Schedule A

Schedule of Benefits and Exclusions

Johns Hopkins University Schedule of Medical 2026–2027 Benefits

Group Number ST0858SH

Benefit	In-Network	Out-of-Network
Plan Year Maximum Benefit (Including Medical Evacuation & Repatriation)	Unlimited	
Plan Year Deductible, Per Covered Person The Plan will waive the Annual Deductible for Second Surgical Opinions, Immunizations, Primary Care Physician Office Visits, Preventive Care, Routine Gynecological Care, Urgent Care Expenses, Prosthesis required as a result of Mastectomy and Pap Smears (Waived for all in-and out of network preventive care)	$150 per plan year	
Plan Year Deductible, Per Family (Waived for all in-network preventative care)	$450 per plan year	
Out-of-Pocket Maximum	$3,000 per Individual/$9,000 Family	$3,000 per Individual/$9,000 Family

Inpatient Hospitalization Benefits

Benefit	In-Network	Out-of-Network
Hospital Room and Board Expense	90% of Preferred Allowance (PA)	70% of Reasonable and Customary Charges (R&C)
Miscellaneous Hospital Expense. Services include anesthesia and operating room; laboratory tests and x-rays; oxygen tent; and drugs; medicines; and dressings.	90% of PA	70% of R&C
In-Hospital Non-Surgical Physician Expenses. Services of a Doctor during hospital confinement. This benefit does not apply when related to surgery.	90% of PA	70% of R&C

Pre-certification simply means calling prior to treatment to obtain approval for a medical procedure or service. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. All requests for certification must be obtained by contacting Cigna at (800) 633-7867. The following inpatient services require pre-certification:

- All inpatient admissions, including length of stay, to a hospital, skilled nursing facility, a facility established primarily for the treatment of substance abuse, or a residential treatment facility.
- All inpatient maternity care, after the initial 48/96 hours.
- All partial hospitalization in a hospital, residential treatment facility, or facility established primarily for the treatment of substance abuse.

If you do not secure pre-certification your Covered Medical Expenses will be subject to a $200 per admission charge.

Surgical Benefits (Inpatient and Outpatient)

Benefit	In-Network	Out-of-Network
Surgical Expense. Expenses incurred for a surgical services, performed by a Physician.	90% of PA	70% of R&C
Anesthesia Expense. Charges of anesthesia during a surgical procedure.	90% of PA	70% of R&C
Assistant Surgeon Expense. Charges of an assistant surgeon during a surgical procedure.	90% of PA	70% of R&C

Ambulatory Surgical Expense. Charges incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center. Must be incurred on the date of surgery or within 48 hours after surgery.	90% of PA	70% of R&C
Pre-Admission Testing Expense. Charges incurred while outpatient before scheduled surgery	90% of PA	70% of R&C
Surgical Second Opinion Expense	100% of PA	100% of R&C
Acupuncture in Lieu of Anesthesia Expense	90% of PA	70% of R&C

Outpatient Benefits

Covered Medical Expenses. Include but are not limited to, Physician's office visits, Hospital or Outpatient Department or Emergency Room visits, durable medical equipment, Clinical lab or Radiological facility.

Benefit	In-Network	Out-of-Network
Hospital Outpatient Department	90% of PA	70% of R&C
Walk-In Clinic Visit Expense	90% of PA	70% of R&C
Emergency Room Expense. Charges for treatment of an Emergency Medical Condition.	100% of PA Subject to Deductible After $150 copay	100% of R&C Subject to Deductible After $150 copay
Urgent Care Expense. Charges for an urgent care provider to evaluate and treat an urgent condition. (Deductible Waived)	100% of PA after $50 copay	100% of R&C after $50 copay
Ambulance Expense. Charges for a commercial or municipal ambulance for transportation to a Hospital or between Hospitals or other medical facilities in a Medical Emergency due to covered accident or sickness. (Deductible Waived)	100% of Actual Charge	
Primary Care Physician Visit. Includes services rendered by physician for initial treatment/diagnosis	100% of PA after $20 copay	100% of R&C after $20 copay
Non-Primary Care Physician Office Visits Expense. Includes services rendered by a specialist and telemedicine services and services by a Consultant (services must be requested by the attending physician for the purpose of confirming or determining a diagnosis).	90% of PA	70% of R&C
Acupuncture Services	90% of PA	70% of R&C
Laboratory and X-ray Expense. Includes diagnostic services, laboratory and x-ray examinations.	90% of PA	70% of R&C
High-Cost Procedures Expense. Services include, but are not limited to C.A.T. Scans, MRI and Laser Treatments as a result of injury or sickness.	90% of PA	70% of R&C
Therapy Expense. Includes Physical Therapy, Chiropractic Care, Speech Therapy, Cardiac Rehabilitation, Inhalation Therapy, Occupational Therapy, Radiation Therapy, Chemotherapy, Dialysis and Respiratory Therapy. Advanced cellular therapies approved by the U.S. Food and Drug Administration (FDA) and a part of the licensed products from the Office of Therapeutic Products (OTP) are eligible for coverage when the prior authorization review is completed and the therapy is determined to be medically necessary and not experimental or investigational or unproven by the utilization review agent. Coverage of both the therapy and related administration services may vary and is determined by the customer's benefit plan.	90% of PA	70% of R&C
Durable Medical Equipment Expense	90% of PA	90% of R&C

