

WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

STUDENT HEALTH CERTIFICATE OF COVERAGE

POLICYHOLDER: Ohio Wesleyan University
(Policyholder)
POLICY NUMBER: WI2324OHSHIP98
POLICY EFFECTIVE DATE: August 1, 2023
POLICY TERMINATION DATE: July 31, 2024
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 Policy Effective Date at 12:00 a.m. local time at the Policyholder's address. We must receive the Policyholder's signed application and the initial Premium for it to take place. 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.

Termination of the Certificate

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

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

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

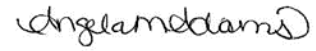
READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THIS CERTIFICATE. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

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**



President
Andrew M. DiGiorgio



Secretary
Angela Adams

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

Administrator: Wellfleet Group, LLC
P.O. Box 15369
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Table of Contents

SECTION I - ELIGIBILITY	4
SECTION II – EFFECTIVE AND TERMINATION DATES.....	5
Effective Dates.....	5
Special Enrollment – Qualifying Life Event	5
Termination Dates.....	5
Dependent Child Coverage.....	6
Extension of Benefits.....	6
Reinstatement Of Reservist After Release From Active Duty.....	6
Refund of Premium.....	6
SECTION III – DEFINITIONS.....	6
SECTION IV – HOW THE PLAN WORKS AND DESCRIPTION OF BENEFITS	15
Schedule of Benefits.....	15
How the Deductible Works.....	16
How Your Out-of-Pocket Maximum Works.....	16
Essential Health Benefits.....	17
Treatment of Covered Injury and Covered Sickness Benefit.....	17
Medical Benefit Payments for In-Network Provider and Out-of-Network Providers.....	17
Preferred Provider Organization	17
Continuity of Care.....	18
Covered Medical Expenses.....	20
Preventive Services.....	20
Inpatient Services.....	21
Mental Health Disorder and Substance Use Disorder Benefits.....	22
Professional and Outpatient Services.....	23
Emergency Services, Ambulance and Non-Emergency Services.....	27
Diagnostic Laboratory, Testing and Imaging Services.....	28
Rehabilitation, Habilitation and Other Therapies.....	29
Other Services and Supplies.....	30
Pediatric Dental and Vision Benefits.....	34
Miscellaneous Dental Services.....	34
Prescription Drugs.....	35
SECTION V - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT	39
SECTION VI - EXCLUSIONS AND LIMITATIONS	39
Coordination Of Benefits.....	45
SECTION VII - GENERAL PROVISIONS	50
Entire Contract Changes.....	50
Notice of Claim	50
Claim Forms.....	50
Proof of Loss.....	50
Time of Payment.....	50
Payment of Claims.....	50
Assignment.....	50
Physical Examination and Autopsy.....	51
Legal Actions.....	51
Conformity with State Statutes.....	51
SECTION VIII - ADDITIONAL PROVISIONS.....	51
SECTION IX – COMPLAINT AND APPEALS PROCEDURES.....	51

SECTION I - ELIGIBILITY

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

Except in the case of withdrawal from School due to Sickness or Injury, any student who withdraws from the Policyholder's School during the first 31 days of the period for which he or she is enrolled shall not be covered under the insurance plan. A full refund of Premium will be made, minus the cost of any claim benefits paid by the Certificate. A student who graduates or withdraws after such 31 days of the period for which he or she is enrolled will remain covered under this Certificate for the term purchased and no refund will be 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 the Insured Student has performed an act that constitutes fraud; or the Insured Student has made an intentional misrepresentation of material fact during their enrollment under this insurance plan in order to obtain coverage for a service, coverage will be terminated immediately upon written notice of termination delivered by Us to the Insured Student.

Who is Eligible

Class

1

Description of Class(es)

All domestic undergraduate students of the Policyholder enrolled in 3.25 OWU credits per term, all International Students and 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

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

Dependent Eligibility

Dependents are not eligible for coverage under this plan.

SECTION II – EFFECTIVE AND TERMINATION DATES

Effective Dates

The Insured Student's Insurance under this Certificate will become effective on the later of:

1. The Policy Effective Date;
2. The beginning date of the term of coverage for which Premium has been paid;
3. The day after Enrollment (if applicable) and Premium payment is received by Us, Our authorized agent or the School;
4. The day after the date of postmark if the Enrollment Form is mailed; or
5. For International Students, 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

The Insured Student can also enroll for coverage within 60 days of the loss of coverage in another health plan if coverage was terminated because the Insured Student is no longer eligible for coverage under the other health plan due to:

1. Involuntary termination of the other health plan;
2. Death of the Spouse;
3. Legal separation, divorce or annulment;
4. A Child no longer qualifies for coverage as a Child under the other health plan.

The Insured Student can also enroll 60 days from exhaustion of the Insured Student's COBRA or continuation coverage.

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

In addition, the Insured Student can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. The Insured Student loses eligibility for Medicaid or a state child health plan.
2. The Insured Student becomes eligible for Medicaid or a state child health plan.

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

Termination Dates

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

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

Dependent Child Coverage

Newly Born Children

A newly born child of the Insured Person will be covered from the moment of birth. Such newborn child will be covered for 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 a Covered Injury or Covered Sickness on the date Your insurance coverage terminates, We will continue to pay benefits for that Covered Injury or Covered Sickness for up to 90 days from the Termination Date while such Confinement continues; or
2. If You are Totally Disabled due to a 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 the Insured Student's insurance ends due to the Insured Student being called or ordered to active duty, such insurance will be reinstated without any waiting period when the student returns to School and satisfies the eligibility requirements defined by the School.

Refund of Premium

Premiums received by Us are fully earned upon receipt. Refund of Premium will be considered only:

1. If a student ceases to be eligible for the insurance and coverage is terminated prior to the next Premium due date, a pro rata refund of Premium (less any claims paid) will be made for such person.
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 means any conveyance designed and constructed or modified and equipped to be used, maintained, or operated to transport individuals who are sick, wounded, or otherwise incapacitated.

Ambulance Service means transportation to or from a Hospital by a licensed Ambulance whether ground, air (fixed wing and rotary wing air) or water Ambulance in a Medical Emergency.

Ambulatory Surgical Center means a facility which meets licensing and other legal requirements and which:

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

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

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

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

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

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

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

Complications of Pregnancy also include non-elective cesarean section, termination of an ectopic pregnancy, and spontaneous termination when a live birth is not possible. (This does not include 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 this Certificate is in force, except with respect to any expenses payable under the Extension of Benefits Provision.

Covered Sickness/Sickness means an illness, disease or condition, including pregnancy and Complications of Pregnancy, that impairs Your normal function of mind or body and which is not the direct result of an Injury which results in Covered Medical Expenses. Covered Sickness includes Mental Health 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 incur before benefits are payable under this Certificate. The amount of the Deductible, if any, will be shown in the Schedule of Benefits.

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

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 an Injury or Sickness. Elective surgery does not include Plastic, Cosmetic, or Reconstructive Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

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

Emergency Medical Condition means 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. Place 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 (fixed wing and rotary wing air), water, 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.

Emergency Services includes:

- Pre-Stabilization services that are provided after You are moved out of the emergency department and admitted to a Hospital; and
- Post-Stabilization services that are provided after You are Stabilized, as part of outpatient Observation Services, 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 You are able to travel using nonmedical transportation or nonemergency medical transportation to an available In-Network Provider or facility located within a "reasonable travel distance", taking into consideration Your medical condition, and the provider or facility furnishing Post-Stabilization services provides written notice and You consent, in accordance with the notice and consent process.

Essential Health Benefits means benefits that are defined in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes the following categories of covered services:

1. Ambulatory patient services;
2. Emergency Services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental Health Disorder and Substance Use Disorder services, including behavioral health Treatment;
6. Prescription drugs;
7. Rehabilitation and Habilitation services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

Experimental/Investigative means the service or supply has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication. For further explanation, see the definition of Medically Necessary/Medical Necessity.

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

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

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

Home Country means the Insured Student's country of citizenship. If the Insured Student has dual citizenship, the Insured Student's Home Country is the country of the passport the Insured Student used to enter the United States.

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 an Inpatient Rehabilitation Facility if such is specifically required for Treatment of physical disability.

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

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

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

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

Insured Person means an Insured Student while insured under this Certificate.

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

International Student means an international student:

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

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

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

Medically Necessary or **Medical Necessity** means health care services that a Physician, exercising prudent clinical judgment, would provide for the purpose of preventing, evaluating, diagnosing or treating an illness, Injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for an illness, Injury or disease; and
3. Not primarily for the convenience of an Insured Person, Physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or Treatment of an Insured Person's illness, Injury or disease.

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

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

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

Nurse means a licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who:

1. Is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
2. Provides medical services which are within the scope of the Nurse's license or certificate who does not ordinarily reside in Your home or is not related to You by blood or marriage.

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

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

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

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

Physical Therapy means any form of the following:

1. Physical or mechanical therapy;
2. Diathermy;
3. Ultra-sonic therapy;
4. Heat Treatment in any form; or
5. Manipulation or massage.

