pulpal therapy (resorbable filling)- anterior, primary tooth (excluding final restoration)	
Pulpal therapy (resorbable filling)- posterior, primary tooth (excluding final restoration). Incomplete endodontic treatment when treatment is discontinued.	
Periodontal Services:	
Periodontal scaling and root planing-four or more teeth per quadrant- Limited to 1 every 24 months	
Periodontal scaling and root planing-one to three teeth, per quadrant- Limited to 1 every 24 months	
Periodontal maintenance- 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy.	
Prosthodontic Services:	
Adjust complete denture-maxillary	
Adjust complete denture-mandibular	
Adjust partial denture-maxillary	
Adjust partial denture-mandibular	
Repair broken complete denture base	
Replace missing or broken teeth complete denture (each tooth)	
Repair resin denture base	
Repair cast framework	
Repair or replace broken clasp	
Replace broken teeth- per tooth	
Add tooth to existing partial denture	

Add clasp to existing partial denture	
Rebase complete maxillary denture- Limited to 1 in a 36-month period 6 months after the initial installation	
Rebase maxillary partial denture- Limited to 1 in a 36-month period 6 months after the initial installation	
Rebase mandibular partial denture- Limited to 1 in a 36-month period 6 months after the initial installation	
Reline complete maxillary denture -Limited to 1 in a 36-month Period 6 months after the initial installation	
Reline complete mandibular denture -Limited to l in a 36-month period 6 months after the initial installation	
Reline maxillary partial denture- Limited to 1 in a 36-month period 6 months after the initial installation	
Reline mandibular partial denture- Limited to 1 in a 36-month period 6 months after the initial installation	
Reline complete maxillary denture (laboratory) -Limited to 1 in a 36-month period 6 months after the initial	
Reline complete mandibular denture (laboratory)- Limited to 1 in a 36-month period 6 months after the initial	
Reline maxillary partial denture (laboratory)·Limited to 1 in a 36-month period 6 months after the initial installation	
Reline mandibular partial denture (laboratory) Rebase/Reline- Limited to 1 in a 36-month period 6 months after the initial installation	
Tissue conditioning (maxillary)	
Tissue conditioning (mandibular)	
Re-cement fixed partial denture	
Fixed partial denture repair, by report	
Oral Surgery:	
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
Removal of impacted tooth - soft tissue	
Removal of impacted tooth- partially bony	
Removal of impacted tooth - completely bony	
Removal of impacted tooth - completely bony with unusual surgical complications	
Surgical removal of residual tooth roots (cutting procedure)	
Coronectomy- intentional partial tooth removal	
Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
Surgical access of an unerupted tooth	
Alveoloplasty in conjunction with extractions - per quadrant	
Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant	
Alveoloplasty not in conjunction with extractions- per quadrant	
Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant	
Removal of exostosis	
Incision and drainage of abscess intraoral soft tissue	
Suture of recent small wounds up to *5* cm	
Excision of pericoronal gingiva	
MAJOR SERVICES (TYPE C)	
Major Restorative Services:	
Detailed and extensive oral evaluation- problem focused, by report	
Inlay- metallic- one surface- An alternate benefit will be provided	
Inlay- metallic- two surfaces -An alternate benefit will be provided	
Inlay- metallic-three surfaces -An alternate benefit will be provided	
Onlay- metallic- two surfaces- Limited to 1 per tooth every 60 months	
Onlay - metallic- three surfaces- Limited to 1 per tooth every 60 months	
Onlay - metallic- four or more surfaces- Limited to 1 per tooth every 60 months	
Crown- porcelain/ceramic substrate- Limited to 1 per tooth every 60 months	
Crown- porcelain fused to high noble metal- Limited to 1 per tooth every 60 months	
Crown- porcelain fused to predominately base metal-Limited to 1 per tooth every 60 months	
Crown- porcelain fused to noble metal-Limited to 1 per tooth every 60 months	
Crown - 3/4 cast high noble metal- Limited to 1 per tooth every 60 months	
Crown - 3/4 cast predominately base metal- Limited to 1 per tooth every 60 months	
Crown - 3/4 porcelain/ceramic- Limited to 1 per tooth every 60 months	
Crown - full cast high noble metal- Limited to 1 per tooth every 60 months	
Crown- full cast predominately base metal-Limited to 1 per tooth every 60 months	
Crown - full cast noble metal- Limited to I per tooth every 60 months	
Crown-titanium- Limited to 1 per tooth every 60 months	

Core buildup, including any pins- Limited to 1 per tooth every 60 months	
Prefabricated post and core, in addition to crown- Limited to 1 per tooth every 60 months	
Crown repair, by report	
Endodontic Services:	
Anterior root canal (excluding final restoration)	
Bicuspid root canal (excluding final restoration)	
Molar root canal (excluding final restoration)	
Retreatment of previous root canal therapy-anterior	
Retreatment of previous root canal therapy-bicuspid	
Retreatment of previous root canal therapy-molar	
Apexification/recalcification- initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
Apexification/recalcification- interim medication replacement (apical closure/calcific repair of perforations, root	
Apexification/recalcification- final visit (includes completed root canal therapy, apical closure/calcific repair of perforations. root resorption. etc.)	
Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp)	
Apicoectomy/periradicular surgery- anterior	
Apicoectomy/periradicular surgery- bicuspid (first root)	
Apicoectomy/periradicular surgery -molar (first root)	
Apicoectomy/periradicular surgery (each additional root)	
Root amputation- per root	
Hemisection (including any root removal)- not including root canal therapy	
Periodontal Services:	
Gingivectomy or gingivoplasty- four or more teeth-Limited to 1 every 36 months	
Gingivectomy or gingivoplasty-one to three teeth	
Gingival flap procedure, four or more teeth-Limited to 1 every 36 months	
Clinical crown lengthening-hard tissue	
Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant- Limited to 1 every 36 months	
Pedicle soft tissue graft procedure	
Free soft tissue graft procedure (including donor site surgery)	
Subepithelial connective tissue graft procedures (including donor site surgery)	
Full mouth debridement to enable comprehensive evaluation and diagnosis	
Prosthodontic Services:	
Complete denture - maxillary-Limited to 1 every 60 months	
Complete denture- mandibular-Limited to 1 every 60 months	
Immediate denture- maxillary-Limited to 1 every 60 months	
Immediate denture- mandibular-Limited to 1 every 60 months	
Maxillary partial denture- resin base (including any conventional clasps, rests and teeth)- Limited to 1 every 60	
Mandibular partial denture- resin base (including any conventional clasps, rests and teeth)-Limited to 1 every 60	
Maxillary partial denture- cast metal framework with resin denture base (including any conventional clasps, rests	
Mandibular partial denture- cast metal framework with resin denture base (including any conventional clasps, rests	
Removable unilateral partial denture-one piece cast metal (including clasps and teeth)-Limited to 1 every 60 months	
Endosteal Implant- 1 every 60 months	
Surgical Placement of Interim Implant Body- 1 every 60 months	
Eposteal Implant- 1 every 60 months	
Transosteal Implant. Including Hardware- 1 every 60 months	
Implant supported complete denture	
Implant supported partial denture	
Connecting Bar-implant or abutment supported- 1 every 60 months	
Prefabricated Abutment- 1 every 60 months	
Abutment supported porcelain ceramic crown - 1 every 60 months	
Abutment supported porcelain fused to high noble metal- 1 every 60 months	
Abutment supported porcelain fused to predominately base metal crown- 1 every 60 months	
Abutment supported porcelain fused to noble metal crown 1 every 60 months	
Abutment supported cast high noble metal crown - 1 every 60 months	
Abutment supported cast predominately base metal crown – 1 every 60 months	
Abutment supported Cast noble metal crown 1 every 60 months	

Implant supported porcelain/ceramic crown- 1 every 60 months	
Implant supported porcelain fused to high metal crown - 1 every 60 months	
Implant supported metal crown- 1 every 60 months	
Abutment supported retainer for porcelain/ceramic fixed partial denture- 1 every 60 months	
Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months	
Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months	
Abutment supported retainer for porcelain fused to noble metal fixed partial denture- 1 every 60 months	
Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months	
Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months	
Abutment supported retainer for cast noble metal fixed partial denture- 1 every 60 months	
Implant supported retainer for ceramic fixed Partial denture- 1 every 60 months	
Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months	
Implant supported retainer for cast metal fixed partial denture - 1 every 60 months	
Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months	
Implant/abutment supported fixed partial denture for partially edentulous arch- 1 every 60 months	
Implant Maintenance Procedures -1 every 60 months	
Repair Implant Prosthesis -1 every 60 months	
Replacement of Semi-Precision or Precision Attachment- 1 every 60 months	
Repair Implant Abutment -1 every 60 months	
Implant Removal-1 every 60 months	
Implant Index -1 every 60 months	
Pontic-cast high noble metal- Limited to 1 every 60 months	
Pontic-cast predominately base metal -Limited to 1 every 60 months	
Pontic-cast noble metal- Limited to 1 every 60 months	
Pontic-titanium-Limited to 1 every 60 months	
Pontic -porcelain fused to high noble metal-Limited to 1 every 60 months	
Pontic-porcelain fused to predominately base metal-Limited to 1 every 60 months	
Pontic-porcelain fused to noble metal Limited to 1 every 60 months	
Pontic-porcelain/ceramic-Limited to 1 every 60 months	
Inlay/on lay- porcelain/ceramic-Limited to 1 every 60 months	
Inlay-metallic-two surfaces-Limited to 1 every 60 months	
Inlay- metallic-three or more surfaces- Limited to 1 every 60 months	
Onlay- metallic- three surfaces- 1 every 60 months	
Onlay- metallic- four or more surfaces -1 every 60 months	
Retainer -cast metal for resin bonded fixed prosthesis -1 every 60 months	
Retainer- porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months	
Crown- porcelain/ceramic- 1 every 60 months	
Crown -porcelain fused to high noble metal - 1 every 60 months	
Crown- porcelain fused to predominately base metal- 1 every 60 months	
Crown- porcelain fused to noble metal - 1 every 60 months	
Crown -3/4 cast high noble metal - 1 every 60 months	
Crown- 314 cast predominately base metal • 1 every 60 months	
Crown 3/4 cast noble metal 1 every 60 months	
Crown - 3/4 porcelain/ceramic- 1 every 60 months	
Crown • full cast high noble metal- 1 every 60 months	
Crown -full cast predominately base metal- 1 every 60 months	
Crown full cast noble metal 1 every 60 months	
Core build up for retainer including any pins 1 every 60 months	
Occlusal guard, by report- 1 in 12 months	
GENERAL SERVICES (TYPE C)	
Anesthesia Services:	
Deep sedation/general anesthesia- first 30 minutes	
Deep sedation/general anesthesia- each additional 15 minutes	
Intravenous Sedation:	
Intravenous conscious sedation/analgesia- first 30 minutes	
Intravenous conscious sedation/analgesia each additional 15 minutes	