Prosthetic Devices Expense. Includes charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of accident or sickness and wigs required as a result of chemo or radiation therapy.	90% of PA	90% of R&C
Dental Injury Expense. For injury to sound natural teeth.	90% of Actual Charge	
Impacted Wisdom Teeth Expense. For removal of one or more impacted wisdom teeth.	90% of Actual Charge	
General Anesthesia for Dental Care Expense	90% of PA	70% of R&C
Allergy Testing and Treatment Expense. Includes charges incurred by a covered person for diagnostic testing and treatment of allergies and immunology services.	90% of PA	70% of R&C

Mental Health Benefits

Benefit	In-Network	Out-of-Network
Mental Health /Outpatient Expense	90% of PA	90% of R&C
Mental Health Inpatient Expense	100% of PA	90% of R&C
Substance Abuse Outpatient Expense. Includes inpatient and intermediate treatment services for substance abuse.	90% of PA	90% of R&C
Substance Abuse Inpatient Expense	100% of PA	90% of R&C
Diagnostic Testing for Attention Disorders and Learning Disabilities Expense. Includes Diagnostic testing for attention deficit disorder or attention deficit hyperactivity disorder.	90% of PA	90% of R&C

Maternity Benefits

Benefit	In-Network	Out-of-Network
Maternity Expense / Newborn Nursery Care. Includes pregnancy, complications of pregnancy, childbirth, other pregnancy-related expenses and inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.	90% of PA	70% of R&C
Prenatal Care and Comprehensive Lactation Support. Includes services received by a pregnant female in a physician's, obstetrician's or gynecologist's office and lactation support and counseling services provided to females during pregnancy and in the post-partum period by a certified lactation support provider.	100% of PA	84% of R&C
Breast Feeding Durable Medical Equipment Expense. Includes the rental or purchase of breast feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk).	100% of PA	84% of R&C

Additional Benefits

Benefit	In-Network	Out-of-Network
Abortion Care Expense. Includes the cost of a non-therapeutic abortion.	100% of Negotiated Charge for Covered Medical Expenses	100% of R&C for Covered Medical Expenses
Wellness/Preventive and Immunizations Expenses. Includes but is not limited to; Routine Physicals, Preventive Care Visits, Laboratory Services, Immunizations (including titers) & Vaccines, GYN exams, Prostate exam and Routine Prostate Cancer Screening. (For more information, please visit: www.healthcare.gov/coverage/preventive-care-benefits/)	100% of PA	84% of R&C

Pap Smear Screening Expense	100% of PA	100% of R&C
Mammogram Expense Testing Expense	100% of PA	100% of R&C
Diabetic Supplies & Outpatient Diabetic Self-Management Education Program	90% of PA	70% of R&C
Non-Prescription Special Medical Formulas Expense	90% of PA	70% of R&C
Non-Prescription Enteral Formula Expense. Includes treatment of malabsorption caused by the following: • Crohn's Disease, • Ulcerative Colitis, • Gastroesophageal Reflux, Gastrointestinal Motility, • Chronic Intestinal Pseudo obstruction • Inherited diseases of amino acids and organic acids.	90% of PA	70% of R&C
Medical Foods and Modified Food Products Expense. Includes medical foods and low protein modified food products for the treatment of inherited metabolic disease when authorized by, and administered under the direction of, a Physician.	90% of PA	70% of R&C
Home Health Care Expense	90% of PA	90% of R&C
Hospice Care Expense	90% of PA	70% of R&C
Hormonal testing	90% of PA	70% of R&C
Transfusion or Dialysis of Blood Expense. Includes the cost of whole blood, blood components and the administration thereof.	90% of PA	70% of R&C
Licensed Nurse and Consulting Expense	90% of PA	70% of R&C
Skilled Nursing Facility Expense	90% of PA	70% of R&C
Rehabilitation Facility Expense	90% of PA	70% of R&C
Cleft Lip/Cleft Palate Treatment Expense	90% of PA	70% of R&C
Clinical Trial Costs Expense	90% of PA	70% of R&C
Speech, Hearing and Language Disorders Expense	90% of PA	70% of R&C
Habilitative Services Expense	90% of PA	70% of R&C
Early Intervention Services Expense	100% of PA	100% of R&C
Outpatient In Vitro Fertilization/ Infertility Expense Infertility and fertility preservation benefits lifetime limit: $100,000 for all medical plan services and prescription drugs combined	90% of PA	70% of R&C
Fertility Preservation Procedures Infertility and fertility preservation benefits lifetime limit: $100,000 for all medical plan services and prescription drugs combined *Dependents are not eligible for fertility preservation procedure benefits.	90% of PA	70% of R&C
Cryopreservation Storage Limited to twelve (12) months for Participants undergoing imminent fertility treatment or for Participants with Iatrogenic infertility (including gender affirmation surgery) and up to a lifetime maximum benefit of $100,000 combined with all Medical Plan services and prescription drugs	90% of PA	70% of R&C
Outpatient Contraceptive Drugs, Devices and Family Planning Services Expense	100% of PA	84% of R&C
Alzheimer's Disease Expense	90% of PA	70% of R&C
Hearing Aid Expense. This benefit is limited to one hearing aid for each impaired ear, every 36 months	90% of PA	70% of R&C