Physician means a health care professional practicing within the scope of his or her license and is duly licensed by the appropriate state regulatory agency to perform a particular service which is covered under this Certificate, and who is not:

1. You;
2. An Immediate Family Member; or
3. A person employed or retained by You.

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

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

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

Qualifying Payment Amount means greater of:

1. the median In-Network Provider 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 Provider 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 Condition 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:
 - is life-threatening, degenerative, potentially disabling, or congenital; and
 - requires specialized medical care over a prolonged period of time.

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

Skilled Nursing Facility means a facility, licensed, and operated as set forth in applicable state law, which:

1. Mainly provides inpatient care and Treatment for persons who are recovering from a Sickness or Injury;
2. Provides 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 and Post-Stabilization means, with respect to an Emergency Medical Condition, to provide such medical Treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Student Health Center means an on-campus facility or a designated facility by the Policyholder that provides:

1. Medical care and Treatment to sick or injured students; and
2. Nursing services.

A Student Health Center does not include:

1. Medical, diagnostic and Treatment facilities with major surgical facilities on its premises or available on a pre-arranged basis; or
2. Inpatient care.

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

Surgeon means a Physician who actually performs surgical procedures.

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

Telehealth Services means 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 a Sickness or Injury that requires prompt medical attention but is not an Emergency Medical Condition.

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: <ol style="list-style-type: none"> 1. The billed charge for the services; or 2. An amount determined using current publicly-available data which is usual and customary when compared with the charges made for a) similar services and supplies and b) to persons having similar medical conditions in the geographic area where service is rendered; or 3. An amount based on information provided by a third-party vendor, which may reflect 1 or more of the following factors: 1) the complexity or severity of Treatment; 2) level of skill and experience required for the Treatment; or 3) comparable providers’ fees and costs to deliver care; or 4. In the case of Emergency Services from an Out-of-Network Provider or facility, and certain non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, the Recognized Amount.

Our reimbursement policies

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

Medical Deductible

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

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

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

Individual

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

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

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

How Your Out-of-Pocket Maximum Works

The In-Network Provider and Out-of-Network Provider Out-of-Pocket Maximums are shown in the Schedule of Benefits. The Out-of-Pocket Maximum is the amount of Covered Medical Expenses the Insured Person has to incur before Covered Medical Expense will be paid at 100% for the remainder of the Policy Year, subject to any benefit maximums or limits that may apply. Any applicable Coinsurance amounts, Deductibles, and Copayments will apply toward the Out-of-Pocket Maximum.

Services that are not Covered Medical Expenses, balance-billed charges, and Premium do not count toward meeting the Out-of-Pocket Maximum.

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

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

Individual

Once the amount of the Copayments, Coinsurance, and Deductibles the Insured Student 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 the Insured Person is 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 Negotiated Charge at an In-Network Provider or the Usual and Customary Charge at an Out-of-Network Provider for Covered Medical Expenses that are incurred as the result of a Covered Injury or Covered Sickness; and
2. Subject to the Exclusions and Limitations provision.

Medical Benefit Payments for In-Network Provider and Out-of-Network Providers

This Certificate provides benefits based on the type of health care provider the Insured Student selects. This Certificate provides access to both In-Network Providers and Out-of-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by In-Network Providers versus Out-of-Network Providers, as shown in the Schedule of Benefits.

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

This plan provides patient protections from Out-of-Network Provider surprise bills (“balance billing”) for Emergency Services and other specified items or services. We comply 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.

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 You is the In-Network cost sharing amount. You can't be balance billed or asked to give up Your protections not to be balance billed for ancillary services, including but 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:

- 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.

Under these circumstances, 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 of the termination, 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 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. Home Health Care;
4. Durable Medical Equipment over \$500;
5. Surgery;
6. Transplant Services;
7. Diagnostic testing/radiology;
8. Chemotherapy/radiation;
9. Infusions/injectables;
10. Botox Injections;
11. Orthognathic Surgery;
12. Genetic Testing, except for BRCA;
13. Orthotics/prosthetics;
14. Non-emergency air Ambulance (fixed wing and rotary wing air) expenses.

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.

Pre-Certification is not a guarantee that benefits will be paid. This does not apply to electronic Pre-Certifications. We will not retrospectively deny benefits 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 and/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 claim for 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 or for Preventive Services.

Preventive Services

The following services shall be covered without regard to any Deductible, Coinsurance, or Copayment requirement that would otherwise apply when provided by an In-Network Provider:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). This also includes 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: <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-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 (HRSA).
4. With respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.,
5. 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 determines that the contraceptive drugs or devices standardly covered under Preventive Services without cost share are not medically appropriate for the Insured Person, the Insured Person may request an exception. If the exception is approved, We will cover that contraceptive service as a Preventive Service. See the Formulary Exception Process under Prescription Drugs for information on how to request an exception.

Important Notes:

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

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

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

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

Inpatient Services

1. **Hospital Care** – Covered Medical Expenses include the following:
 - Room and Board Expenses, including general nursing care. Benefits may not exceed the daily semi-private room rate unless intensive care unit is required.
 - Intensive Care Unit, including 24-hour nursing care.
 - Hospital Miscellaneous Expenses, while Hospital Confined or as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as:
 - a. The cost for use of an operating room;

- b. Prescribed medicines (excluding take-home drugs);
 - c. Laboratory tests;
 - d. Therapeutic services;
 - e. X-ray examinations;
 - f. Casts and temporary surgical appliances;
 - g. Oxygen, oxygen tent; and
 - h. Blood and blood plasma.
2. **Preadmission Testing** for routine tests performed as a preliminary to Your being admitted to a Hospital. These tests must be performed within 5 working days prior to admission. This benefit is limited to routine tests such as complete blood count, urinalysis, and chest x-rays. Unless otherwise payable under this Certificate, We will pay for major diagnostic procedures under the Hospital Miscellaneous Expenses benefit. This includes tests such as CAT scans, cardiac catheterization, MRI's, NMR's, and blood chemistries.
 3. **Physician's Visits while Confined.** Physician's visits will be paid for either inpatient or outpatient visits when incurred on the same day, but not both. Surgeon's fees are not payable under this benefit.
 4. **Skilled Nursing Facility Benefit** for services received in a licensed Skilled Nursing Facility. Services must be Medically Necessary.
The following services are not covered:
 - a. Custodial Care service and supplies, and
 - b. Confinement for Custodial Care or residential care.
 5. **Inpatient Rehabilitation Facility Expense Benefit,** for the services, supplies and treatments rendered to You in an Inpatient Rehabilitation Facility. You must enter an Inpatient Rehabilitation Facility:
 - a. After being discharged from a Hospital Confinement for a Covered Sickness or Coverage Injury; and
 - b. The services, supplies and Treatments rendered at the Inpatient Rehabilitation Facility must be related to the same Covered Sickness or Covered Injury.

Services, supplies and Treatments by an Inpatient Rehabilitation Facility include:

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

The following services are not covered:

 - a. Admission to a Hospital mainly for physical therapy;
 - b. Long term Rehabilitation in an Inpatient setting.
 6. **Registered Nurse Services while Confined** when private duty nursing care is prescribed by the attending Physician. General nursing care provided by the Hospital is not covered under this benefit.
 7. **Physical Therapy while Confined** when prescribed by the attending Physician.

Mental Health Disorder and Substance Use Disorder Benefits

1. **Inpatient and Outpatient Mental Health Disorder Benefit** for Treatment of Mental Health Disorders provided by a Hospital, including a psychiatric health facility and residential treatment facility, and Physician's visits 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); Psychiatric and Neuro Psychiatric testing.

Coverage also includes, but is not limited to the following:

1. **Habilitation Services for Autism and Applied Behavioral Analysis Benefits.** Benefits include, but are not limited to:
 - (1) Outpatient physical rehabilitation services, including:
 - Speech and language therapy and occupational therapy, performed by a licensed therapist.
 - Clinical therapeutic intervention defined as therapies supported by empirical evidence, which includes 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 the state 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 treatment plans.
2. **Behavioral Health Services.** Benefits include inpatient services, outpatient services, and Physician's visits (home and office) for Treatment of 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.
2. **Inpatient and Outpatient Substance Use Disorder Benefit** for Treatment of Substance Use Disorders provided by a Hospital, including a psychiatric health facility and residential treatment facility, and Physician's visits 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); 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.

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

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

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

3. **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 other Covered Medical Expenses 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 Human Leukocyte Antigen (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.

The following services are not covered:

- 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 Certificate;
- 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 on the Schedule of Benefits.

Benefits will also be provided for the travel 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 a mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and Treatment of physical complications for all stages of mastectomy, including lymphedemas. This benefit also covers cosmetic surgery specifically and solely for: Reconstruction due to bodily Injury, infection or other disease of the involved part.

OTHER PROFESSIONAL SERVICES

1. **Gender Affirming Treatment Benefit** for Medically Necessary expenses incurred for services and supplies provided in connection with gender affirming Treatment when You have been diagnosed with gender identity disorder or gender dysphoria. Covered Medical Expenses include the following:
 - a. Counseling by qualified mental health professional;
 - b. Hormone therapy, including monitoring of such therapy;
 - c. Gender affirming surgery and procedures.
2. **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 Person 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 the Schedule of Benefits for any applicable limits when therapy is provided in the home.
- j. Home Infusion Therapy

Custodial Care service and supplies are not covered under this benefit.

3. **Hospice Care Coverage** when, as the result of a Covered Injury or Covered Sickness, You require Hospice care, We will pay Covered Medical Expenses incurred for such care. Hospice care 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 care and inpatient respite.