Consultations:		
Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)		
Medications:		
Therapeutic drug injection, by report		
Post-Surgical Services:		
Treatment of complications (post-surgical) unusual circumstances, by report		
MEDICALLY NECESSARY ORTHODONTIAL SERVICES (TYPE D)		
Orthodontic Services-covered for persons with severe and handicapping malocclusion		
Limited orthodontic treatment of the primary dentition		
Limited orthodontic treatment of the transitional dentition		
Limited orthodontic treatment of the adolescent dentition		
Interceptive orthodontic treatment of the primary dentition		
Interceptive orthodontic treatment of the transitional dentition		
Comprehensive orthodontic treatment of the transitional dentition		
Comprehensive orthodontic treatment of the adolescent dentition		
Removable appliance therapy		
Periodic orthodontic treatment visits (as part of contract)		
Orthodontic retention (removal of appliances, construction and placement of retainer(s)		
Pediatric Vision Care Benefit (including low vision services) (to the end of the month in which the Insured Person turns age 19) Limited to 1 visit per Policy Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of Usual and Customary Charge after Deductible for Covered Medical Expenses	
Miscellaneous Dental Services		
Accidental Injury Dental Treatment Limited to $3,000 per Injury per Policy Year	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Treatment for Temporomandibular (TMJ) or Craniomandibular Joint (CMJ) Disorder and Craniomandibular Jaw Disorders	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

PRESCRIPTION DRUGS		
Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy or Student Health Center. **Retail Pharmacy Supply Limits -** We will pay for no more than a 30-day supply of the Prescription Drug purchased at a retail pharmacy. You are responsible for one (1) Cost Sharing amount for up to a 30-day supply.		
TIER 1 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$20 Copayment then the plan pays 100% 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	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$40 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses
More than a 60 day supply filled at a Retail pharmacy	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$60 Copayment then the plan pays 100% 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 See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$40 Copayment then the plan pays 100% 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	$80 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$80 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses

More than a 60 day supply filled at a Retail pharmacy	$120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$120 Copayment then the plan pays 100% 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 See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$60 Copayment then the plan pays 100% 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	$120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$120 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses
More than a 60 day supply filled at a Retail pharmacy	$180 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$180 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses
Specialty Prescription Drugs		
For each fill up to a 30 day supply.	50% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Actual Charge after Deductible for Covered Medical Expenses
More than a 30 day supply but less than a 61 day supply	50% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Actual Charge after Deductible for Covered Medical Expenses
More than a 60 day supply	50% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Actual Charge after Deductible for Covered Medical Expenses

Zero Cost Medications		
In addition to ACA Preventive Care medications, certain Generic Drugs are covered at no cost to you. These zero cost generics can be identified in the Formulary posted on Our website www.wellfleetstudent.com	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	100% of Actual Charge for Covered Medical Expenses Deductible Waived
Tobacco Cessation		
Tobacco cessation prescription and over-the-counter drugs will be covered for two 90-day treatment regimens only. Any additional prescription drug treatment regimens will be subject to the cost sharing below. 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, visit www.wellfleetstudent.com or call 877-657-5030.	100% of Actual Charge for Covered Medical Expenses	
Tobacco cessation prescription drugs beyond the coverage above. Additional regiments of over-the-counter drugs are excluded.	Paid the same as any other Retail Pharmacy Prescription Drug Fill	
Orally administered anti-cancer prescription drugs (including specialty drugs)		
Benefit	Greater of: Chemotherapy Benefit; or Home Infusion Therapy Benefit	
Diabetic Supplies (for Prescription supplies purchased at a pharmacy)		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill	

SECTION I - ELIGIBILITY

An Eligible Student must attend classes at the Policyholder's School for at least the first31 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 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 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.

Who is Eligible

Class	Description of Class(es)
1	All domestic undergraduate students of the Policyholder enrolled in 3.25 OWU credits per term, all International Students, and all student athletes of the Policyholder.

Class 1: All students, as determined by the Policyholder, are eligible for coverage under the Policy. Eligible students are required to have health insurance coverage and will be automatically enrolled in the Student Health Insurance Plan at registration and the premium will be added to the student's tuition fees unless proof of comparable coverage is provided by completing the waiver.

Who is not Eligible

Dependents are not eligible for coverage under this plan.

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.

Special Enrollment – Qualifying Life Event
You can also enroll for coverage within 60 days of the loss of coverage in a health plan if coverage was terminated because You 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 can also enroll 60 days from exhaustion of Your COBRA or continuation coverage.

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 can also enroll for coverage within 60 days of the occurrence of one of the following events:
1. You lose eligibility for Medicaid or a state child health plan.
2. You 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.

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. Dependent coverage is not available under this plan. When this 31 day provision has been exhausted, all Dependent coverage ends. No further benefits will be paid.

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.

Reinstatement Of Reservist After Release From Active Duty: If Your 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.
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.
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.
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.

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, fixed wing and rotary wing air transportation 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.

Continuing Care Patient means an individual who, with respect to a provider or facility,:

- is undergoing a course of Treatment for a serious and complex condition from a provider or facility;
- is undergoing a course of institutional or inpatient care from a provider or facility;
- is scheduled to undergo nonelective surgery from a provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of Treatment for the pregnancy from a provider or facility; or
- is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving Treatment for such illness from such provider or 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 Charge therefore;
2. Not in excess of the charges that would have been made in the absence of this insurance;
3. Not in excess of the Negotiated Charge; and
4. Incurred while 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.

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 an accidental traumatic bodily injury or other medical condition that manifests itself by acute symptoms of such severity (including severe pain) that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:
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. Result in serious impairment to the individual's bodily functions; or
3. Result in serious dysfunction of a bodily organ or part of the individual.

Emergency Services means, with respect to an Emergency Medical Condition: transportation services, including but not limited to Ambulance Services(ground and/or air, water, fixed wing and rotary wing air transportation), 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.

<u>Emergency Services include:</u>
- pre-stabilization services that are provided after the patient is moved out of the emergency department and admitted to a hospital, and
- post-stabilization covered services that are provided after the individual is stabilized, as part of an outpatient observation, or an inpatient or outpatient stay related to the emergency visit (regardless of the department of the hospital), unless the attending emergency physician or treating provider determines that the patient is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a "reasonable travel distance", taking into consideration the individual's medical condition, and the provider or facility furnishing post-stabilization services provides written notice, and
- The patient consents, in accordance with the notice and consent process.

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 services;
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.

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 or a residential treatment 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 or a residential treatment facility. 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 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.

Maintenance Prescription Drug means a Prescription Drug used to treat a condition that is considered chronic or long-term and which usually requires daily use of Prescription Drug. Refer to the Formulary for tier status.

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.

Non-Preferred Drug means a Formulary drug that may have a higher out-of-pocket cost.

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.

Preferred Drug means a Formulary Brand-Name Prescription Drug that may have a lower out-of-pocket cost.

Qualifying Life Event means an event that qualifies a Student to apply for coverage for him/herself due to a Qualifying Life Event under this Certificate.

Qualifying Payment Amount means greater of:
1. the median in-network rate;
2. the amount for the service calculated using the same method the health benefit plan generally uses to determine payments for out-of-network health care services; and
3. the amount that would be paid by Medicare.

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

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

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

Serious and Complex Conditions means,
- in the case of an acute illness, a condition that is serious enough to require specialized medical Treatment to avoid the reasonable possibility of death or permanent harm; or
- in the case of a chronic illness or condition, a condition that:
    i. is life-threatening, degenerative, potentially disabling, or congenital; and
    ii. requires specialized medical care over a prolonged period of time.

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.

Stabilize/ Stabilization means, the Treatment given to You as necessary and within reasonable probability to assure that deterioration is not likely from or during Your discharge or transfer from an emergency care setting or department to another facility or department in the Hospital if the medical condition could result in any of the following:
- Serious jeopardy to Your health; or
- Serious impairment to bodily functions; or
- Serious dysfunction to any bodily organ or part; or
- In the case of a woman having contractions, "Stabilize" means medical Treatment necessary to deliver, including the placenta.