Routine Vison Care for Children under age 19 One exam/fitting per plan year, including prescription eyeglasses (lenses and frames, limited to one per plan year) or contact lenses (in lieu of eyeglasses). Includes coverage of contact lenses when Medically Necessary for treatment of Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders and Irregular Astigmatism. Eyeglass lenses include glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses. Includes coverage of the following benefits for low vision: one comprehensive low vision evaluation every five years, one Medically Necessary low vision aid every five years, such as high-power spectacles, magnifiers or telescopes; and follow-up care – four visits in any five year period. Precertification is required for all low vision services.	100% of PA	84% of R&C
Scalp Hair Prostheses	90% of PA	70% of R&C
Coverage for Bones of Face, Neck and Head Expense	90% of PA	70% of R&C
Reconstructive Breast Surgery, Post Hospitalization and Mastectomy Prosthetic Devices Expense	90% of PA	70% of R&C
Treatment of Morbid Obesity Expense	90% of PA	70% of R&C
Assessment of Metabolic Risk (in a patient whose Body Mass Index (BMI) is 25 kg/m2 or greater to include: (1) fasting lipid profile, (2) TSH, (3) liver enzymes, and (4) a fasting glucose or hemoglobin A1C level	90% of PA	70% of R&C
Prosthetic and Orthopedic Devices Expense	90% of PA	90% of R&C
Gender Affirming Surgery Expenses	90% of PA	70% of R&C

Dental Care for Children under age 19

Dental Care for Children under age 19	Coverage
Preventive	100% of R&C
Basic Dental Care	70% of R&C
Major Dental (Endodontics, Periodontics and Prosthodontics)	50% of R&C
Orthodontics (Only provided for a patient with a severe, Dysfunctional, handicapping malocclusion that meets a minimum score of 15 on the Handicapping Labio-Lingual Deviations form, excluding points for esthetics. Routine orthodontia is not covered.	50% of R&C

Prescription Drug Benefit

Prescription Drug Benefit	At SHWB-PC	In-Network	Out-of-Network	Mail Order
Prescription Drug Benefit. (Note: Prescription Drugs considered to be wellness/preventive under the Affordable Care Act (ACA), including prescription contraceptives, are payable with no cost sharing. Co-payment will apply for a Brand drug when there is a Generic equivalent available.)	$8 SHWB-PC co-pay per prescription	Plan pays 100% of the Negotiated Rate after $15 co-pay for a generic drug, $0 co-pay for generic contraceptives,	100% of R&C after $15 Deductible for each Generic Prescription Drug; $25 Deductible for	$30 Deductible for each Generic Prescription Drug; $50 Deductible for each Brand Name

Co-pays per 30-day supply Three (3) month supply at retail pharmacy available for two (2) copays.		or $25 co-pay fora brand name drug	each Brand Name Prescription Drug You must pay out-of-pocket for prescriptions at a Non-Preferred pharmacy and then submit the receipt for reimbursement	Prescription Drug The above co-pays apply to both In-Network and Out-of-Network Mail Order Prescriptions
Specialty Prescription Drugs with Copay Assistance Program. For each fill up to a 30-day supply.		75% of the Negotiated Charge for Covered Medical Expenses	Not Covered	
Travel Vaccines: Travel vaccine coverage includes all routine vaccines recommended for adults (including any needed booster doses) plus any vaccines specifically recommended due to travel to designated countries (e.g., yellow fever, Japanese encephalitis, polio, typhoid [both oral and injectable], influenza, meningococcal, hepatitis B). Medications prescribed for Malaria prophylaxis (including doxycycline and atovaquone/progunail) are also covered and do not require prior authorization).	100%	90% of PA	70% of R&C	N/A
Infertility Services: Infertility and Medically Necessary fertility preservation benefits lifetime limit: $100,000 for all medical plan services and prescription drugs combined**.**				