When approved by Your Physician, Covered Medical Expenses include:

- a. Inpatient Confinement at a Hospice care facility.
- 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.
- d. Counseling services.
- e. Skilled nursing care (by an R.N. or L.P.N.) and home health aid.
- f. Diagnostic services.
- g. Physical Therapy, speech therapy, and inhalation therapies, if part of the treatment plan.

The following services are not covered:

- a. Services provided by volunteers;
- b. Housekeeping services.

OFFICE VISITS

1. **Physician's Office Visits.** Physician's Visits include second surgical opinions, specialists, and consultant services. Benefits will be paid for either outpatient or inpatient visits on the same day, but not both. Surgeon fees are NOT payable under this benefit.
2. **Telehealth Services** for health care delivery, diagnosis, consultation, or Treatment provided to You by a Physician.
3. **Acupuncture Services** that are Medically Necessary and provided by a Physician licensed to perform such services.
4. **Allergy Testing and Treatment, including injections.** This includes tests that You need such as PRIST, RAST, and scratch tests. This also includes the administration of allergy therapy, injections, allergy serum, and supplies used for allergy therapy.
5. **Chiropractic Care Benefit** for Treatment of a Covered Injury or Covered Sickness and performed by a Physician includes osteopathic or chiropractic services to correct a muscular or skeletal problem.

Charges incurred for the following are not covered under this benefit:

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

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

Emergency Services, Ambulance and Non-Emergency Services

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

If You receive Emergency Services from an Out-of-Network Provider or facility, the most the Out-of-Network Provider or facility may bill You is the In-Network cost sharing amount. The Post-Stabilization services will no longer qualify as Emergency Services once the Out-of-Network Provider or facility determines that You can travel using non-medical or non-emergency transportation, the Out-of-Network Provider satisfies the consent and notice requirements, and You are in a condition to receive notice of, and to consent to, Out-of-Network Treatment.

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

In case of a medical emergency:

When You experience an Emergency Medical Condition, You should go to the nearest emergency room. You can also dial 911 or Your local emergency response service for medical and Ambulance assistance. If possible, call Your Physician but only if a delay will not harm Your health.

2. **Urgent Care Centers (non-life-threatening conditions)** services provided at an Urgent Care Center, as shown in the Schedule of Benefits. In the case of a life-threatening condition, You should go to the nearest emergency room.
3. **Emergency Ambulance Service**, with respect to an Emergency Medical Condition, for transportation by a licensed Ambulance including ground, and/or air (fixed wing and rotary wing), water transportation:
 - From the scene of an Accident or medical emergency to the closest Hospital to provide Emergency Services;
 - From one Hospital to another Hospital if the first Hospital cannot provide the Emergency Services You need;
 - From a Hospital or Skilled Nursing Facility to Your home or to another facility, if an Ambulance is the only safe way to transport You;
 - From Your home to a Hospital, if an Ambulance is the only safe way to transport You.

Except as provided above, transportation from a facility to Your home is not covered.

Your plan also covers transportation to a Hospital by professional air Ambulance (fixed wing or rotary wing) or water Ambulance when:

- Professional ground Ambulance transportation is not available;
- Your condition is unstable, and requires medical supervision and rapid transport;
- You are travelling from one Hospital to another; and
- The first Hospital cannot provide the Emergency Services You need; and
- The two (2) conditions above are met.

4. **Non-Emergency Ambulance Expenses** for Medically Necessary transportation by a licensed Ambulance, whether by ground or air Ambulance (fixed wing and rotary wing) (as appropriate), when the 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 when prescribed by a Physician.
Specific diagnostic services include, but are not limited to:
 - a. X-ray and other radiology services, including mammograms for any person diagnosed with breast disease
 - b. Magnetic Resonance Angiography (MRA)
 - c. Laboratory and pathology services
 - d. Cardiographic, encephalographic, and radioisotope tests
 - e. Nuclear cardiology imaging studies
 - f. Ultrasound services and allergy tests
 - g. Electrocardiograms (EKG)
 - h. Electromyograms (EMG), except that surface EMG's are excluded
 - i. Echocardiograms
 - j. Bone density studies
 - k. Diagnostic tests to evaluate the need for a transplant procedure
 - l. Echographies and Doppler studies
 - m. Brainstem evoked potentials (BAER)
 - n. Somatosensory evoked potentials (SSEP)
 - o. Visual evoked potentials (VEP)
 - p. Nerve conduction studies
 - q. Muscle testing
 - r. Electrocardiograms
 - s. Digital breast tomosynthesis and ultrasounds

Complex imaging for preoperative testing is covered under this benefit. Whether performed 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 when prescribed by a Physician.
4. **Chemotherapy and Radiation Therapy:**
 - a. **Chemotherapy** for the treatment or control a serious illness including chemotherapy, oral chemotherapy drugs for the treatment by chemical or biological antineoplastic agents, including the cost of such agents.
 - b. **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); and materials and supplies used in therapy; Treatment planning.

Rehabilitation, Habilitation and Other Therapies

1. **Inhalation Therapy** for the Treatment of a Covered Injury or Covered Sickness, by the administration of medicine, water vapors, gases, or anesthetics by inhalation. Covered Medical Expenses 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 or 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.
2. **Cardiac Rehabilitation.** Benefits are available 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.
3. **Pulmonary Rehabilitation.** Benefits are available for pulmonary Rehabilitation services as part of an inpatient Hospital stay if it is part of a treatment plan ordered by a Physician. A course of outpatient pulmonary Rehabilitation may also be eligible for coverage if it is performed at a Hospital, Skilled Nursing Facility, or Physician's office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by a Physician.

These services may also restore Your functional status after an Illness or Injury:

- Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short term therapy.
- Inhalation therapy administered in Physician's office which includes breathing exercises, exercise not elsewhere classified, and other counseling.

Pulmonary Rehabilitation in an acute inpatient Rehabilitation setting is not a covered service.

4. **Rehabilitation Therapy and Habilitation Services** when prescribed by the attending Physician, limited to 1 visit per day. Benefits include day Rehabilitation program services provided through a day Hospital for physical medicine and Rehabilitation. This day Rehabilitation program is for those patients who do not require Inpatient care but still require a Rehabilitation therapy program of 4 to 8 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 Medical Expense. Day Hospital is a facility that provides day Rehabilitation services on an outpatient basis.
 - a. **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 a Covered Sickness, Covered Injury, or loss of a body part.

The following services are not covered under Physical Therapy:

- maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness;

- repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients);
 - 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;
 - general exercise programs;
 - diathermy, ultrasound and heat treatments for pulmonary conditions;
 - diapulse;
 - work hardening.
- b. **Speech Therapy** for the correction of a speech impairment resulting from a Covered Injury or Covered Sickness.
- c. **Occupational Therapy** for the Treatment of a physically disabled Insured Person by means of constructive activities designed and adapted to promote the restoration of the Insured Person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the Insured Person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).

The following services not covered under Occupational Therapy:

- supplies (looms, ceramic tiles, leather, utensils);
- therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again;
- general exercises to promote overall fitness and flexibility;
- therapy to improve motivation; suction therapy for newborns (feeding machines);
- soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial;
- adaptations to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

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.

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 Covered Medical Expenses 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 (NIH)

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

Benefits include, but are not limited to, the following services and supplies:

- Insulin preparations
- Foot care to minimize the risk of infection
- Injection aids for the blind
- Diabetic test agents
- Prescribed oral medications whose primary purpose is to control blood sugar
- Injectable glucagon
- Glucagon emergency kits

Equipment

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

Training

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

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

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

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

3. **Dialysis Treatment** of an acute or chronic kidney ailment, provided in an Outpatient facility of a Hospital, a free-standing renal Dialysis facility or in Your home. Covered Medical Expenses for home Treatment will include equipment, training and medical supplies. Private Duty Nursing is not covered.
4. **Durable Medical Equipment** for the rental or purchase of Durable Medical Equipment (DME), including, but not limited to, Hospital beds, wheelchairs, walkers, braces that stabilize an injured body part, 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
- h. Medical and surgical supplies for the management of diseases

Durable Medical Equipment does not include:

- a. Air Conditioners;
- b. Ice bags/cold pack pump;
- c. Raised toilet seat;
- d. Rental of equipment if the Insured Person is in a facility that is expected to provide such equipment;
- e. Trans lift chairs;
- f. Treadmill exerciser;
- g. Tub chair used in shower;
- h. Massage devices;
- i. Personal hygiene and convenience items such as humidifiers, hot tubs, or physical exercise equipment even if prescribed by a Physician;
- j. Items used in the home for general use such as 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
- Branched-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, delivery, postpartum care, and other obstetrical services, and postnatal visits.

- a. **Hospital stays** for mother and newly born child will be provided for up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the caesarean section delivery is the result of Complications of Pregnancy. If the delivery is the result of Complications of Pregnancy, the Hospital stay will be covered the same as for any other Covered Sickness. Services of a licensed Nurse midwife are covered when rendered in a Hospital or licensed outpatient facility rendering maternity services.