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 did not have the ability to request such services from an In-Network provider, like 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 the health care services provided through the use of information and communication technology by a health care professional, within the professional's scope of practice, who is located at a site other than the site where either of the following is located:

- The patient receiving the services;
- Another health care professional with whom the provider of the services is consulting regarding the patient.

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 an illness or injury that requires prompt medical attention but is not an Emergency Medical Condition and services are provided at an Urgent Care Center, as shown in the Schedule of Benefits.

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

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

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

Special terms used

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

Service or Supply	Reasonable Amount Rate
Professional services and Inpatient and outpatient charges of hospitals	The lesser of: 1. The billed charge for the services; or 2. An amount determined using current publicly-available data which is usual and customary when compared with the charges made for a) similar services and supplies and b) to persons having similar medical conditions in the geographic area where service is rendered; or

	3. An amount based on information provided by a third party vendor, which may reflect 1 or more of the following factors: 1) the complexity or severity of Treatment; 2) level of skill and experience required for the Treatment; or 3) comparable providers' fees and costs to deliver care; or 4. In the case of Emergency Services from an Out-of-Network Provider or facility including Ambulance (ground and/or air, water, fixed wing and rotary wing air transportation), and non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center without your consent, the Recognized Amount.

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

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

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

Our reimbursement policies are based on Our review of:

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

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

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

You, or Your(s) means an Insured Person, Insured Student 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 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. 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.

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 Out-of-Pocket Maximum.

Individual
Once the amount of the Copayments, Coinsurance and Deductibles You have incurred for Covered Medical Expenses during the Policy Year meets the:

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

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

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 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 Charge 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 select. This Certificate provides access to both In-Network Providers and Out-of-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by In-Network Providers versus Out-of-Network Providers, as shown in the Schedule of Benefits.

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

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

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

Note, however, that We will pay at the In-Network level for Treatment by an Out-of-Network Provider, and will calculate Your cost sharing amount at the In-Network Provider level, and Your cost share will be applied to Your In-Network Deductible and Out-of-Pocket Maximum if:
1. there is no In-Network Provider in the Preferred Provider service area available to provide a Preventive Service or treat You for a specific Covered Injury or Covered Sickness; or

2. You have an Emergency Medical Condition and receive Emergency Services from an Out-of-Network Provider or facility. The most the Out-of-Network Provider or facility may bill You is the In-Network cost sharing amount (such as Deductibles, Copayments and Coinsurance). You can't be balance billed for these Emergency Services.

This includes services You may get after You're in 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 without your consent You is the In-Network cost sharing amount. You can't be balance billed or asked to give up Your for ancillary services, including but is not limited to, emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, Assistant Surgeon, hospitalist, intensivist services, and items and services provided by an Out-of-Network Provider if there is no In-Network Provider who can furnish such item or service at such facility, or items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network Provider satisfied proper notice and consent.

   However, if You received notice from the Out-of-Network Provider of their non-network status under the following circumstances, We will pay Covered Medical Expenses at the Out-of-Network level as shown in the Schedule of Benefits:

   - If the appointment is scheduled at least 72 hours prior to the date of service, and notice is provided not later than 72 hours prior to the date of service; or
   - If the appointment is scheduled within 72 hours prior to the date of service, and notice is provided on the date the appointment is scheduled; or
   - If the appointment is scheduled on the date of service, and notice is provided no later than 3 hours prior to the service; and
   - You gave written consent to Treatment, this Certificate will pay Covered Medical Expenses at the Out-of-Network level as shown in the Schedule of Benefits.

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

Continuity of Care

If You are a Continuing Care Patient 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 ending on the earlier of:

- 90 days from the date of the notice to You, or
- The date on which you are no longer a Continuing Care Patient with respect to the In-Network Provider.

Pre-Certification Process

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

Out-of-Network – You or Your Out-of-Network Provider are responsible for calling Us at the phone number found on the back of Your ID card and starting the Pre-Certification process. For Inpatient services the call must be made at least 5 working days prior to Hospital Confinement. For Outpatient services, the call must be made at least 5 working days prior to the start of the Outpatient service. In the case of an emergency, the call must take place as soon as reasonably possible.

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

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. Home 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) precertification required after the 12th visit;
17. Occupational Therapy (Outpatient) precertification required after the 12th visit;
18. Chiropractic Services (Outpatient) precertification required after the 12th visit.

Pre-Certification is not required for an Emergency Medical 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 or Out-of-Network Providers.

Pre-Certification is not a guarantee that Benefits will be paid, this does not apply to electronic pre-certifications. We will not retrospectively deny if all criteria is met at the time the services are rendered.

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

Our agent will make this determination within forty-eight (48) hours for an urgent request and four (4) business days for non-urgent requests following receipt of all necessary information for review. If additional information is needed to make a determination Our agent will notify Your Provider within 24 hours with the specific information that is required.

Notice of an Adverse Benefit Determination made by Our agent will be in writing or secure electronic transmission process 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.

Retro Review is permitted for a claim that is submitted for a service where Pre-Certification was required but not obtained if the service in question meets all of the following criteria:
1. The service is directly related to another service for which Pre-Certification was obtained and already performed;
2. The new service was not known to be needed at the time the original Pre-Certification was performed;
3. The need for the new service was revealed at the time the original authorized service was performed.

Once the request and all necessary information is received, the claim will be reviewed for coverage and medical necessity. The new service will not be denied based solely on the fact that a Pre-Certification approval was not received originally.

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.

Urgent Care claims means a medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:
1. Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state;
2. In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

Urgent care requests can be submitted in writing or by a secure electronic transmission process (facsimile is not considered a secure electronic transmission).

Opioid dependency Treatment is considered an Urgent Care request in accordance with applicable state and federal laws.

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

COVERED MEDICAL EXPENSES

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

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). Such as, but not limited to, cytologic screening for the presence of cervical cancer and mammography screening to detect the presence of breast cancer in adult women. These can be found at the following websites: www.uspreventiveservicestaskforce.org/recommendations; and http://www.healthcare.gov/coverage/preventive-care-benefits/.
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. 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.
4. With respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration, including the following:

a. Women's contraceptives for each of the methods identified by the FDA, sterilization procedures, and counseling. This includes Generic and single-source Brand Name Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Name Drugs will be covered under the Prescription Drug benefit.
b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per Policy Year.
c. Gestational diabetes screening.

5. 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.

Contraception Exception Process
If an Insured Person's attending Physician recommends a particular service or FDA-approved item based on a determination of Medical Necessity with respect to that Insured Person, We must cover that service or item without cost sharing. We must defer to the determination of the attending Physician. Medical Necessity may include considerations such as severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service, as determined by the attending Physician.

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** not to exceed 1 visit per day of confinement per provider. 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.

   Exclusions under this benefit include**:**
   a. Custodial Care service and supplies, and
   b. Confinement for Custodial Care or residential care.

5. **Inpatient Rehabilitation Facility Expense Benefit**, including Physical Medicine and Day Rehabilitation Program, for the services, supplies and Treatments rendered to You in an **Inpatient Rehabilitation** Facility or through a Day Hospital. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

   A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the Insured Persons ability to function as independently as possible; including:
   a. Charges for room, board, and general nursing services;
   b. Charges for Skilled Rehabilitation nursing care;
   c. Charges for physical, occupational, or speech therapy and services of a social worker or psychologist.

   Non covered services for Physical Medicine and Inpatient Rehabilitation include, but are not limited to**:**
   a. Admission to a Hospital mainly for physical therapy;
   b. Long term rehabilitation in an Inpatient setting.

   Benefits include a day rehabilitation program for those Insured Persons who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a Day Hospital. Day rehabilitation program services may consist of physical therapy, occupational therapy, speech therapy, nursing services, and neuro psychological services. A minimum of two Therapy services must be provided for this program to be a Covered Service.

6. **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 services including but not limited to a residential treatment facility for the Treatment of Mental Health Disorders as specified on the Schedule of Benefits. Outpatient services including but not limited to the following: Intensive Outpatient Programs; Partial Hospitalization, Electronic Convulsive Therapy, Repetitive Transcranial Magnetic Stimulation (rTMS); and Psychiatric and Neuro Psychiatric testing.

2. **Inpatient and Outpatient Substance Use Disorder Benefit** for services including but not limited to a residential treatment facility for the Treatment of Substance Use Disorders as specified on the Schedule of Benefits. Outpatient services including but not limited to the following: Intensive Outpatient Programs; Partial Hospitalization, Electronic Convulsive Therapy, Repetitive Transcranial Magnetic Stimulation (rTMS); and Psychiatric and Neuro Psychiatric testing.

3. **Behavioral Health Services** includes coverage for Biologically Based Mental Illness services. Biologically Based Mental Illness means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Behavioral Health Services will be paid on the same basis as any other Covered Sickness.

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. Male sterilization is a covered service under this benefit.

   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. These benefits include, but are not limited to, necessary acquisition procedures, harvest and storage, and including medically necessary preparatory myeloablative therapy, and initial evaluation/testing to determine eligibility as a transplant candidate. Also included is obtaining an organ from a live donor, including complications from the surgery for up to six weeks from the date the organ is obtained.