Covered Medical Services

The following are benefits under this Plan. The benefits below are subject to applicable Deductible, Coinsurance, and copayments as outlined in the Schedule of Benefits, and subject to all other provisions, limitations and exclusions set forth herein and in the Plan document.

A. Inpatient Hospitalization Benefits

a. Hospital Room and Board

Charges made by a Hospital for room and board in a semiprivate room, Intensive Care Unit, cardiac care unit, or burn care unit, but excluding charges for a private room (unless Medically Necessary) which are in excess of the Hospital's semiprivate room rate.

b. In-Hospital Physician Expenses

Charges for the non-surgical services of the attending Physician, or a consulting Physician.

c. Miscellaneous Hospital Expense

- Charges made by a Hospital for necessary medical supplies and services, including X-rays, laboratory, and anesthetics and the administration thereof; and
- Charges made by a Hospital for drugs and medicines obtained through written prescription by a Physician.

NOTE: All inpatient hospital admissions, convalescent facility, skilled nursing facility, a facility established primarily for the treatment of substance abuse, or a residential treatment and all inpatient maternity care after the initial 48/96 hours require pre-certification. If you do not secure pre-certification for non-emergency inpatient admissions, or provide notification for emergency admissions, your Covered Medical Expenses will be subject to a $200 per admission charge.

B. Surgical Benefits (Inpatient and Outpatient)

a. Acupuncture in Lieu of Anesthesia

Covered Charges as described in the schedule of benefits will include services administered by a legally qualified Physician, Nurse Practitioner or Physician Assistant participating within the scope of their license for:

- Adult postoperative and chemotherapy nausea and vomiting;
- Nausea due to Pregnancy;
- Postoperative dental pain;
- Chronic low back pain secondary to osteoarthritis; and
- Fibromyalgia/myofacial pain.

b. Ambulatory Surgical

- Charges incurred for outpatient surgery performed at a Physician's office, Ambulatory Surgical Center, the outpatient department of a Hospital, Birthing Center or Freestanding Health Clinic;
- Charges must be incurred on the date of surgery or within 48 hours after surgery.

c. Anesthesia

Charges for anesthesia during a surgical procedure.

Charges for anesthesia and associated Hospital or Ambulatory Surgical Center in conjunction with dental care provided to a Covered Person who:

- is seven (7) years of age or younger or is developmentally disabled;
- is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the enrollee or Insured; and
- is an individual for whom a superior result can be expected from dental care provided under general anesthesia.

Such charges will also be covered when provided in conjunction with dental care provided to a Covered Person who:

- is an extremely uncooperative, fearful, or uncommunicative person with dental needs of such magnitude that treatment should not be delayed or deferred; and
- is an individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

d. Assistant Surgeon

The SHIP will pay for a surgical assistant when the nature of the procedure is such that the services of an assistant, who is a Physician, are Medically Necessary.

e. Mastectomy

When services relating to a mastectomy are Medically Necessary, coverage will include:

- Treatment of the physical complication of the mastectomy, including lymphedema;
- All stages of reconstruction of the breast on which the mastectomy was or is to be performed;
- Prosthesis; and
- Surgery and reconstruction of the other breasts to produce a symmetrical appearance.

f. Gender Affirming Services

The Plan allows coverage for gender affirming services when all of the following criteria are met:

1. Non-procedural outpatient services and tracheal shave: no pre-certification required. Includes but is not limited to the following:
   - Behavioral health services, including but not limited to counseling for gender dysphoria or gender incongruence and related psychiatric conditions (e.g., anxiety, depression)
   - Hormonal therapy, including but not limited to androgens, anti-androgens, GnRH analogues (Prior authorization requirements may apply), estrogens, and progestins.
   - Laboratory testing to monitor prescribed hormonal therapy
   - Age-related, gender-specific services, including but not limited to preventive health, as appropriate to the individual's anatomy (e.g., cancer screening [e.g., cervical, breast, prostate]; treatment of a prostate medical condition).
   - Speech therapy
   - Outpatient tracheal shave procedure (chondrolaryngoplasty)
2. Gender-affirming surgeries and procedures: pre-certification required.
   1. Requirements for "Top Surgery" (mastectomy, breast reduction or breast augmentation)