A shorter stay is also covered if the attending Physician or certified nurse-midwife, with the consent of the mother, discharges the mother and newborn earlier based upon the evaluation of:

- The antepartum, intrapartum, and postpartum course of the mother and infant;
- The gestational stage, birth weight, and clinical condition of the infant;
- The demonstrated ability of the mother to care for the infant after discharge;
- The availability of post-discharge follow-up to verify the condition of the infant after discharge.

Home Births are also covered when services are rendered by a certified nurse-midwife.

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

- b. **Inpatient Physician charges or Surgeon charges** will be covered the same as for any other Covered Sickness for both mother and newborn child.
- c. **Physician-directed Follow-up Care** including:
1. Physician assessment of the mother and newborn;
 2. Parent education;
 3. Assistance and training in breast or bottle feeding;
 4. Assessment of the home support system;
 5. Performance of any prescribed clinical tests; and
 6. Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric obstetrical and nursing professionals.

The mother could be discharged earlier. If so, this benefit will apply to services provided in a medical setting or through post-delivery Home Health Care visits for the services listed above. Any Home Health Care visit must be provided by an individual knowledgeable and experienced in maternity and newborn care. All Home Health Care visits that are made necessary by early discharge from the Hospital must be performed within 72 hours after discharge. When a mother or a newborn receives at least the number of hours of inpatient care shown in item "a", the Home Health Care visit benefit will apply to follow-up care that is determined to be necessary by the health care professionals responsible for discharging the mother or newborn.

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

Services that are duplicated when provided by both a certified Nurse-midwife and a Physician are not covered.

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 including cochlear implants.
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. **Student Health Center Expense Benefit** if an Insured Person incurs Covered Medical Expenses as the result of Treatment at a Student Health Center, We will pay the Covered Medical Expenses incurred. Benefits will not exceed the amount shown in the Schedule of Benefits.
10. **Non-emergency Care While Traveling Outside of the United States** for Medically Necessary Treatment when You are traveling outside of the United States.

Pediatric Dental and Vision Benefits

1. **Pediatric Dental Care Benefit** for dental care services for Insured Persons (to the end of the month in which the Insured Person turns age 19). Please refer to the Schedule of Benefits section of this Certificate for cost-sharing requirements.
2. **Pediatric Vision Care Benefit** for Insured Persons (to the end of the month in which the Insured Person turns age 19). For routine vision exams provided by an ophthalmologist or optometrist.

We will provide benefits for:

- 1 vision examination per Policy Year. The examination will include refraction and glaucoma testing; and
- 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year;
- 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;
- Aphakic prescription lenses prescribed after cataract surgery has been performed;
- Low vision services including comprehensive low vision evaluations and prescribed optical devices, such as high-power spectacles, magnifiers, and telescopes.

Miscellaneous Dental Services

1. **Accidental Injury Dental Treatment** as the result of Injury to Sound, Natural Teeth. Routine dental care and Treatment are not payable under this benefit. Damage to teeth due to chewing or biting is not deemed an accidental Injury and is not covered.
2. **Sickness Dental Expense Benefit** when, by reason of Sickness, You require Treatment for impacted wisdom teeth or dental abscesses, We will pay the Covered Medical Expenses incurred for the Treatment.
3. **Treatment for Temporomandibular Joint (TMJ) 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. 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: (1) when prescribed for a Hospice patient in a Hospice care program; (2) a patient diagnosed with a terminal condition (but not a Hospice patient); (3) 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 under this Certificate, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
 1. The drug is approved 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 You request a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available, You will be responsible for the cost difference between the Brand-Name Prescription Drug and the Generic Prescription Drug equivalent, and the cost sharing that applies to Brand-Name Prescription Drugs. This DAW penalty does not apply to Your Out-of-Pocket Maximum or Deductible.
 - c. **Investigational Drugs and Medical Devices** – The Prescription Drug benefit includes a drug or device that is Investigational if the intended use of the drug or device is included in the labeling authorized by the FDA or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature.
 - d. **Specialty Prescription Drugs** are limited to no more than a 30 day supply. However, if the Specialty Prescription Drug dispensed is the smallest package size available and exceeds a 30 day supply, You are responsible for the cost sharing defined for the day supply as shown in the Schedule of Benefits.

Specialty Drugs – are Prescription Drugs which:

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

Specialty Prescription Drugs are identified in the Formulary posted on Our website at www.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 benefits. Self-administered Prescription Drugs will not be covered when dispensed through a Physician’s office or outpatient Hospital, except in emergency situations. While Insured Persons may self-administer these medications, they can still obtain these medications at the pharmacy and have them administered at an office visit. Coverage exceptions may be granted if self-administered Prescription Drugs are required as part of a hospitalization or emergency room visit. The list of self-administered Prescription Drugs only covered under the Prescription Drug benefit and excluded from the medical benefit can be found here: www.wellfleetstudent.com.
- f. **Retail Pharmacy Supply Limits** – We will pay for no more than a 30 day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for 1 cost sharing amount for up to a 30 day supply. However, if the Prescription Drug dispensed is the smallest package size available and exceeds a 30 day supply, You are responsible for the cost sharing defined for the day supply as shown in the Schedule of Benefits.
- g. **Step Therapy** – When medications for the Treatment of any medical condition are restricted for use by a step therapy or fail-first protocol, the prescribing practitioner shall have access to a clear and convenient process to request an override of the restriction from Us. An override of that restriction will be granted by Us upon completion of the review if all necessary information to perform the override review has been provided, under the following documented circumstances:
 1. The prescribing practitioner can demonstrate, based on sound clinical evidence, that the preferred Treatment required under step therapy or fail-first protocol has been ineffective in the Treatment of Your disease or medical condition; or
 2. Based on sound clinical evidence or medical and scientific evidence:
 - a. The prescribing practitioner can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the Insured Person and known characteristics of the drug regimen; or
 - b. The prescribing practitioner can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to You.
- h. **Quantity Limits** – Some Outpatient Prescription Drugs are subject to quantity limits. The quantity limits help the prescriber and pharmacist check that the Outpatient Prescription Drug is used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by Us to set these quantity limits.

- i. **Tier Status** – The tier status of a Prescription Drug may change periodically. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Prescription Drug that becomes available as a Generic Prescription Drug) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website at www.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, including a contraceptive Prescription Drug or device, is not on Our Formulary, You, Your Authorized Representative or Your prescribing Physician may request a Formulary exception for clinically appropriate Prescription Drug in writing, electronically or telephonically. If coverage is denied under Our standard or expedited Formulary exception process, the Insured Person is entitled to an external appeal as outlined in the External Appeal section of this Certificate. Refer to the Formulary posted on Our website at www.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 Insured Person’s request. If We approve the request, We will cover the Prescription Drug while You are taking the Prescription Drug, including any refills. This approval authorization requires renewal at least every 12 months.

Expedited Review of Formulary Exception – If You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain maximum function or if You are undergoing a current course of Treatment using a Non-Formulary Prescription Drug, You may request an expedited review of a Formulary exception. These requests should include a statement from Your prescribing Physician that harm could reasonably come to You if the requested drug is not provided within the timeframes for Our standard Formulary exception process. We will make a decision and notify You or Your Authorized Representative and the prescribing Physician no later than 24 hours after Our receipt of Your request. If We approve the request, We will cover the Prescription Drug. This approval authorization requires renewal at least every 12 months. Refer to the Formulary posted on Our website at www.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** – Tobacco cessation Prescription Drugs and OTC drugs will be covered for two 90-day treatment regimens only. Any additional prescription drug treatment regimens will be subject to the cost sharing as shown in the Schedule of Benefits. For details on the current list of tobacco cessation Prescription Drugs and OTC drugs covered with no cost sharing during the two 90-day treatment regimens allowed, refer to the Formulary posted on Our website www.wellfleetstudent.com or call the toll-free number on Your ID card.
- m. **Zero Cost Drugs** – In addition to ACA Preventive Care medications, certain Prescription Drugs are covered at no cost to You. These zero cost drugs can be identified in the Formulary posted on Our website at www.wellfleetstudent.com.

- n. **Preventive contraceptives** - Your Outpatient Prescription Drug benefits cover certain Prescription drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a Physician and the prescription is submitted to the pharmacist for processing. Your outpatient Prescription Drug benefits also cover related services and supplies needed to administer covered devices. At least 1 form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive prescription drugs 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.

- o. **Orally administered anti-cancer drugs, including chemotherapy drugs** - Covered Medical Expenses include any drug prescribed for the Treatment of cancer if it is recognized for Treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication. Coverage for oral anti-cancer Prescription Drugs will not be less favorable than chemotherapy under the medical benefit.
- p. **Diabetic supplies** - The following diabetic supplies may be obtained under Your Prescription Drug benefit upon prescription by a Physician:
- Insulin
 - Insulin syringes and needles
 - Blood glucose and urine test strips
 - Lancets
 - Alcohol swabs
 - Blood glucose monitors and continuous glucose meters

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

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

- a. Prescription Drugs, devices and products, or Prescription Drugs with over the counter equivalents and any Prescription Drugs, devices or products that are therapeutically comparable to an over the counter drug, device, or product, except as required for Preventive Services.
- b. Off label drug use, except as provided under the Off-Label Drug Treatments provision and/or prohibited by law.
- c. Prescription Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original prescription order.