   There are instances where a provider requests approval for HLA testing, donor searches and or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing.

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.

Non covered services for Organ Transplant Surgery include, but not limited to:
a. Routine harvesting and storage of stem cells from newborn cord blood;
b. The purchase price of any organ or tissue;
c. Donor services if the recipient is not an Insured Person under this plan;
d. Services for or related to the transplantation of animal or artificial organs or tissues;
e. 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) while at the transplant facility. Benefits are limited as shown in the Schedule of Benefits.

Benefits will also be provided for the expenses of a donor including transportation (coach class only), lodging, and meal expenses.

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.

OTHER PROFESSIONAL SERVICES

1. **Home Health Care Expenses** includes home health care services provided by a home health agency in the home, but only when all of the following criteria are met:
   a. The Insured Person is homebound for medical reasons.
   b. The Insured Peron is physically unable to obtain the services on an outpatient basis.

   Home health care eligible health services include, but are not limited to:
   a. Medical/social and diagnostic services
   b. Nutritional guidance
   c. Medical and surgical supplies
   d. Durable medical equipment
   e. Private duty nursing (provided by an R.N. or L.P.N. for non-hospitalized acute illness or injury if your condition requires skilled nursing care)
   f. Prescription drugs (if provided and billed by a home health care agency)

g. Intermittent skilled nursing services (by an R.N. or L.P.N.)
h. Home health aide services when the Insured Person is receiving skilled nursing or therapy services. The services are provided by trained personnel that are employed by the home health care agency. Other organizations may provide services when we approve it. Their duties must be assigned and be supervised by a professional nurse employed by the home health care agency.
i. Therapy services (except manipulation therapy, which is not covered when provided in the home). Please see your schedule of benefits for any applicable limits when therapy is provided in the home.

Non covered services under this benefit includes Custodial Care service and supplies.

2. **Hospice Care Coverage** may be provided in the home or at a hospice care facility where medical, social and psychological services are given to help treat patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible, an Insured Person must have a life expectancy of six months or less, as confirmed by their provider. These benefits will continue if they live longer than six months.

   When approved by your Physician, covered services include:
   a. Inpatient confinement at a Hospice
   b. Medical supplies, equipment and appliances (benefits are not covered for equipment when the Insured Person is in a Facility that should provide such equipment.
   c. Prescription Drugs given by the Hospice.
   d. Counseling services
   e. Skilled nursing care (by an R.N. or L.P.N.) and home health aid
   f. Diagnostic services
   g. Physical, speech and inhalation therapies, if part of the treatment plan.

   Non-Covered Services for Hospice Care include but are not limited to:
   a. Services provided by volunteers
   b. Housekeeping services.

OFFICE VISITS

1. **Physician's Office Visits**. We will not pay for more than 1 visit per day to the same Physician. 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. **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 or any other method as required by state law.

3. **Allergy Testing and Treatment including injections** this includes tests that You need such as PRIST, RAST, and scratch tests. 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 includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy services as specified in the Schedule of Benefits. Manipulation Therapy services rendered in the home as part of Home Health Care Services are not covered.

   Non covered service for Chiropractic Care include but not limited to:
   This benefit does not cover charges incurred for:

a. Acupuncture,
b. heat Treatment,
c. diathermy,
d. massage, in any form, except to the extent provided in the Schedule of Benefits

EMERGENCY SERVICES, AMBULANCE AND NON-EMERGENCY SERVICES

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

   If You receive Emergency Services from an Out-of-Network Provider or facility, the most the Out-of-Network Provider or facility may bill You is the In-Network cost sharing amount. The post-stabilization services will no longer qualify as Emergency Services once the Out-of-Network Provider or facility determines that You can travel using non-medical or non-emergency transportation, the Out-of-Network Provider provides proper notice and 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)** are used when a medical problem that is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorized you to go to an emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.

3. **Emergency Ambulance Service,** with respect to an Emergency Medical Condition, includes transport by professional ambulance services (including ground, water, fixed wing and rotary wing air transportation):
   - From the scene of an accident or medical emergency to the closest hospital to provide emergency services.
   - From one hospital to another hospital.
   - From hospital or skilled nursing facility to an Insured's home or to another facility, if an ambulance is the only safe way to transport an Insured.
   - From an Insured's home to a hospital, if an ambulance is the only safe way to transport an Insured.

   The plan also covers transportation when ordered by an employer, school, fire or public safety official and an Insured cannot refuse or if We require the Insured Person to move from a Non-Preferred Provider facility to a Preferred Provider facility.

   Treatment by medical personnel from an ambulance service is covered even if an Insured is not transported. But only if they meet the requirements for health services.

Ambulance trips must be made to the closest local facility that can provide health services appropriate for an Insured's condition. If none of these facilities are in the local area, an Insured is covered for trips to the closest facility outside of the area.

Non-covered Services for Ambulance include but are not limited to:
- A Physician's office or clinic;
- A Morgue or Funeral Home.

4. **Non-Emergency Ambulance Service** for Medically Necessary transportation by a professional ambulance services (including ground, water, fixed wing and rotary wing air transportation) 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.

   Specific diagnostic services include, but are not limited to:
   1. X-ray and other radiology services, including mammograms for any person diagnosed with breast disease
   2. Magnetic Resonance Angiography (MRA)
   3. Laboratory and pathology services
   4. Cardiographic, encephalographic, and radioisotope tests
   5. Nuclear cardiology imaging studies
   6. Ultrasound services and allergy tests
   7. Electrocardiograms (EKG)
   8. Electromyograms (EMG), except that surface EMG's are excluded
   9. Echocardiograms
   10. Bone density studies
   11. Diagnostic tests to evaluate the need for a transplant procedure
   12. Echographies and Doppler studies
   13. Brainstem evoked potentials (BAER)
   14. Somatosensory evoked potentials (SSEP)
   15. Visual evoked potentials (VEP)
   16. Nerve conduction studies
   17. Muscle testing
   18. Electrocorticograms

   Complex imaging for preoperative testing is covered under this benefit. Whether perform in a hospital or physician's office, IV tubing or dye are covered as part of the test.

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** Chemotherapy, oral chemotherapy drugs, for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents. Radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning**.**
5. **Home Infusion Therapy** Benefit for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services that are delivered and administered through an IV in the Insured's home. Home IV therapy includes, but is not limited to:
   - Injections (intra-muscular, subcutaneous, continuous subcutaneous)
   - Total Parenteral Nutrition (TPN)
   - Enteral nutrition therapy
   - Antibiotic therapy
   - Pain management
   - Chemotherapy.

REHABILITATION AND HABILITATION THERAPIES

1. **Cardiac Rehabilitation:** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered**.**

2. **Pulmonary Rehabilitation** to restore an individual's functional status after an illness or injury. Covered services include, but are not limited to, outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in a Physician's office, including, but not limited to, breathing exercise, exercise not elsewhere classified and other counseling. Pulmonary rehabilitation in an acute inpatient rehabilitation setting is not a covered service.

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

4. **Inhalation Therapy** for the treatment of a Covered Injury or Illness, by the administration of medicine, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; non-pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with our without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

5. **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part.

   Non covered services include but are not limited to:
   a. maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness;
   b. repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients);
   c. range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities;
   d. general exercise programs;
   e. diathermy, ultrasound and heat treatments for pulmonary conditions;
   f. diapulse;
   g. work hardening.

6. **Speech Therapy** for the correction of a speech impairment.

7. **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).
   Non covered services include but are not limited to:
   a. supplies (looms, ceramic tiles, leather, utensils);
   b. therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again;
   c. general exercises to promote overall fitness and flexibility;
   d. therapy to improve motivation; suction therapy for newborns (feeding machines);
   e. soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial;
   f. adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

8. **Habilitation Services** when prescribed by the attending Physician. Habilitative Services for children (0 to 21) with a medical diagnosis of Autism Spectrum disorder at a minimum shall include:
   1. Out-Patient Physical Rehabilitation Services including
      a. Speech and Language therapy and/or Occupational therapy, performed by licensed therapists;
      b. Clinical Therapeutic Intervention defined as therapies supported by empirical evidence, which include but are not limited to Applied Behavioral Analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of Ohio to perform the services in accordance with a treatment plan.
   2. Mental/Behavioral Health Outpatient Services performed by a licensed Psychologist, Psychiatrist, or Physician to provide consultation, assessment development and oversight of the treatment plan.

   See the Schedule of Benefits for any applicable benefit limitations.

OTHER SERVICES AND SUPPLIES

1. **Covered Cancer Clinical Trials** includes coverage for routine costs associated with Your participation in a clinical trial for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709. Coverage does not include the studied device, equipment or drug, data collection services and any service not associated with direct clinical care to You.

   In addition, services include routine costs if You are participating in any stage of a Cancer Clinical Trial. Benefits are available for routine patient care rendered as part of a cancer clinical trial if the services would be eligible health services under this Certificate and the clinical trial meets the requirements.