1. Single letter of referral or recommendation from a qualified health care provider with training and experience in medical care for gender affirmation patients; and
2. Persistent, well-documented gender dysphoria; and
3. Capacity to make a fully informed decision and to consent for treatment; and
4. Age of majority (18 years of age or older); and
5. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Top surgery may require associated procedures, each of which should be listed for Prior Authorization separately. These include but are not limited to:

1. Nipple-areola reconstruction
2. Pectoral implants
3. Skin grafts

NOTE: Cosmetic issues due to approved and performed top surgery are part of the risks of this surgery and are considered Healthcare Acquired Conditions (HAC's). As such, modification procedures to correct cosmetic issues due to previously approved and performed top surgery is not a covered benefit.

2. Requirements for "Bottom Surgery" (hysterectomy and salpingo-oophorectomy, gonadectomy or orchiectomy, and genital reconstructive surgery (vaginoplasty, phalloplasty, or metoidioplasty))
    1. Single letter of referral or recommendation from a qualified health care provider (with minimum of Master's degree or equivalent) with training and experience in medical care for gender affirmation patients with written documentation submitted to the physician performing the surgery; and
    2. Persistent, well-documented gender identity disorder; and
    3. Documentation of at least 12 months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical or other contraindication); and
    4. Documentation of 12 months of living in a gender role that is congruent with their gender identity (real life experience) and for vaginoplasty, phalloplasty or metoidioplasty. This criterion is not applicable for hysterectomy and salpingo-oophorectomy, gonadectomy or orchiectomy.
    5. Capacity to make a fully informed decision and to consent for treatment; and
    6. Age of majority (18 years of age or older); and
    7. If significant medical or mental health concerns are present, they must be reasonably well controlled.

    Bottom surgery may require associated procedures, each of which should be listed for pre-certification separately. These include but are not limited to:

    1. Hysterectomy, salpingo-oophorectomy, orchiectomy
    2. Vaginectomy/colpectomy, vulvectomy, metoidioplasty, phalloplasty, scrotoplasty, urethroplasty/urethromeatoplasty, insertion of testicular prosthesis
    3. Vaginoplasty, electrolysis of donor site tissue to be used to line the vaginal canal or male urethra, penectomy, vulvoplasty, repair of introitus, coloproctostomy
    4. Electrolysis for skin grafting

3. Requirements for facial bone reconstruction/facial gender surgery (FGS)
    1. Persistent, well-documented gender dysphoria or gender incongruence; and
    2. Capacity to make a fully informed decision and to consent for treatment; and
    3. Age of majority (18 years of age or older); and
    4. If significant medical or mental health concerns are present, they must be reasonably well controlled.
4. Requirements for Ancillary Procedures and services beyond major facial bone reconstruction:
    1. Persistent, well-documented gender identity disorder; and
    2. Capacity to make a fully informed decision and to consent for treatment; and
    3. Age of majority (18 years of age or older); and
    4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

    Ancillary procedures and services beyond major facial bone reconstruction include but are not limited to:

    1. Hair transplant
    2. Wrinkle removal
    3. Nose procedures
    4. Dermabrasion
    5. Chemical peel
    6. Eyelid lifts
5. Covered Procedures. The following procedures (a non-exclusive list) are covered benefits if pre-certified is provided as part of the procedures described above:

- Brow Lift
- Buttock Implant
- Calf Implants
- Cheek/malar implants (included in standard facial feminization surgery (FFS))
- Chin/nose implants or genioplasty (included in standard FFS)
- Colpcleisis – vaginal walls sewn together (included in bottom surgery)
- Electrolysis
- Hair Grafts
- Forehead contouring (included in standard FFS)
- Jaw implant (included in standard FFS)
- Jaw reduction (jaw contouring) Jaw and/or Chin reshaping (included in standard FFS)
- Lip Reduction/shortening
- Lipofilling of hips, thighs, buttocks
- Mastectomy with liposuction of the chest
- Mons lift/mons reduction – lifting and tightening and/or reduction of the mons pubis area (included in bottom surgery)
- Nipple/areola complex Reconstruction (both male to female and female to male) (included in top surgery)

- Perineoplasty – narrows vaginal opening (included in bottom surgery)
- Rhinoplasty
- Scalp (hairline) advancement

6. Exceptions and Additional Rules.
    1. The following procedures are NOT covered benefits under this Plan:

- Blepharoplasty
- Mastopexy – breast lift

    2. Voice modification surgery is covered only if voice therapy is unsuccessful.
    3. Certain diagnosis code or treatment code-dependent services that fall under each of the above categories, require special review and pre-certification. This includes procedures with unlisted/unspecified/other codes, custom preparation prostheses, investigational procedures, custom preparation prostheses, etc.
        1. Each code will also fit under one of the above covered categories.
        2. Each code must meet the requirements for the applicable category.
        3. In addition, the following information needs to be submitted for each code:
            1. If it is an unlisted/unspecified/other code the following is required:

- An accurate, detailed description of the item, service or procedure performed, as identified by an unlisted code.
- Documentation supporting the use of the unlisted code vs. other available CPT or HCPCS code, if appropriate.