- d. Prescription Drugs not approved by the FDA.
- e. Charges for the administration of any Prescription Drug.
- f. Prescription 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, or with chemotherapy performed in the office, or drugs eligible for coverage under the medical benefits.
- g. Any Prescription Drug which is primarily for weight loss.
- h. Prescription Drugs not requiring a prescription by federal law (including Prescription Drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- i. Prescription Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- j. Fertility Prescription Drugs, unless covered elsewhere in this Certificate.
- k. Oral immunizations, and biologicals, although they are federal legend Drugs, are payable under the medical benefits 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 as specifically provided under Preventive Services.
- l. Prescription Drugs in quantities which exceed the limits established by this Certificate.
- m. Compound Prescription Drugs unless there is at least one ingredient that requires a prescription.
- n. Prescription Drugs for the treatment of Onychomycosis (toenail fungus).
- o. Certain Prescription Drugs are not covered when any version or strength becomes available over the counter, except as specifically provided under Preventive Services.
- p. Brand-Name Prescription Drugs with generic equivalents, except as specifically provided under Preventive Services.

SECTION V - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

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

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

Loss of hand or foot means the complete severance through or above the wrist or ankle joint. Loss of eye means the total permanent loss of sight in the eye. The Principal Sum is the largest amount payable under this benefit for all losses resulting from any one (1) Accident.

SECTION VI - EXCLUSIONS AND LIMITATIONS

Exclusion Disclaimer: Any exclusion in conflict with the Patient Protection and Affordable Care Act or any state-imposed requirements will be administered to comply with the requirements of the federal or state guideline, whichever is more favorable to You.

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

General Exclusions

- **International Students Only** - Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible.
- Treatment, service or supply which is not Medically Necessary or does not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines for the diagnosis, care or Treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended or approved by the Student Health Center or by Your attending Physician or dentist.
- Medical services rendered by a provider employed for or contracted with the Policyholder, including team Physicians or trainers, except as specifically provided in the Schedule of Benefits or as part of the Student Health Center benefits provided by this plan.
- Medical services received from an individual or entity that is not a Physician, as defined in this Certificate or recognized by Us.
- Treatment, service or supply 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.
- Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services covered by Student Health Fees.
- Expenses incurred for completion of claim forms or charges for medical records or reports unless otherwise required by law.
- Expenses incurred for missed or canceled appointments.
- Expenses incurred for mileage, lodging and meals costs, and other travel related expenses, except as specifically provided for under the Certificate.
- Benefits which are payable under Medicare Parts A, B, and/or D or would have been payable if You had applied for Parts A, B and/or D, except as specified elsewhere in this Certificate or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if You have not enrolled in Medicare Part B, We will calculate benefits as if You had enrolled.
- Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
- Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which You are required to pay.
- Services that are duplicated when provided by both a certified Nurse midwife and a Physician.
- Expenses payable under any prior policy which was in force for the person making the claim.
- Loss resulting from war or any act of war, whether declared or not, or Loss sustained while in the armed forces of any country or international authority.
- Injury sustained as the result of Your operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle Accident takes place.
- Expenses incurred 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 the 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.
- Any procedures, equipment, services, supplies, or charges to the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- Expenses incurred prior to the Insured Person's Effective Date of coverage.
- Expenses incurred after:
 - The date insurance terminates as to an Insured Person, except as specified in the extension of benefits provision; and
 - The end of the Policy Year specified in the Policy.
- Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.

- Loss resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear Accident.
- Expenses incurred for court ordered testing or care unless Medically Necessary.
- Expenses for which an Insured Person has no legal obligation to pay in the absence of this or like coverage.
- Expenses incurred for the following:
 - Physician or other practitioners' charges for consulting with the Insured Person 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 the 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.
 - Expenses incurred 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.
- Expenses incurred 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.
- Expenses incurred 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.
- Expenses incurred for marital counseling.
- Expenses incurred for services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified in the Certificate.
- Expenses incurred for services to reverse voluntarily induced sterility.
- Expenses incurred 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;
 - 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.
- Expenses incurred for 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.

- Expenses incurred for telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or as otherwise described in the Certificate.
- Expenses incurred for care received in an emergency department which is not Emergency Services, except as specified in the Certificate. This includes but is not limited to suture removal in an emergency department.
- Expenses incurred for self-help training and other forms of non-medical self-care, except as otherwise provided in this Certificate.
- Expenses incurred for examinations relating to research screenings.
- Expenses for stand-by charges of a Physician.
- Expenses incurred for physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes, unless required under Preventive Services.
- Services of private duty Nurse except as provided in the Certificate.
- Expenses incurred for 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.
- Expense incurred 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.
- Expenses incurred for surgical treatment of gynecomastia.
- Complications directly related to a service or treatment that is a non-covered service under the Certificate because it was determined by Us to be Experimental/Investigative or non-Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non-Medically Necessary service.
- Expenses incurred for treatment of telangiectatic dermal veins (spider veins) by any method.
- Expense incurred for reconstructive services except as specifically provided in the Certificate, or as required by law.
- Expenses incurred for Human Growth Hormone for children born small for gestational age.
- Charges for hot or cold packs for personal use.
- Expenses that are not recommended and approved by a Physician.
- Medical services or supplies 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.
- 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.

- Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary because of Injury, infection or disease.
- Expenses incurred for surgical Treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.
- Sleep Disorders, except for a sleep study performed in the Insured Person's home, the diagnosis, and Treatment of obstructive sleep apnea.

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).

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

- Infertility Treatment (male or female)-this includes but is not limited to:
 - Procreative counseling;
 - Premarital examinations;
 - Genetic counseling and genetic testing;
 - Impotence, organic or otherwise;
 - Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
 - In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
 - Costs for an ovum donor or donor sperm;
 - Sperm storage costs;
 - Cryopreservation and storage of embryos;
 - Ovulation induction and monitoring;
 - Artificial insemination;
 - Hysteroscopy;
 - Laparoscopy;
 - Laparotomy;
 - Ovulation predictor kits;
 - Reversal of tubal ligations;
 - Reversal of vasectomies;
 - Costs for and relating to surrogate motherhood (maternity services are covered for Insured Persons acting as surrogate mothers);
 - Cloning; or
 - Medical and surgical procedures that are Experimental or Investigative, unless Our denial is overturned by an External Appeal Agent.
- Elective abortions.

Vision

- Adult Vision (routine) 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 the Pediatric Vision Care Benefits, and except in the case of a Covered Injury or Covered Sickness 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.

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;
- Food supplements, dietary supplements; except as specifically provided in the Certificate;
- Cosmetic drugs or medicines including, but not limited to, products that improve the appearance of wrinkles or other skin blemishes;
- Refills in excess of the number specified or dispensed after 1 year of date of the prescription;
- Drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
- Any drug or medicine purchased after coverage under the Certificate terminates;
- Any drug or medicine consumed or administered at the place where it is dispensed;
- If the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
- Prescription digital therapeutics;
- 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;

- Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply, except as required for Preventive 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;
- Any drug or medicine for the purpose of weight control;
- Fertility drugs;
- Sexual enhancements drugs;
- Vision correction products.

SUBROGATION AND RECOVERY RIGHTS

Right of Recovery: If the amount of the payment made by Us is more than We should have paid under the 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 Covered Injury or Covered Sickness through the act or omission of another person, and if benefits are paid under the Policy due to such Covered 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 Covered 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 the Policy. 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.
 - d.
 - a. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.
 - b. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.
3. Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
4. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

5. Longer or shorter length of coverage. The Plan that covered the person as an employee, member, Policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

- A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.
- B. If an Insured Person is enrolled in 2 or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by 1 Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

COORDINATION DISPUTES

If You believe that We have not paid a claim properly, You should first attempt to resolve the problem by contacting Us at the toll-Free number on Your ID card or at www.wellfleetstudent.com. If You are still not satisfied, You may call the Ohio Department 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 VII - GENERAL PROVISIONS

Entire Contract Changes

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

Notice of Claim

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

Claim Forms

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

Proof of Loss

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

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

Physical Examination and Autopsy

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

Legal Actions

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

Conformity with State Statutes

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

SECTION VIII - ADDITIONAL PROVISIONS

1. We do not assume any responsibility for the validity of assignment.
2. You will have free choice of a legally qualified Physician with the understanding that the Physician-patient relationship will be maintained.
3. Our acknowledgment of the receipt of notice given under this Certificate, or the furnishing of forms for filing proofs of Loss or acceptance of such proof, or the investigation of any claim hereunder will not operate as a waiver of any of Our rights in defense of any claim arising under this Certificate.
4. This Certificate is not in lieu of and does not affect any requirement of coverage by Workers' Compensation Insurance.
5. All new persons in the groups or classes eligible to and applying for this insurance will be added in the respective groups or classes in which they are eligible.
6. The insurance of any Insured Person will not be prejudiced by the failure on the part of the Policyholder to transmit reports, pay Premium or comply with any of the provisions of this Certificate when such failure is due to inadvertent error or clerical mistake.
7. All books and records of the Policyholder containing information pertinent to this insurance will be open to examination by Us during the Certificate term and within one year after the termination of this Certificate.
8. Benefits are payable under this Certificate only for those expenses incurred while You are covered. No benefits are payable for expenses incurred after the date Your insurance terminates, except as may be provided under an Extension of Benefits.