   Cancer Clinical Trial means a cancer clinical trial that meets all of the following criteria:
   1. The purpose of the trial is to test whether the intervention may improve the participant's health or the treatment is given with the intention of improving the participant's health, and is not designed to test toxicity or disease pathophysiology
   2. The trial does one of the following:
      a. Tests how to administer and the responses to health care services, items, or drugs for cancer treatment
      b. Compares the effectiveness of a health care service, item, or drug for cancer treatment
      c. Studies new uses of health care services, items, or drugs for cancer treatment

   3. The trial is approved by one of the following:
      a. The National Institutes of Health
      b. The Food and Drug Administration
      c. The Department of Defense

d. The Department of Veterans Affairs
e. The Centers for Disease Control and Prevention
f. The Agency for Health Care Research and Quality
g. The Centers for Medicare & Medicaid Services
h. Cooperative group or center of any of the entities described above
i. The Department of Energy

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 for the blind
   - Diabetic test agents
   - Prescribed oral medications whose primary purpose is to control blood sugar
   - Injectable glucagon
   - Glucagon emergency kits

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

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

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

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

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

3. **Dialysis Treatment** of an acute or chronic kidney ailment, provided in an Outpatient facility of a Hospital, a free-standing renal Dialysis facility or in 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, cochlear implants, Hospital beds, wheelchairs, walkers, braces that stabilize an injured body part and braces to treat curvature of the spine. Benefits will also include breast prosthesis, whether internal or external, following a mastectomy. 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.

   Covered DME items include, but are not limited to:
   a. Hemodialysis equipment
   b. Crutches and replacement of pads and tips

c. Pressure machines
d. Infusion pump for IV fluids and medicines
e. Tracheotomy tube
f. Cardiac, neonatal and sleep apnea monitors
g. Augmentive communication devices, when approved based on the condition

Non covered services for DME items include but are not limited to:
a. Air Conditioners
b. Ice bags/cold pack pump
c. Raised toilet sear
d. Rental of equipment if the Member is in a Facility that is expected to provide such equipment
e. Translift chairs
f. Treadmill exerciser
g. Tub chair used in shower.

Medical and surgical supplies include certain supplies and equipment for the management of diseases. This does not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

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. **Maternity Benefit** includes prenatal and postpartum care and obstetrical services. Coverage also includes the services and supplies needed for circumcision by a provider. After a child is born, eligible health services include:
   a. A minimum of 48 hours of inpatient care in a hospital after a vaginal delivery.
   b. A minimum of 96 hours of inpatient care in a hospital after a cesarean delivery.
   c. A shorter stay, if the attending physician, with the consent of the mother, discharges the mother or newborn earlier based upon the evaluation of:
      i. The antepartum, intrapartum, and postpartum course of the mother and infant
      ii. The gestational stage, birth weight, and clinical condition of the infant
      iii. The demonstrated ability of the mother to care for the infant after discharge
      iv. The availability of post-discharge follow-up to verify the condition of the infant after discharge

   d. The mother could be discharged earlier. If so, the plan will pay for post-delivery home visits for follow-up care for the mother and newborn when ordered and supervised by the attending physician or an advanced practice registered nurse, except that if a certified nurse-midwife is attending the mother in collaboration with a physician, the decision may be made by the certified nurse-midwife. If the mother is discharged earlier than the minimum lengths of stay, we will pay for all follow-up care received within 72 hours after discharge. If the mother receives at least the minimum number of hours of inpatient care, we will pay for eligible health services as recommended by the attending physician. The follow-up care includes:

i. Parent education
ii. Assistance and training in breast or bottle feeding
iii. Physical assessment of the newborn, mother and home support system
iv. The collection of an adequate sample for the hereditary and metabolic newborn screening.

Clinical tests and other services that are in line with the follow-up care recommended in the protocols and guidelines developed by national organizations representing the providers.

Coverage also includes benefits for therapeutic abortions when performed to save the life or health of the mother, or as a result of incest or rape.

Non-covered Service for Maternity Benefit include but are not limited to services that are duplicated when provided by both a certified Nurse-midwife and a Physician.

7. **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.

Prosthetic Devices for artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
a. Replace all or part of a missing body part and its adjoining tissues; or
b. Replace all or part of the function of a permanently useless or malfunctioning body part.

Covered prosthetic devices may include, but are not limited to:
a. Left ventricular artificial devices (LVAD), but only when used as a bridge to a heart transplant
b. Breast prosthesis following a mastectomy, and four surgical bras per contract year
c. Intraocular lens implantation for the treatment of cataract or aphakia
d. Contact lenses or glasses following lens implantation
e. The first pair of contact lenses or eye glasses that replace the function of the human lens for conditions caused by cataract surgery or injury (a donor lens is not the first lens)
f. Cochlear implant
g. Colostomy and other ostomy supplies directly related to ostomy care
h. Wigs (not to exceed one per contract year)
i. Restoration prosthesis
j. Aids and supports for defective parts of the body including but not limited to:
    i. Internal heart valves, mitral valve, internal pacemaker, pacemaker power sources
    ii. Synthetic or homograft vascular replacements
    iii. Fracture fixation devices internal to the body
    iv. Replacements for injured or diseased bone and joint substances
    v. Mandibular reconstruction appliances
    vi. Bone screws, plates and vitallium heads for joint reconstruction

Non covered services for Prosthetic appliance include but are not limited to:
a. Dentures, replacing teeth or structures directly supporting teeth
b. Dental appliances
c. Such non-rigid appliance as elastic stockings, garter belts, arch supports and corsets
d. Artificial heart implants
e. Wigs (except as described above following cancer treatment).
f. Penile prosthesis in men suffering impotency resulting from disease or injury.

Orthotic Devices include initial purchase, fitting and repair of a custom-made rigid or semi-rigid supportive device used to support, align, prevent or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fitting and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic device is billed with it but not if billed separately.

Covered orthotic devices may include, but are not limited to:
a. Cervical collars
b. Ankle foot orthosis
c. Back and special surgical corsets
d. Splints
e. Trusses and supports
f. Slings
g. Wristlets
h. Built-up shoe
i. Custom made shoe inserts

Orthotic appliances may be replaced once per year per Insured Person when Medically Necessary. Additional replacements will be allowed for an Insured Person under age 18 due to rapid growth, or when an appliance is damaged and cannot be repaired.

Non covered services for Orthotic devices include but not limited to:
a. Orthopedic shoes (except therapeutic shoes for diabetics)
b. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace
c. Standard elastic stockings, garter belts, and other supplies not specially made and fitted
d. Garter belts or similar devices.

8. **Outpatient Private Duty Nursing** services for non-hospitalized care performed by a R.N. or L.P.N for a Covered Injury or Covered Sickness if the condition requires skilled nursing care and visiting nursing care is not adequate. Services must be:
   - rendered in the home;
   - prescribed by the attending Physician as being Medically Necessary; and
   - performed by a certified Home Health Care Agency.

9. **Child Health Supervision Services** from the moment of birth to age nine when Dependent Coverage is part of this Certificate.

   As used in this benefit:
   Child Health Supervision Services means a Periodic Review of a child's physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, or, in the case of the hearing screening, under the direction of an audiologist or Physician or in collaboration with a Physician.

   Period Review means a review performed in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

   Other covered services include routine hearing screenings and routine vision screenings.

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 or 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 precertification 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
      x. Hi-index lenses

MISCELLANEOUS DENTAL SERVICES

1. **Accidental Injury Dental Treatment** as the result of Injury. Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

   Covered Services for accidental dental include but are not limited to:
   a. oral examinations
   b. x-rays

c. tests and laboratory examinations
d. Restorations
e. prosthetic services
f. oral surgery
g. mandibular/maxillary reconstruction
h. anesthesia

Other covered dental services include facility charges for Outpatient services for the removal of teeth or for other dental processes if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient.

See Schedule of Benefits for any limitations to cost sharing. This limit will not apply to Outpatient facility charges, anesthesia billed by a Provider (other than the Physician performing the service) or to services that We are required by law to cover.

Note: Treatment must be received within 365 days of Injury and excludes broken fillings or damage caused by biting or chewing. The benefit limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than the Physician performing the service, or to services that We are required by law to cover.

Non covered services under this benefit include but not limited to:
a. orthodontic braces and orthodontic appliances.
b. routine dental care and treatment

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

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-certification. Pre-certification may be required for coverage of an opioid analgesic prescribed for the treatment of chronic pain, except for the following: when prescribed for a hospice patient in a hospice care program; a patient diagnosed with a terminal condition (but not a hospice patient); a patient who has cancer or another condition associated with their cancer or history of cancer. 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** – Refer to the Schedule of Benefits.

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

b. The prescribing practitioner can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to You.

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

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

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

k. **Formulary Exception Process** – If a Prescription Drug is not on Our Formulary, You, Your Authorized Representative or Your prescribing Physician may request a Formulary exception for clinically appropriate Prescription Drug in writing, electronically or telephonically. If coverage is denied under Our standard or expedited Formulary exception process, the Covered Person is entitled to an external appeal as outlined in the External Appeal section of this Certificate. Refer to the Formulary posted on Our website at www.wellfleetstudent.com or call the number on Your ID card to find out more about this process.

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

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

l. **Tobacco cessation prescription and over-the-counter drugs** – Refer to the Schedule of Benefits.

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 -** Coverage for oral anti-cancer prescription drugs under the pharmacy benefit will not be less favorable than for chemotherapy under the medical benefit.

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 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 does not apply to a schedule II controlled substance, opioid analgesic, or benzodiazepine, as defined under Ohio law.