            2. All codes, including unlisted/unspecified/other code, require the following:

- Medical necessity for service, procedure or item; and
- Supporting clinical documentation that is pertinent to the item, service or procedure performed, such as:
- Imaging report;
- Invoice;
- Laboratory/pathology report;
- Operative/office notes; and
- Procedure notes/reports

Note: Procedures not expressly set forth as a covered benefit pursuant to the above language, are considered cosmetic, are excluded from coverage, and will not be paid or reimbursed by the Plan.

Note on gender specific services for transgender persons:

Gender-specific services may be Medically Necessary, as determined under the terms of the Plan and in the sole and absolute discretion of the Plan Administrator, for transgender persons appropriate to their anatomy. Examples include:

1. Breast cancer screening may be Medically Necessary for female to male transgender persons who have not undergone a mastectomy;
2. Prostate cancer screening may be Medically Necessary for male to female transgender individuals who have retained their prostate.

g. Pre-Admission Testing

Charges made for preadmission tests on an outpatient basis for a scheduled Hospital admission or surgery.

h. Surgical

If two (2) or more surgical procedures are performed at one (1) time through the same incision in the same operative field, the maximum allowable amount for the surgery will be either the amount for the primary procedure and 50% of the amount for the secondary or lesser procedure(s), or if not in the network, the Reasonable and Customary Charge for the major procedure and 50% of the Reasonable and Customary Charge for the secondary or lesser procedure(s). No additional benefit will be paid under the SHIP for incidental surgery done at the same time and under the same anesthetic as another surgery.

NOTE: Necessary surgical procedures incidental to providing a wellness benefit required by the SHIP's voluntarily compliance with HHS guidelines will be covered at the same rate as any other Wellness expense. Surgical procedures not required under HHS regulations, such as vasectomies, will be paid as any other Covered Medical Expense.

Coverage is provided for a Covered Person who receives less than forty-eight (48) hours of inpatient hospitalization following the surgical removal of a testicle, or who undergoes the surgical removal of a testicle on an outpatient basis, as follows:

C. Outpatient Benefits

Covered Medical Expenses include but are not limited to, Physician's Office Visits, Hospital or Outpatient Department or Emergency Room Visits, Durable Medical Equipment, Clinical Lab or Radiological Facility.

a. Allergy Testing and Treatment

Covered charges include charges incurred for diagnostic testing of allergies and immunology services including but not limited to:

- Laboratory tests,
- Physician office visits (including visits to administer injections),
- Prescribed medication for testing,
- Other Medically Necessary supplies and services.

b. Ambulance Services

Charges incurred for a professional ambulance for transportation to a hospital, or between hospitals or other medical facilities when required due to the emergency nature of a covered Accident or Sickness.

c. Dental Injury

Coverage includes dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, and/or reposition sound natural teeth that are damaged, lost, or removed and other body tissues of the mouth fractured or cut due to a covered injury, provided:

- The tooth is be free from decay, in good repair, and firmly attached to the jawbone at the time of the injury.
- The injury is from damage other than eating or chewing.

Covered benefits include:

- The first denture or fixed bridgework to replace lost teeth,
- The first crown needed to repair each damaged tooth,
- An in-mouth appliance used in the first course of orthodontic treatment after the injury,

- Surgery needed to: treat a fracture, dislocation or wound; alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

d. Durable Medical Equipment

Coverage will be provided for no more than one (1) item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- Made to withstand prolonged use,
- Made for and mainly used in the treatment of a disease or injury,
- Suited for use in the home,
- Not normally of use to person's who do not have a disease or injury,
- Not for use in altering air quality or temperature,
- Not merely for convenience or independence such as phone alerting systems, massage devices, over bed tables, communication aids, or other such item,
- Not for exercise or training.

e. Emergency Room

Charges incurred for Medically Necessary care at an emergency treatment center, walk in medical clinic or ambulatory clinic (including clinics located at a Hospital).

f. High-Cost Procedures Expense

Charges for High Cost Procedures include charges for the following procedures and services:

- C.A.T. Scan;
- Magnetic Resonance Imaging; and
- Contrast Materials for these tests.

g. Hospital Outpatient Department or Walk-in Clinic

- Outpatient department charges;
- Benefits do not include expenses incurred for the use of an outpatient surgical facility.

h. Laboratory and X-ray

Charges incurred for X-rays, microscopic tests, laboratory tests, electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved and performed by Physicians throughout the United States.

i. Physician Office Visits

Charges made by legally-licensed Physician, Nurse Practitioner or Physician Assistant for medical care and/or treatment including office visits, hospital outpatient visits/exams, telemedicine services, and clinic care.