SECTION IX – COMPLAINT AND APPEALS PROCEDURES

Our customer service representatives at Wellfleet Group, LLC (www.wellfleetstudent.com) are trained to answer Your questions about Your coverage under this Certificate. 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 Your coverage under this Certificate. We invite 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 to appeal the Adverse Benefit Determination 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, including Experimental or Investigative 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 You in an internal appeal or external review process of an Adverse Benefit Determination who is any of the following:

- A person to whom You have given express, written consent to represent them in an internal appeals process or external review process of an Adverse Benefit Determination;
- A person authorized by law to provide substituted consent for You;
- A family member of Yours or Your treating health care professional, but only when You are 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.

Final Adverse Benefit Determination means an Adverse Benefit Determination that is upheld at the completion of a health plan issuer's internal appeals process.

Independent Review Organization (IRO) means an entity that is accredited to conduct independent external reviews of Adverse Benefit Determinations.

Rescission/rescind(ed) means to retroactively cancel or discontinue coverage. Rescind 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.

THE COMPLAINT PROCEDURE

If You have a complaint, problem, or claim concerning benefits or services, please contact Us. Please refer to Your ID 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 benefits under this Certificate. 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 Your 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 Procedures.

APPEAL PROCEDURES

As an Insured Person under this Certificate, 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 benefit determination or to address a concern You have regarding confidentiality or privacy. Your coverage will stay in force during any appeal until the Termination Date of Your coverage.

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 Care 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, You or Your 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. We 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 an 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 DOR 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 You or Your provider by telephone, secure electronic transmission process (facsimile is not considered a secure electronic transmission) or other reasonable means. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to Your 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 ID card or the number provided for appeals on any written notice of an Adverse Benefit Determination 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 Insurance Company
Attention: Appeals Unit
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 Benefit Determination that You receive from Us.

You 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 Benefit Determination, 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 this Certificate. If the clinical peer determines that the service is covered by this Certificate, 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 Pre-Certification decision, other than a retrospective post-claim review decision or the denial of any prior approval required by this Certificate, 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 Your permission. 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 Benefit Determination (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:
 - Could seriously jeopardize Your life or health or Your ability to regain maximum function, or,
 - 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 Our 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:
 - Was de minimis (minor);
 - Does not cause or is not likely to cause prejudice or harm to You;
 - Was for good cause and beyond Our control;
 - 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 if 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 this Certificate, or You are 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. You do 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, You must generally exhaust Our 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

You are 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 Investigative, the requested health care service is not explicitly excluded in this Certificate, and the treating Physician certifies at least one (1) of the following:
 - Standard health care services have not been effective in improving Your condition.
 - Standard health care services are not medically appropriate for You.
 - 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:

- 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 Treatment is delayed until after the time frame of an expedited internal appeal.
- Your treating Physician certifies that the Final 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 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 You received Emergency Services, but have not yet been discharged from a facility.
- An expedited internal appeal is already in progress for an Adverse Benefit Determination of Experimental or Investigative Treatment and Your 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 You).

EXTERNAL REVIEW BY THE OHIO DEPARTMENT OF INSURANCE

You are entitled to an external review by the Ohio Department of Insurance in 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 Medical Condition 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 Ohio Department of Insurance, You, or Your 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. You 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 You 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 You that, within 10 business days after receipt of the notice, You 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 You 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 You in writing and provide You with the reason for the denial and inform You 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's 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, You, 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 You and other information such as:

- Your 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 Us or Our 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 You, 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 IRO 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 IRO'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 Investigative 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 You except to the extent You have other remedies available under applicable state or federal law. You 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.

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: The 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.

Specialty Prescription Drug Copayment Assistance Program - Prior Authorization May Be Required.

Please note: Amounts You pay out-of-pocket for covered Specialty Prescription Drugs will be applied towards the Deductible (if applicable) and Out-of-Pocket Maximum. Copayment Assistance may be available to You for certain Specialty Prescription Drugs when Your prescription is filled at a participating network pharmacy. Copayment Assistance dollars paid by the drug manufacturer for covered Specialty Prescription Drugs will not be applied towards the Deductible (if applicable) or Out-of-Pocket Maximum. Any amounts paid by You for a covered Specialty Prescription Drug after Copayment Assistance will be applied to the deductible (if applicable) and Out-of-Pocket Maximum.

Coinsurance Amounts:

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

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, air (fixed wing and rotary wing), or water 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.

How You Can Request a Cost Estimate for Proposed Covered Services

You may request an estimate of the costs You will have to pay when Your health care provider proposes a procedure, or other covered service. You can request this cost estimate by logging on to the www.wellfleetstudent.com website, typing in the name of Your school and logging into Your secure Wellfleet school webpage. Click the "Cost of Care Estimator" link and follow the steps to perform the following:

- Search for a Provider
- Request a Cost Estimate for health care services, and
- View Ratings and Reviews of Providers

You can also print cost estimate results.

To request a cost estimate by phone, or if You need assistance with creating a cost estimate, call the toll-free phone number shown on Your ID card.

Dental and Vision Benefit Payments

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

Preferred Provider Organization:

To locate an In-Network Provider in Your area, consult Your Provider Directory or call toll-free 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. We comply 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 SPECIFIED BELOW, ANY APPLICABLE COPAYMENTS ARE APPLIED AFTER DEDUCTIBLE IS MET.**

6. UNLESS OTHERWISE SPECIFIED BELOW, ANY DAY OR VISIT LIMITS WILL BE APPLIED TO IN-NETWORK AND OUT-OF-NETWORK COMBINED.

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK	OUT-OF-NETWORK
INPATIENT SERVICES		
<p>Hospital Care Includes Hospital Room and Board Expenses and Hospital Miscellaneous Expenses.</p> <p>Subject to Semi-Private room rate unless intensive care unit is required.</p> <p>Room and Board includes intensive care.</p> <p>Pre-Certification Required</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>60% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Preadmission Testing</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>60% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Physician's Visits while Confined</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>60% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Skilled Nursing Facility Benefit</p> <p>Pre-Certification Required</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>60% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Inpatient Rehabilitation Facility Expense Benefit</p> <p>Pre-Certification Required</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>60% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Registered Nurse Services for private duty nursing while Confined</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>60% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Physical Therapy while Confined (inpatient)</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>60% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Physical Therapy while Confined (inpatient) Maximum Visits per Policy Year</p>	<p>60</p>	<p>60</p>

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 listed on the back of Your ID card

<p>Inpatient Mental Health Disorder and Substance Use Disorder Benefit including Behavioral Health Services and residential treatment facilities</p> <p>Pre-Certification Required</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>60% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Outpatient Mental Health Disorder and Substance Use Disorder Benefit, including Behavioral Health Services</p> <p>Physician’s Office Visits including, but not limited to, Physician visits; individual and group therapy; medication management</p> <p>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</p>	<p>\$25 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p> <p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>80% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>60% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>

PROFESSIONAL AND OUTPATIENT SERVICES

Surgical Expenses

<p>Inpatient and Outpatient Surgery includes: Pre-Certification Required Surgeon Services Anesthetist Assistant Surgeon</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>60% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Outpatient Surgical Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>60% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>

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		
Gender Affirming Treatment 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
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
Acupuncture Services (Medically Necessary Treatment only)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Acupuncture Services Maximum visits per Policy Year	30	30
Allergy Testing and Treatment, including injections	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	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	30	30
Tuberculosis screening (TB), Titers, QuantiFERON B tests including shots (other than covered under Preventive Services)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
EMERGENCY SERVICES, AMBULANCE AND NON-EMERGENCY SERVICES		
Emergency Services in an emergency department for Emergency Medical Conditions.	\$200 Copayment per visit after Deductible then the plan pays 80% of the Negotiated Charge for Covered Medical Expenses	Paid 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 (fixed wing and rotary wing), water transportation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Non-Emergency Ambulance Expenses ground and/or air (fixed wing and rotary wing) transportation Pre-Certification Required for non-emergency air Ambulance (fixed wing and rotary wing air)	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 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, HABILITATION AND OTHER THERAPIES		
Inhalation Therapy	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	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	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy Maximum Visits for each therapy per Policy Year for Physical Therapy, and Occupational Therapy and Speech Therapy Combined with Habilitation Services Therapy The Maximum Visits do not apply to Rehabilitation Therapy for a Mental Health Disorder or Substance Use Disorder or Autism Spectrum Disorders.	30	30
Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy	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, and Occupational Therapy and Speech Therapy Combined with Rehabilitation Services Therapy The Maximum Visits do not apply to Habilitation Services for a Mental Health Disorder, Substance Use Disorder or Autism Spectrum Disorders.	30	30

OTHER SERVICES AND SUPPLIES		
Covered Clinical Trials	Same as any other Covered Sickness	
Diabetic Services and Supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	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 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
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
Student Health Center Expense Benefit	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	
Non-emergency Care While Traveling Outside of the United States	60% of Actual Charge after Deductible for Covered Medical Expenses Subject to \$10,000 maximum per Policy Year	
PEDIATRIC DENTAL AND VISION CARE		
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19) Type A – Basic Services Preventive Dental Care Limited to 1 dental exam every 6 months	See the Dental Care Schedule of Benefits below and Pediatric Dental Care Benefits description for further information. 100% of Usual and Customary Charge for Covered Medical Expenses	