Non covered drugs under this Prescription Drug benefit for any drug or medicine:

a. Prescription Drugs dispensed by any Mail Service program other than the PBM's mail Service, unless prohibited by law, except as required for Preventive Care Services and unless covered elsewhere in this certificate.
b. Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product, except as required for Preventive Care Services.
c. Off label use, except as otherwise prohibited by law.
d. Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
e. Drugs not approved by the FDA.
f. Charges for the administration of any Drug.
g. Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.
h. Any Drug which is primarily for weight loss.
i. Drugs not requiring a prescription by federal law (including Drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
j. Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
k. Fertility Drugs, unless covered elsewhere in this certificate.

l. Oral immunizations, and biologicals, although they are federal legend Drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter Drugs, devices or products, they are not Covered Services, unless such over the counter methods are prescribed by a Physician, except as specifically provided under Preventive Services.
m. Drugs in quantities which exceed the limits established by the Plan.
n. Compound Drugs unless there is at least one ingredient that requires a prescription.
o. Treatment of Onychomycosis (toenail fungus).
p. Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter except for Preventive Services.
q. Brand-Name Prescription Drugs with generic equivalents, except as specifically provided under Preventive Services.

SECTION V - 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 the Insured Person's 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 the Insured Person could be eligible.
- Which are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.
- Received from an individual or entity that is not a Provider, as defined in this Certificate, or recognized by Us.
- Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, subject to the internal and external review process. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.
- For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to an Insured Person, then this Exclusion does not apply. This exclusion applies if the Insured Person receives the benefits in whole or in part. This exclusion also applies whether or not the Insured Person claims the benefits or compensation.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
- For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
- For court ordered testing or care unless Medically Necessary.
- For which an Insured Person has no legal obligation to pay in the absence of this or like coverage.
- For the following:
    - Physician or Other Practitioners' charges for consulting with Insured Persons by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Insured Person except as otherwise described in this Certificate.
    - Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with Providers not directly responsible for an Insured Person's care.
    - Charges that are not documented in Provider records.

- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

- Received from a dental or medical department maintained by or on behalf of a School, mutual benefit association, labor union, trust or similar person or group, or as part of the Student Health Center benefits provided by this plan.
- Prescribed, ordered or referred by or received from a member of an Insured Person's immediate family, including an Insured Person's spouse, child, brother, sister, parent, in-law, or self.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For mileage, lodging and meals costs, and other Insured Person travel related expenses, except as specifically stated as a Covered Service.
- For which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if an Insured Person had applied for Parts A, B and/or D, except, as specified elsewhere in this Certificate or as otherwise prohibited by federal law, as addressed in the section titled "Medicare" in General Provisions. For the purposes of the calculation of benefits, if the Insured Person has not enrolled in Medicare Part B, We will calculate benefits as if they had enrolled.
- Charges in excess of Our Maximum Usual and Customary.
- Incurred prior to an Insured Person's Effective Date.
- Incurred after the termination date of this coverage except as specified elsewhere in this Certificate.
- For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves an Insured Person's present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
- For the following:
  - Custodial Care, convalescent care or rest cures.
  - Domiciliary care provided in a residential institution, (except for Mental Health Disorder and Substance Use Disorder treatment), treatment center, halfway house, or school because an Insured Person's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
  - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
  - Care provided or billed by a residential facility (except for Mental Health Disorder and Substance Use Disorder treatment), including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
  - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
  - Wilderness camps.
- For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
  - cleaning and soaking the feet.
  - applying skin creams in order to maintain skin tone.
  - other services that are performed when there is not a localized illness, injury or symptom involving the foot.
- For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.
- For marital counseling.
- For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- For services to reverse voluntarily induced sterility.
- For personal hygiene, environmental control, or convenience items including but not limited to:

    - Air conditioners, humidifiers, air purifiers;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;
    - Safety helmets for Insured Persons with neuromuscular diseases; or
    - Sports helmets.
- Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
- For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or as otherwise described in this Certificate.
- For care received in an emergency room which is not Emergency Care, except as specified in this Certificate. This includes, but is not limited to suture removal in an emergency room.
- For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
- For self-help training and other forms of non-medical self-care, except as otherwise provided in this Certificate.
- For examinations relating to research screenings.
- For stand-by charges of a Physician.
- Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes except as required under Preventive Services.
- For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.
- For Manipulation Therapy services rendered in the home as part of Home Care Services.
- Services and supplies for sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
- For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bio energetic synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
- For surgical treatment of gynecomastia.
- Complications directly related to a service or treatment that is a non- Covered Service under this Certificate because it was determined by Us to be Experimental/Investigational or non- Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non- Medically Necessary service.
- Treatment of telangiectatic dermal veins (spider veins) by any method.
- Reconstructive services except as specifically stated in the **Covered Services** section of this Certificate, or as required by law.
- Human Growth Hormone for children born small for gestational age.
- 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.
- 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.

- Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
- Expenses that are not recommended and approved by a Physician.
- Routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal or artificial organs or tissues.
- 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.
- Sleep Disorders, except for the diagnosis and Treatment of obstructive sleep apnea.
- Charges for hot or cold packs for personal use.

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.
- 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.
- Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

Family Planning:
  - Cloning; or
  - Medical and surgical procedures that are Experimental or Investigative, unless Our denial is overturned by an External Appeal Agent.
- Elective abortions.

Vision
- 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.
- Prescriptions, fitting, or purchase of eyeglasses or contact lenses, except for benefits provided under Pediatric Vision, and except in the case of Injury or as otherwise provided and unless covered elsewhere in this Certificate.
- Vision correction surgery, Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision (including LASIK, radial keratotomy or keratomileusis), except as provided herein or when due to a disease process. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery for treatment of cataract or aphakia, contact lenses or glasses following lens implantation.

Dental

- Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
- Dental Implants, except for the benefit covered under the Pediatric Dental benefit, unless covered elsewhere in this Certificate.
- Extraction of impacted wisdom teeth or dental abscesses.

Hearing

- Charges for hearing exams, hearing screening, hearing aids and the fitting or repair or replacement of hearing aids 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;
- 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;
- For Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply, except as required for Preventive Care Services;
- Nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

SUBROGATION AND RECOVERY RIGHTS

Right of Recovery: If the amount of the payment made by Us is more than We should have paid under this Policy, We may recover the excess from one or more of: (a) The person We have paid; (b) The person for whom We have paid; (c) Insurance companies or any other plan; or (d) other organization. The amount of the payments made includes the reasonable cash value of any benefit provided in the form of services.

Right to Subrogation: If the Insured Person suffers an Injury or Covered Sickness through the act or omission of another person, and if benefits are paid under this Policy due to such Injury or Covered Sickness, then We will be entitled to a refund of benefits We have paid from such recovery, as permitted by law. The refund of benefits shall be allowable to the extent the Insured Person recovers or may recover for the same Injury or Covered Sickness from another plan, including a third party, its insurer, or the Insured Person's uninsured motorist insurance. Further, We have the right to offset subsequent benefits payable to the Insured Person under the Policy against such recovery in the event the Insured Person has not cooperated with previous attempts to recover.

Upon Our request, the Insured Person must complete the required forms and return them to Us or to Our administrator. The Insured Person must notify Us of any pending or contemplated claims against third parties. The Insured Person must cooperate fully with Us in asserting a right to recover. The Insured Person will be personally liable for reimbursement to Us to the extent of any recovery obtained by the Insured Person from any third party. If it is necessary for Us to institute legal action against the Insured Person for failure to repay Us, the Insured Person will be personally liable for all costs of collection, including reasonable attorney's fees.

We may file a lien in an Insured Person's action against the third party and have a lien upon any recovery that the Insured Person receives whether by settlement, judgment, or otherwise, and regardless of how such funds are designated. If the Insured Person recovers less than the amount we are owed, The Insured Person will only owe us what they recover. However, the amount the Insured Person owes us will be diminished in the same proportion as their amount was diminished, as described in Ohio Revised Code section 2323.44.

Limitation to Our Recovery Rights: We may exercise Our Right to Subrogation against third parties unless We are precluded from enforcing such right where a responsible third party has extinguished its liability or has been relieved of liability by contract or operation of law. If We are precluded from exercising Our Right to Subrogation, We may exercise Our Right to Reimbursement.

We, in exercising Our Right to Subrogation, will not seek to recover more than We paid under this plan. We, in exercising Our Right to Reimbursement, will not seek to recover more than the amount recovered from a third party.

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-Certification of admissions, and preferred provider arrangements.

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

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

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

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

c. For a dependent child covered under more than one Plan of individuals who are not 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.
    i. 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.
    ii. 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.

COORDINATION DISPUTES

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. Toll Free Number: 1-877-657-5030 or www.wellfleetstudent.com. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526 / 614-644-2673, or visit the Department's website at http://insurance.ohio.gov.

SECTION VI - 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 90 days unless the claimant was legally incapacitated.

Time of Payment: Indemnities payable under this Certificate will be paid immediately or within 30 days after 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 3 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.

SECTION VII - 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 VIII – COMPLAINT AND APPEALS PROCEDURE

Our customer service representatives at Wellfleet Group, LLC (www.wellfleetstudent.com) are trained to answer Your questions about Your health benefit plan. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including Coinsurance and Copayment amounts,
- Specific claims or services You have received,

- Physicians or Hospitals in the Network,
- Provider directories.

Complaint and Appeal procedures have been established to provide fair, reasonable, and timely solutions to complaints that You may have concerning the Plan. The Plan invites You to share any concerns that You may have over benefit determinations, coverage and eligibility issues, or the quality of care rendered by medical Providers in Our Networks.