Coverage is also provided on a nondiscriminatory basis for covered services when delivered or arranged by a participating nurse practitioner with no annual service limitation that is less than other preferred care providers. If the services are in connection with surgery and the physician is the surgeon who performed the surgery, no benefits will be payable under this provision.

j. Therapy

Charges for the following types of outpatient therapies:

- Physical Therapy

- Chiropractic Care
- Speech Therapy
- Inhalation Therapy
- Cardiac Rehabilitation
- Occupational Therapy
- Radiation Therapy
- Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy
- Dialysis
- Respiratory Therapy

Advanced cellular therapies approved by the U.S. Food and Drug Administration (FDA) and a part of the licensed products from the Office of Therapeutic Products (OTP) are eligible for coverage when the prior authorization review is completed and the therapy is determined to be medically necessary and not experimental or investigational or unproven by the utilization review agent. Coverage of both the therapy and related administration services may vary and is determined by the customer's benefit plan.

k. Urgent Care

Covered charges include treatment by an urgent care provider to evaluate and treat a non-emergency condition.

A covered person should not seek medical care or treatment form an urgent care provider if their illness, injury, or condition is an emergency condition. The Covered Person should call 911 or go directly to the emergency room of a hospital for medical assistance.

A Covered Person should not be discouraged from exercising the option of calling the local pre-hospital emergency medical service system by dialing 911 (or its local equivalent) when he or she is confronted with an emergency medical condition.

D. Maternity Benefit

a. Maternity

- Prenatal care of the mother and/or fetus is treated as any other Covered Medical Expense.
- Inpatient care for the mother and/or newborn child will be provided for a minimum of 48 hours following a vaginal delivery, or a minimum of 96 hours following a cesarean section. However the mother's or newborn's attending Physician, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In such cases, covered services may include, Home Visits, Parent Education, and assistance and training in breast or bottle-feeding and the performance of any necessary and appropriate clinical tests, provided, however, that the first (1st) home visit be conducted by a Registered Nurse, Physician, or certified nurse midwife, and provided that any subsequent home visits determined to be clinically necessary shall be provided by a licensed health care provider.
- Authorization is not needed for initial inpatient care, however, should care be needed longer than the 48/96 hours described above, written documentation of medical necessity may be required.
- Covered medical expenses include services of a certified nurse midwife, provided that expenses for such services are reimbursed when such services are performed by any other duly licensed practitioner.
- Complications of pregnancy, are considered a sickness and are covered under this benefit.

- Charges made by a Birthing Center or Freestanding Health Clinic (Payment will be limited to the amount that would have been paid if that person were in a Hospital.)

b. Newborn Nursery Care

Covered Charges will include benefits for routine care of a covered person's newborn child as follows:

- Hospital charged for routine nursery care during the mother's confinement, but for not more than four (4) days for a normal delivery;
- Physician's charges for circumcision; and
- Physician's charges for visits to the newborn child in the hospital and consultations, but not for more than one (1) visit per day.

E. Additional Benefits

a. Abortion Care Expense

Covered charges include the cost of a non-therapeutic abortion.

b. Alzheimer's Disease

Covered Medical Expenses include care for Alzheimer's disease, including nursing home care for intermediate and custodial levels of care.

c. Amino Acid-Based Elemental Formula

Covered Medical Expenses include coverage for amino acid-based elemental formula for the diagnosis and treatment of:

- Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
- Severe food protein induced enterocolitis syndrome;
- Eosinophilic disorders, as evidenced by the results of a biopsy; and
- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

d. Antigen Testing

Coverage will be provided for Human Leukocyte Antigen or Histocompatibility Locus Antigen testing necessary to establish bone marrow transplant donor suitability. Coverage shall include the costs of testing for A, B or DR antigens, or any combination thereof, consistent with rules, regulations and criteria established by the department of public health.

e. Blood Products

Coverage is provided for blood products, other than whole blood or concentrated red blood cells.

f. Bone Marrow Transplants for Breast Cancer

Covered Charges for expenses incurred by a covered person who has been diagnosed with breast cancer that has progressed to the metastatic disease as follows:

- If recommended by the treating oncologist, referral to and participation in clinical trial on the grounds that the proposed procedure shows promise as a useful treatment for the Covered Person's Cancer and is likely to be at least as effective as conventional treatment;

- A bone marrow transplant, provided the Covered Person meets the criteria established for enrollment in a clinical trial even if not formally enrolled in the clinical trial; and
- Coverage for the bone marrow transplant itself.