<p>The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care:</p> <p>Type B – Intermediate Services</p> <p>Type C – Major Services</p> <p>Type D:</p> <ul style="list-style-type: none"> • Medically Necessary Orthodontic Services • General Services <p>Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.</p>	<p>50% of Usual and Customary Charge for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge for Covered Medical Expenses</p>
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Dental Care Schedule of Benefits

Type A – Basic Services

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 set of radiographic images including bitewings - 1 every 60 (sixty) months
 Intraoral - periapical radiographic image
 Intraoral - additional periapical image
 Intraoral - occlusal radiographic image
 Extraoral – Each Additional Radiographic Image
 Bitewing - single image Adult - 1 set every calendar year/Children - 1 set every 6 months
 Bitewings - two images - Adult - 1 set every calendar year/Children - 1 set every 6 months
 Bitewings - four images - Adult - 1 set every calendar year/Children - 1 set every 6 months
 Vertical bitewings – 7 to 8 images – Adult - 1 set every calendar year/Children - 1 set every 6 months
 Panoramic radiographic image – 1 image every 60 (sixty) months
 Cephalometric radiographic image
 2D Oral / Facial Photographic Images-obtained intraorally and extraorally
 3D photographic image
 Interpretation of Diagnostic Image
 Lab test
 Collect & Prep Genetic Sample-1 per lifetime
 Genetic Test-Specimen Analysis-1 per lifetime
 Diagnostic Models

Preventive Services

Prophylaxis – Adult - Limited to 1 every 6 months
 Prophylaxis – Child - Limited to 1 every 6 months
 Topical Fluoride – Varnish -1 in 12 months for adults, 2 every 12 months for dependent children based on age limits

Topical application of fluoride (excluding prophylaxis) - 2 every 12 months for dependent children based on age limits
Sealant - per tooth – unrestored permanent molars - Less than age 19 - 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
Sealant Repair –Per tooth-Permanent tooth-1 every 36 months
Interim Caries Medicament-Permanent teeth 1 per tooth every 36 months (Molars/Bicuspid excluding Wisdom Teeth)
Caries preventive medicament application – per tooth - 1 every 36 months
Space maintainer – fixed – unilateral - Limited to children under age 19
Space Maintainer- Fixed-bilateral, Maxillary-Limited to children under age 19
Space Maintainer- Fixed-bilateral, mandibular-Limited to children under under age 19
Space maintainer - removable – unilateral - Limited to children under age 19
Space Maintainer removable-bilateral,maxillary-Limited to children under age 19
Space Maintainer Removable bilateral,mandibular-Limited to children under age 19
Re-cement or re-bond bilateral space maintainer-maxillary
Re-cement or re-bond bilateral space maintainer-mandibular
Re-cement or re-bond unilateral space maintainer-per quadrant
Distal space maintainer fixed

Additional Procedures Covered as Basic Services

Palliative treatment of dental pain – minor procedure
Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)
Consultation With Medical Professional
Office Visit- after regularly scheduled hours

Type B – Intermediate Services

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)
Resin Crown-1 every 60 months
Porcelain Inlay-1 every 60 months
2 Surface Porcelain Inlay-1 every 60 months
3 or More Surf. Porcelain Onlay-1 every 60 months
Re-cement inlay or re-bond inlay, onlay veneer or partial coverage restoration
Re-cement or re-bond indirectly fabricated or prefabricated post and core
Re-cement or re-bond crown
Reattachment of Tooth Fragment
Prefabricated porcelain crown - primary - Limited to 1 every 60 months
Prefabricated stainless steel crown - primary tooth – Under age 15 - Limited to 1 per tooth in 60 months
Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 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) - *Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.*

Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration). Incomplete endodontic treatment when you discontinue treatment. - *Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.*

Pulpal regeneration – initial visit - Limited to 1 per lifetime

Pulpal regeneration – interim medication replacement - Limited to 1 per lifetime

Pulpal regeneration – completion of treatment - Limited to 1 per lifetime

Periodontal Services

Periodontal scaling and root planning-four or more teeth per quadrant – Limited to 1 every 24 months

Periodontal scaling and root planning-one to three teeth, per quadrant – Limited to 1 every 24 months

Scaling gingival inflammation - Limited to 1 every 6 months combined with prophylaxis and periodontal maintenance

Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth

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-mandibular

Repair broken complete denture base-maxillary

Replace missing or broken teeth - complete denture (each tooth)

Repair resin partial denture base-mandibular

Repair resin partial denture base-maxillary

Repair cast partial framework-mandibular

Repair cast partial framework-maxillary

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

Rebase hybrid prosthesis-Replacing the base material connected to the framework-Limited to a 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 1 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 installation

Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation

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

Soft liner for complete or partial removable denture-indirect-A discrete procedure provided when the dentist

determines placement of the soft liner is clinically indicated-Limited to a 1 in 36-month period 6 months after the initial installation

Tissue conditioning (maxillary)

Tissue conditioning (mandibular)

Recement 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

Collect-Apply Autologous Product-1 every 36 months

Bone replacement graft for ridge preservation-per site

Buccal/Labial Frenectomy

Lingual Frenectomy

Excision of pericoronal gingiva

Type C – Major Services

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 - porcelain fused to titanium and titanium alloys - 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 1 per tooth every 60 months
Crown – titanium– Limited to 1 per tooth every 60 months
Prefabricated porcelain/ceramic crown – permanent tooth - limited to 1 per tooth every 60 months
Resin crown - Limited to 1 per tooth every 60 months
Core buildup, including any pins– Limited to 1 per tooth every 60 months
Post and core-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
Inlay Repair
Onlay Repair
Veneer Repair
Resin infiltration/smooth surface - Limited to 1 in 36 months

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 resorption, etc.)
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) does not include final restoration
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
Surgical repair of root resorption - anterior
Surgical repair of root resorption – premolar
Surgical repair of root resorption – molar
Surg Exp of Root-Anterior
Surg Exp of Root-Premolar
Surg Exp of Root-Molar
Hemisection (including any root removal) - not including root canal therapy
Intentional removal of coronal tooth structure for preservation of the root and surrounding bone

Periodontal Services

Gingivectomy or gingivoplasty – four or more teeth - Limited to 1 every 36 months
Gingivectomy or gingivoplasty – one to three teeth - Limited to 1 every 36 months
Gingivectomy or gingivoplasty - with restorative procedures, per tooth - Limited to 1 every 36 months
Gingival flap procedure, four or more teeth – Limited to 1 every 36 months
Gingival flap procedure, including root planning - one to three contiguous teeth or tooth bounded spaces per quadrant – 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
Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant

– Limited to 1 every 36 months

Bone replacement graft - first site in quadrant - Limited to 1 every 36 months

Pedicle soft tissue graft procedure

Autogenous connective tissue graft procedures (including donor site surgery)

Non-Autogenous connective tissue graft - Limited to 1 every 36 months

Free soft tissue graft 1st tooth

Free soft tissue graft-additional teeth

Subepithelial tissue graft/each additional contiguous tooth, implant or edentulous tooth position in same graft site

Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material)-each additional contiguous tooth, implant or edentulous tooth position in same graft site-Limited to 1 every 36 months

Full mouth debridement to enable comprehensive evaluation and diagnosis– Limited to 1 per lifetime

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 months

Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months

Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)– Limited to 1 every 60 months

Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months

Immediate maxillary partial denture-resin base (including any conventional clasps, rests and teeth)-Limited to 1 every 60 months

Immediate mandibular partial denture-resin base (including any conventional clasps, rests and teeth)-Limited to 1 every 60 months

Immediate maxillary partial denture-cast metal framework with resin denture base (including any conventional clasps, rests and teeth)-Limited to 1 every 60 months

Immediate mandibular partial denture-cast metal framework with resin denture base (including any conventional clasps, rests and teeth)-Limited to 1 every 60 months

Immediate maxillary partial denture-flexible base (including any clasps, rests and teeth)-Limited to 1 every 60 months

Immediate mandibular partial denture-flexible base (including clasps, rests and teeth)-Limited to 1 every 60 months

Removable Unilateral Partial denture-one piece cast metal (including clasps and teeth), maxillary-Limited to 1 every 60 months

Removable Unilateral partial denture-one piece cast metal (including clasps and teeth), mandibular-Limited to 1 every 60 months

Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant - Limited to 1 every 60 months

Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant - Limited to 1 every 60 months

Add metal substructure to acrylic full denture (per arch)-Limit 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