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 Covered Services from an Out-of-Network Provider at an In-Network Facility, and believe those services are covered under the No Surprise Billing Act, You have the right to appeal that claim. If Your appeal of a Surprise Billing claim is denied, then You have a right appeal the adverse decision to an Independent Review Organization (IRO) as set out in the Standard and Expedited External Review provisions appearing in this section.

Definitions:

"Adverse benefit determination" means a decision by a health plan issuer:

- To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:
  - A determination that the health care service does not meet the health plan issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, include experimental or investigational treatments;
  - A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non-employer group, to participate in a plan or health insurance coverage;
  - A determination that a health care service is not a covered benefit;
  - The imposition of an exclusion, including exclusions for pre-existing conditions, source of Injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-employer group;
- To rescind coverage on a health benefit plan.

"Authorized representative" means an individual who represents a covered person in an internal appeal or external review process of an adverse benefit determination who is any of the following:

- A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;
- A person authorized by law to provide substituted consent for a covered individual;
- A family Covered Person or a treating health care professional, but only when the covered person is unable to provide consent.

"Concurrent review" means a request for Pre-Certification that is conducted during the course of treatment or admission. If a concurrent review request is not approved, the Insured Person who is receiving an ongoing course of treatment may proceed with an Expedited External Review while simultaneously pursuing an appeal through Our Internal Appeal process.

"Covered person" means a policyholder, subscriber, enrollee, Covered Person, or individual covered by a health benefit plan. "Covered person" does include the covered person's authorized representative with regard to an internal appeal or external review.

"Covered benefits" or **"benefits"** means those health care services to which a covered person is entitled under the terms of a health benefit plan.

"Final adverse benefit determination" means an adverse benefit determination that is upheld at the completion of a health plan issuer's internal appeals process.

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health plan issuer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan.
"Health plan issuer" includes a third party administrator to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent.
"Independent review organization" means an entity that is accredited to conduct independent external reviews of adverse benefit determinations.
"Rescission" or **"to rescind"** means a cancellation or discontinuance of coverage that has a retroactive effect. "Rescission" does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.
"Superintendent" means the superintendent of insurance.

The Complaint Procedure
If You have a complaint, problem, or claim concerning benefits or services, please contact Us. Please refer to Your Identification Card for Our address and telephone number.

A complaint is an expression of dissatisfaction that can often be resolved by an explanation from Us of Our procedures and your benefit document. You may submit Your complaint by letter or by telephone call. If Your complaint involves issues of Covered Services, You may be asked to sign a release of information form so We can request records for Our review.

You will be notified of the resolution of Your complaint if a claim or request for benefits is denied in whole or in part. We will explain why benefits were denied and describe Your rights under the Appeal Procedure.

Appeal Procedures
As a Covered Person of this Plan you have the right to appeal decisions to deny or limit your health care benefits. The explanation of why We denied your claim or request for benefits will describe the steps you should follow to initiate your appeal and how the appeal process works. An appeal is a request from you for Us to change a previous determination or to address a concern you have regarding confidentiality or privacy. Coverage for the Insured Person will stay in force during any Appeal until the end of the Policy year.

Electronic Urgent and Non-Urgent Appeals Submissions
Electronic Appeals process for adverse benefit determinations shall include all of the following:
1. For **Urgent Care** services, the appeal shall be considered within forty-eight (48) hours after the appeal is received.
2. For **Non-Urgent** services, the appeal shall be considered within ten (10) calendar days after the appeal is received.
3. The appeal will be between the treating Physician and a Clinical Peer.
4. If the appeal does not resolve the disagreement, the Insured Person or their authorized representative may request an External Review.

If additional information is needed to make a determination Our agent will notify Your Provider within 24 hours with the specific information that is required.

Internal Appeals
An initial determination by Us can be appealed for internal review. The Plan will advise you of your rights to appeal to the next level if a denial occurs after an initial determination.

You have the right to designate a representative (e.g. your Physician) to file appeals with Us on your behalf and to represent you in any level of the appeals process. If a representative is seeking an appeal on your behalf, We must obtain a signed Designation of Representation (DOR) form from you. The appeal process will not begin until We have received the properly completed DOR form except that if a Physician requests expedited review of an appeal on your behalf, the Physician will be deemed to be your designee for the limited purpose of filing for expedited review of the appeal without receipt of a signed form. We will forward a Designation of Representation form to you for completion in all other situations.

We will accept oral or written comments, documents or other information relating to an appeal from the Covered Person or the Covered Persons Provider by telephone, secure electronic transmission process (facsimile is not considered a secure electronic transmission) or other reasonable means. Covered Persons are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Covered Person's appeal.

To obtain information on Our appeal procedures or to file an oral appeal please call the toll free customer service number listed on the back of your Identification Card or the number provided for appeals on any written notice of an adverse decision that you receive from Us.

We will also accept appeals filed in writing. If you wish to file your appeal in writing, you must mail it to: Wellfleet Group, LLC at P.O. Box 15369, Springfield, MA 01115; toll-free 877-657-5030; website: www.wellfleetstudent.com or to the address provided for filing an appeal on any written notice of an adverse decision that you receive from Us.

An Insured Person may also contact the Ohio Department of Insurance for assistance:

Ohio Department of Insurance ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)
File a Consumer Complaint: http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

Upon Our receipt of your written or oral appeal at the appeals address or telephone number provided above or provided on any notice of an adverse decision, We will send you an acknowledgment within five (5) business days notifying you that you will receive a written response to the appeal once an investigation into the matter is complete. Our acknowledgment may be oral for those appeals We receive orally.

Appeals are reviewed by persons who did not make the initial determination and who are not the subordinates of the initial reviewer. If a clinical issue is involved, We will use a clinical peer for this review. A clinical peer is a Physician or Provider who has the same license as the Provider who will perform or has performed the service. The clinical peer will review your medical records and determine if the service is covered by your benefit document. If the clinical peer determines that the service is covered by your benefit document We must pay for the service; if the clinical peer determines that the service is not covered We may deny the services.

If you are appealing an adverse precertification decision other than a retrospective post-claim review decision or the denial of any prior approval required by the Plan, We will provide you with a written response indicating Our decision within a reasonable period of time appropriate to the medical circumstances but not later than thirty (30) calendar days of the date We receive your appeal request. If more information is needed to make a decision on your Appeal, We will send a written request for the information after receipt of the Appeal. No extensions of time for additional information may be taken on these Appeals without the permission of the Covered Person. Therefore, We will make a decision based upon the available information if the additional information requested is not received. Urgent reviews will be completed within 72 hours and Concurrent reviews will be completed within 24 hours of Our receipt of the Appeal.

If your coverage has been rescinded, you will be provided with thirty (30) calendar days advance notice before your coverage is rescinded. You have the right to request an Internal appeal of a rescission of your coverage. Once the Internal appeal process is exhausted, you have the additional right to request an independent external review.

If you are appealing any other type of adverse decision (including retrospective post-claim review decisions) and sufficient information is available to decide the Appeal, We will provide you with a written response indicating Our decision within a reasonable period of time appropriate to the medical circumstances but not later than thirty (30) calendar days from receipt of the Appeal request. If more information is needed to make a decision on your Appeal, We shall send a written request for the information after receipt of the Appeal. If the additional information requested is not received within forty-five (45) calendar days of the Appeal request, We shall conduct its review based upon the available information.

Expedited Reviews

Expedited Review of an appeal may be initiated orally, in writing, secure electronic transmission process or by other reasonable means available to you or your Provider. Expedited Review is available only if the medical care for which coverage is being denied has not yet been rendered. We will complete expedited review of an appeal as soon as possible given the medical exigencies but no later than seventy-two hours (72 hours) after Our receipt of the request and will communicate Our decision by telephone or by secure electronic transmission process to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending Physician or ordering Provider, and the facility rendering the service.

You may request an expedited review for:

- Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:
  1. Could seriously jeopardize Your life or health or Your ability to regain maximum function, or,
  2. 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 care or Treatment that is the subject of the claim.
- Except as provided above, a claim involving urgent care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
- Any claim that a Physician with knowledge of Your medical condition determines is a claim involving urgent care.

Exhaustion of Internal Appeals Process

The internal appeal process must be exhausted prior to initiating an external review except in the following instances:

- We agree to waive the exhaustion requirement; or
- You did not receive a written decision of Our internal appeal within the required time frame; or
- We failed to meet all requirements of the internal appeal process unless the failure:
  1. Was de minimis (minor);
  2. Does not cause or is not likely to cause prejudice or harm to you;
  3. Was for good cause and beyond Our control;
  4. Is not reflective of a pattern or practice of non-compliance; or
- An expedited external review is sought simultaneously with an expedited internal review.

Concurrent Internal and External Review

If you are in the process of an Expedited Internal appeal You may request that an Expedited External Review be conducted simultaneously in the following circumstances:

- Your treating Physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize your life or health or would jeopardize Your ability to regain maximum function if treated after the time frame of an Expedited Internal Appeal.
- Your treating Physician will be notified within 24 hours after their request has been submitted.

Understanding the External Review Process

Under Chapter 3922 of the Ohio Revised Code all health plan issuers must provide a process that allows a person covered under a health benefit plan or a person applying for health benefit plan coverage to request an independent external review of an adverse benefit determination. This is a summary of that external review process. An adverse benefit determination is a decision by Us to deny benefits because services are not covered, are excluded, or limited under the plan, or the covered person is not eligible to receive the benefit.