Connecting Bar – implant or abutment supported - 1 every 60 months

Prefabricated Abutment – 1 every 60 months

Custom 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 Maintenance Procedures -1 every 60 months
 Scaling and debridement implant-1 every 60 months
 Implant supported crown – porcelain fused to predominantly base alloys - 1 every 60 months
 Implant supported crown – porcelain fused to noble alloys - 1 every 60 months
 Implant supported crown – porcelain fused to titanium and titanium alloys - 1 every 60 months
 Implant supported crown – predominantly base alloys - 1 every 60 months
 Implant supported crown – noble alloys - 1 every 60 months
 Implant supported crown – titanium and titanium alloys - 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
 Remove broken implant retaining screw-1 every 12 months
 Abutment supported crown – porcelain fused to titanium and titanium alloy - 1 every 60 months
 Implant supported retainer – porcelain fused to predominantly base alloys - 1 every 60 months
 Implant supported retainer for FPD – porcelain fused to noble alloys - 1 every 60 months
 Implant Removal - 1 every 60 months
 Debridement periimplant defect - Limited to 1 every 60 months
 Debridement and osseous periimpant defect - Limited to 1 every 60 months
 Bone graft periimplant defect
 Bone graft implant replacement
 Implant/abutment supported removable denture for edentulous arch-maxillary- 1 every 60 months
 Implant/abutment supported removable denture for edentulous arch-mandibular- 1 every 60 months
 Implant/abutment supported removable denture for partially edentulous arch-maxillary- 1 every 60 months
 Implant/abutment supported removable denture for partially edentulous arch-mandibular- 1 every 60 months
 Implant/abutment supported fixed denture for edentulous arch-maxillary- 1 every 60 months
 Implant/abutment supported fixed denture for edentulous arch-mandibular- 1 every 60 months
 Implant/abutment supported fixed denture for partially edentulous arch-maxillary- 1 every 60 months
 Implant/abutment supported fixed denture for partially edentulous arch-mandibular- 1 every 60 months
 Implant supported retainer – porcelain fused to titanium and titanium alloys - 1 every 60 months
 Implant supported retainer for metal FPD – predominantly base alloys - 1 every 60 months
 Implant supported retainer for metal FPD – noble alloys - 1 every 60 months
 Implant supported retainer for metal FPD – titanium and titanium alloys - 1 every 60 months
 Implant Index - 1 every 60 months
 Semi-precision abutment – placement - 1 every 60 months

Semi-precision attachment – placement - 1 every 60 months
 Abutment supported retainer – porcelain fused to titanium and titanium alloys - 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 fused to titanium and titanium alloys - 1 every 60 months
 Pontic - porcelain/ceramic – Limited to 1 every 60 months
 Inlay/onlay – 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
 Resin retainer-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
 Retainer crown – porcelain fused to titanium and titanium alloys - 1 every 60 months
 Crown - 3/4 cast high noble metal - 1 every 60 months
 Crown - 3/4 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
 Retainer crown $\frac{3}{4}$ titanium and titanium alloys - 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
 Cleaning and inspection of removable complete denture, maxillary-1 every 6 months
 Cleaning and inspection of removable complete denture, mandibular-1 every 6 months
 Cleaning and inspection of removable partial denture, maxillary-1 every 6 months
 Cleaning and inspection of removable partial denture, mandibular-1 every 6 months
 Repair/reline occlusal guard-1 every 24 months for patients 13 and older
 Occlusal guard adjustment-1 every 24 months for patients 13 and older
 Occlusal guard-hard appliance, full arch - 1 in 12 months for patients 13 and older
 Occlusal guard-soft appliance, full arch - 1 in 12 months for patients 13 and older
 Occlusal guard-hard appliance, partial arch - 1 in 12 months for patients 13 and older

Type D – Medically Necessary Orthodontic Services

Orthodontia Services

Limited orthodontic treatment of the primary dentition
 Limited orthodontic treatment of the transitional dentition
 Limited orthodontic treatment of the adolescent dentition
 Limited orthodontic treatment of the adult dentition
 Comprehensive orthodontic treatment of the transitional dentition
 Comprehensive orthodontic treatment of the adolescent dentition
 Comprehensive orthodontic treatment of the adult dentition
 Removable appliance therapy

Fixed appliance therapy
 Pre-orthodontic treatment examination to monitor growth and development
 Periodic orthodontic treatment visit (as part of contract)
 Orthodontic retention (removal of appliances, construction and placement of retainer(s))

Type D – General Services

Anesthesia Services

Deep sedation/general anesthesia-first 15 minutes
 Deep sedation/general anesthesia - each 15 minute increment

Intravenous Sedation

Intravenous moderate (conscious) sedation/analgesia-first 15 minutes
 Intravenous moderate (conscious) sedation/analgesia-each 15 minute increment

Medications

Therapeutic drug injection, by report
 Infiltration of a sustained release therapeutic drug-single or multiple sites

Post- Surgical

Treatment of complications (post-surgical) unusual circumstances, by report

<p>Pediatric Vision Care Benefit (including low vision services) (to the end of the month in which the Insured Person turns age 19)</p> <p>Limited to 1 vision examination per Policy Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year.</p> <p>Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.</p>	<p>100% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
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MISCELLANEOUS DENTAL SERVICES

<p>Accidental Injury Dental Treatment Subject to \$1,500 per tooth</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>60% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Sickness Dental Expense Benefit</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>60% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Treatment for Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) and Craniomandibular Jaw Disorders</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>60% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>

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.

<p>TIER 1 (Including Enteral Formulas)</p> <p>For each fill up to a 30 day supply filled at a Retail pharmacy</p> <p>Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.</p> <p>See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.</p>	<p>\$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>\$20 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>
<p>More than a 30 day supply but less than a 61-day supply filled at a Retail pharmacy</p>	<p>\$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>\$40 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>
<p>More than a 60 day supply filled at a Retail pharmacy</p>	<p>\$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>\$60 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>
<p>TIER 2 (Including Enteral Formulas)</p> <p>For each fill up to a 30 day supply filled at a Retail pharmacy</p> <p>Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.</p> <p>See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.</p>	<p>\$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>\$40 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>

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 for Covered Medical Expenses Deductible Waived
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 for Covered Medical Expenses Deductible Waived
TIER 3 (Including Enteral Formulas) For each fill up to a 30- day supply filled at a Retail Pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	\$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 for Covered Medical Expenses Deductible Waived
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 for Covered Medical Expenses Deductible Waived
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 for Covered Medical Expenses Deductible Waived
Specialty Prescription Drugs		
For each fill up to a 30 day supply. Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	50% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Actual Charge for Covered Medical Expenses Deductible Waived

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 for Covered Medical Expenses Deductible Waived
More than a 60 day supply	50% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Actual Charge for Covered Medical Expenses Deductible Waived

Specialty Prescription Drugs with Copayment Assistance Program

Copayment Assistance Program - Prior Authorization May Be Required: Amounts You pay out-of-pocket for covered Specialty Prescription Drugs will not exceed the applicable Tier's cost share per 30 day supply and will be applied towards the Deductible (if applicable) and Out-of-Pocket Maximum. Copayment Assistance may be available to You for certain Specialty Prescription Drugs when Your prescription is filled at a participating network pharmacy. Visit www.wellfleetstudent.com for the applicable Specialty Prescription Drugs. Copayment Assistance dollars paid by the drug manufacturer for covered Specialty Prescription Drugs will not be applied towards the Deductible (if applicable) or Out-of-Pocket Maximum. Any amounts paid by You for a covered Specialty Prescription Drug after Copayment Assistance will be applied to the deductible (if applicable) and Out-of-Pocket Maximum. For details, contact the Copayment Assistance Program at 636-271-5280.

For each fill up to a 30 day supply.	75% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
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Zero Cost Drugs

In addition to ACA Preventive Care medications, certain Generic Drugs are covered at no cost to You. Refer to Your Formulary Guide. Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	100% of Actual Charge for Covered Medical Expenses Deductible Waived
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Tobacco Cessation

Two 90-day Treatment regimens for tobacco cessation Prescription Drugs and over-the-counter drugs. Any additional Prescription Drug treatment regimens will be subject to the cost sharing below.	100% of Actual Charge for Covered Medical Expenses	
Tobacco cessation Prescription Drugs beyond the coverage described above. Additional over-the-counter drug treatment regimens 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: <ul style="list-style-type: none"> • 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
Accidental Death and Dismemberment	
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 Certificate.	

HIPAA Notice of Privacy Practices

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

PLEASE REVIEW IT CAREFULLY

Effective: August 01, 2019

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

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

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

Our Responsibilities

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

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

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

Overview of this Notice

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

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

YOUR HEALTH INFORMATION

How We Acquire Your Information

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

How We use Your Health Information

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

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

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

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

Additionally:

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

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

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

Authorizations

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

YOUR RIGHTS

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

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

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

- Psychotherapy notes;
- Information compiled 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 ACCESSIBILITY 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.

مہینتہ: اذیتنک تھحتتہ تہیر عطا (**Arabic**)، نإف تآمدخ ددعاسملا تیوغللا تہیناجملا تھاتم کلا۔ ءاجر لالاصتلاً ب (877) 657-5030۔

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)**, udostępniłmy 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。

ی سراف امشد نابز رگا :مچوت (**Farsi**) دشاب ی م امشد رایتخا رد ن انگیار روط هج ی نابز دادما تآمدخ ،تسا . (877) 657-5030 تمس یا بیگرید .

कृपा ध्या दः यद आप हंद (Hindi) भाषी ह तो आपके लए भाषा सहायता सेवाएं: शुल् उपलब् ह। कृपा पर काल कर (877) 657-5030

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

ប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ(Khmer) សេវាកម្មភាសាជំនួយឥតគិតថ្លៃមានសម្រាប់អ្នក។
សូមទូរស័ព្ទមកលេខ (877) 657-5030 ។

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

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

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

ગુજરાતી (Gujarati) યુ ના: જો તમે જરાતી બોલતા હો, તો િન:લુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે. 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፣ በገዳ ሊያገዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደው(877) 657-5030

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਿ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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ (877) 657-5030

**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;
- any policy 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.

For more information about the Ohio Life & Health Insurance Guaranty Association, visit our website at: www.olhiga.org.

As of 11/15/2018