The adverse benefit determination may involve an issue of medical necessity, appropriateness, health care setting, or level of care or effectiveness. An adverse benefit determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

Opportunity for External Review
An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. The covered person does not pay for the external review. There is no minimum cost of health care services denied in order to qualify for an external review. However, the covered person must generally exhaust the health plan issuer's internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the adverse benefit determination.

External Review by an IRO - A covered person is entitled to an external review by an IRO in the following instances:
- The adverse benefit determination involves a medical judgment or is based on any medical information.
- The adverse benefit determination indicates the requested service is experimental or investigational, the requested health care service is not explicitly excluded in the covered person's health benefit plan, and the treating Physician certifies at least one (1) of the following:
  - Standard health care services have not been effective in improving the condition of the covered person.
  - Standard health care services are not medically appropriate for the covered person.
  - No available standard health care service covered by Us is more beneficial than the requested health care service.

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within thirty (30) days. An expedited review for urgent medical situations is normally completed within seventy-two (72) hours and can be requested if any of the following applies:
- The covered person's treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal.
- The covered person's treating physician certifies that the final adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of a standard external review.
- The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not yet been discharged from a facility.
- An expedited internal appeal is already in progress for an adverse benefit determination of experimental or investigational treatment and the covered person's treating physician certifies in writing or by secure electronic transmission process that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

NOTE: An expedited external review is not available for retrospective final adverse benefit determinations (meaning the health care service has already been provided to the covered person).

External Review by the Ohio Department of Insurance - A covered person is entitled to an external review by the Department in the either of the following instances:
- The adverse benefit determination is based on a contractual issue that does not involve a medical judgment or medical information.
- The adverse benefit determination for an emergency medical condition indicates that medical condition did not meet the definition of emergency AND Our decision has already been upheld through an external review by an IRO.

Request for External Review
Regardless of whether the external review case is to be reviewed by an IRO or the Department of Insurance, the covered person, or an authorized representative, must request an external review through Us within 180 days of the date of the notice of final adverse benefit determination issued by Us. All requests must be in writing or secure electronic transmission process except for a request for an expedited external review. Expedited external reviews may be requested electronically or orally. The covered person will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete We will initiate the external review and notify the covered person in writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the covered person that, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. We will also forward all documents and information used to make the adverse benefit determination to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete We will inform the covered person in writing and specify what information is needed to make the request complete. If We determine that the adverse benefit determination is not eligible for external review, We must notify the covered person in writing and provide the covered person with the reason for the denial and inform the covered person that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by Us and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the health benefit plan and all applicable provisions of the law.

IRO Assignment
When We initiate an external review by an IRO, the Ohio Department of Insurance web based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of health care service. An IRO that has a conflict of interest with Us, the covered person, the health care provider or the health care facility will not be selected to conduct the review.

IRO Review and Decision
The IRO must consider all documents and information considered by Us in making the adverse benefit determination, any information submitted by the covered person and other information such as; the covered person's medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the health benefit plan, the most appropriate practice guidelines, clinical review criteria used by the health plan issuer or its utilization review organization, and the opinions of the IRO's clinical reviewers.

The IRO will provide a written notice of its decision within 30 days of receipt by Us of a request for a standard review or within seventy-two (72) hours of receipt by Us of a request for an expedited review. This notice will be sent to the covered person, Us and the Ohio Department of Insurance and must include the following information:
A general description of the reason for the request for external review.

- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review.
- The dates over which the external review was conducted.
- The date on which the independent review organization's decision was made.
- The rationale for its decision.
- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision.

NOTE: Written decisions of an IRO concerning an adverse benefit determination that involves a health care treatment or service that is stated to be experimental or investigational also includes the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

Binding Nature of External Review Decision
An external review decision is binding on Us except to the extent We have other remedies available under state law. The decision is also binding on the covered person except to the extent the covered person has other remedies available under applicable state or federal law. A covered person may not file a subsequent request for an external review involving the same adverse benefit determination that was previously reviewed unless new medical or scientific evidence is submitted to Us.

CONTACT INFORMATION

If You Have Questions About Your Rights or Need Assistance
You may contact Us:
Wellfleet Insurance Company
Attention: Appeals Unit
Wellfleet Group, LLC
P.O. Box 15369
Springfield, MA 01115-5369
Toll Free Number: 1-877-657-5030
Fax Number: 413-733-4612
Web page: www.wellfleetstudent.com

You may also contact the Ohio Department of Insurance:
Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)

File a Consumer Complaint:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

Appeal Filing Time Limit
We expect that you will use good faith to file an appeal on a timely basis. However, We will not review an appeal if it is received by Us after 180 days have passed since the incident leading to your appeal.

WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

The Policy/Certificate to which this rider is attached is amended as follows. The following benefit is hereby added and any exclusion that conflicts with this Rider is deleted:

STUDENT HEALTH CENTER EXPENSE BENEFIT RIDER

BENEFITS FOR COVERED INJURY/SICKNESS	BENEFIT AMOUNT PAYABLE
Student Health Center Expense	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived

Student Health Center Expense Benefit if an Insured Student incurs expenses as the result of Treatment at a Student Health Center, we will pay the expenses incurred. Benefits will not exceed the amount shown above.

Student Health Center means an on-campus facility or 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 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.

There are no other changes to the Policy/Certificate.

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

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

WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

The Policy/Certificate to which this rider is attached is amended as follows. The following benefit is hereby added and any exclusion that conflicts with this Rider is deleted:

NON-EMERGENCY CARE BENEFIT RIDER

BENEFITS FOR COVERED INJURY/SICKNESS	BENEFIT AMOUNT PAYABLE
Non-emergency Care While Traveling Outside of the United States	60% of Actual Charge after Deductible for Covered Medical Expenses for Medically Necessary treatment when You are traveling outside of the United States. Subject to $10,000 maximum per Policy Year

Non-Emergency Care While Traveling outside of the United States
Benefits will be payable for Medically Necessary treatment for non-emergency care while traveling outside of the United States**.**

There are no other changes to the Policy/Certificate.

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

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

WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

The Policy/Certificate to which this rider is attached is amended as follows. The following benefit is hereby added and any exclusion that conflicts with this Rider is deleted:

GENDER TRANSITION BENEFIT RIDER

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Gender Transition Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

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 procedure covered by Your plan.

There are no other changes to the Policy/Certificate.

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

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

WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

The Policy/Certificate to which this rider is attached is amended as follows. The following benefit is hereby added and any exclusion that conflicts with this Rider is deleted:

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT RIDER

Principal Sum ……...……...$10,000

Loss must occur within 365 days of the date of a covered Accident.

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

If, as the result of a covered Accident, You sustain any of the following losses within the time shown above, 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 Accident.

There are no other changes to the Policy/Certificate.

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

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

Notice Concerning Coverage Limitations and Exclusions under the Ohio Life and Health Insurance Guaranty Association Act

Residents of Ohio who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Ohio Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is *NOT* provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. *However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.*

Ohio Life and Health Insurance Guaranty Association
5005 Horizons Drive, Suite 200
Columbus, OH 43220

Ohio Department of Insurance
50 West Town Street
Third Floor-Suite 300
Columbus, OH 43215

The state law that provides for this safety-net coverage is called the Ohio Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract; if they are insured under a group insurance contract, issued by a member insurer; or if they are the payee or beneficiary of a structured settlement annuity contract. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a medical, health or dental care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- anypolicy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000, except as specified below, no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. The association will not pay more than $100,000 in cash surrender values, $500,000 in major medical insurance benefits, $300,000 in disability or long-term care insurance benefits, $100,000 in other health insurance benefits, $250,000 in present value of annuities, or $300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages, the association will pay a maximum of $300,000, except for coverage involving major medical insurance benefits, for which the maximum of all coverages is $500,000.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: For unallocated annuities that fund governmental retirement plans under §§401, 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than $300,000 in the aggregate per individual, except as noted above. For covered unallocated annuities that fund other plans, a special limit of $1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

HIPAA Notice of Privacy Practices

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

PLEASE REVIEW IT CAREFULLY

Effective: August 01, 2019

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

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

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

Our Responsibilities

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

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

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

Overview of this Notice

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

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

YOUR HEALTH INFORMATION

How We Acquire Your Information

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

How We use Your Health Information

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

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

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

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

Additionally:

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

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

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

Authorizations

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

YOUR RIGHTS

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

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

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

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

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

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

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

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

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

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

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

CONTACT

For all inquiries, requests and complaints, please contact:

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

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

This Notice is Subject to Change

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

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

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

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

COLLECTING YOUR INFORMATION

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

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

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

SHARING YOUR INFORMATION

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

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

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

HEALTH INFORMATION

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

SAFEGUARDING YOUR INFORMATION

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

ACCESSING YOUR INFORMATION

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

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

CORRECTING YOUR INFORMATION

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

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

CONTACTING US

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

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

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

NOTICE OF NON-DISCRIMINATION AND ACCESSIBIILITY REQUIREMENTS

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

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

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

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

1. Interpreters
2. information translated into other languages

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

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

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

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

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

ADVISORY NOTICE TO POLICYHOLDERS

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

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

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

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

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

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

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

Women's Health & Cancer Rights Act

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

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

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

LANGUAGE ASSISTANCE PROGRAM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

សូមទូរស័ព្ទមកលេខ (877) 657-5030 ។

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

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

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

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

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

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

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

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

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