The clinical trial will be conducted:

- At a licensed health facility which participates in a National Cancer Institute (NCI) sponsored or approved research in any cancer specialty area, or
- At a licensed health facility which has a formal agreement with an academic medical center to provide bone marrow transplantation as part of an NIC sponsored approved research protocol.

Definitions:

- "Bone Marrow Transplant" means use of high dose chemotherapy and radiation in conjunction with transplant of autologuous bone marrow or peripheral blood stem cells which originate in the bone marrow.
- "Metastatic Disease" means Stage III and Stage IV breast Cancer, as well as stage II breast cancer which has spread to ten (10) or more lymphnodes, as defined by the American College of Surgeons.

g. Cardiac Rehabilitation

Such treatment shall be initiated within 26 weeks after the diagnosis of such disease and be recommended by the attending Provider/Practitioner. Phase I consists of acute inpatient hospitalization, whether for heart attack or heart surgery, highly supervised with a tailored exercise program with continuous monitoring during exercise. Phase II consists of outpatient supervised treatment for Covered Persons who have left the Hospital but still need a certain degree of supervised physical therapy and monitoring during exercise. Phase II services are usually tailored to meet the Covered Person's individual needs. Benefits are not payable for Phase III, which consists of outpatient services without supervision. The Phase III program is developed for patients who are well enough to continue exercising on their own, monitoring their own progress.

h. Cleft Lip and Cleft Palate Treatment Expense

Include inpatient and outpatient charges incurred for a congenital cleft lip or cleft palate or both. Such charges are included to the extent they would have been so included if incurred for treatment of a disease.

Covered treatment means any of the services or supplies listed below given for the management of the birth defect known as cleft lip or cleft palate or both.

- Inpatient and outpatient orthodontics
- Oral surgery. This includes pre-operative and post-operative care performed by a physician.
- Otologic treatment.
- Audiological treatment
- Speech/language treatment

i. Clinical Trial

Covered charges will include expenses for routine patient costs (as defined in 42 USC §300gg-8(a)) for items and services furnished in connection with participation in a clinical trial that meets the following conditions:

- The purpose of the trial is to treat a Covered Person in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition;

- The Covered Person meets the patient selection criteria enunciated in the study protocol for participation in said clinical trial;
- The available clinical or pre-clinical data provides a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial and that benefits will be at least as effective as a non-trial alternative;
- The patient has provided documentation of informed consent for participation in the clinical trial, in a manner that is consistent with current legal and ethical standards;
- The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient;
- The clinical trial is (A) approved or funded by one or more of (i) the National Institutes of Health (NIH), (ii) the Centers for Disease Control and Prevention, (iii) the Agency for Health Care Research and Quality, (iv) the Centers for Medicare and Medicaid Services, (v) a cooperative group or center of the entities described in clauses (i) through (iv), (vi) a qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants, (vii) the Department of Veterans Affairs, the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed or approved through a system of peer review that meets requirements established by the Secretary of Labor; (B) conducted under an investigational new drug application reviewed by the Food and Drug Administration; or (C) a drug trial that is exempt from having an FDA new drug application;
- The clinical trial does not unjustifiably duplicate existing studies; and
- The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training, and treat a sufficient volume of patients to maintain that expertise.

j. Coverage for Bones of Face, Neck and Head Expense, Temporomandibular Joint Syndrome (TMJ) Treatment

Coverage is provided for diagnostic or surgical procedures involving a bone or joint of the face, neck or head, on the same basis that coverage is provided for a bone or joint of the skeletal structure. If the procedure is Medically Necessary to treat a Condition caused by a congenital deformity, disease or injury.

k. Dental Expense for Impacted Wisdom Teeth

Covered Medical Expenses for removal of one or more impacted wisdom teeth.

l. Dermatological

Covered Charges include diagnosis and treatment of skin disorders. Any associated laboratory fees would be provided under the Laboratory expense.

m. Diabetic Testing Supplies & Outpatient Diabetic Self-Management Education Program

Charges incurred for diabetic self-management training, education services, supplies and equipment for the treatment of insulin- and non-insulin-dependent diabetes and elevated blood glucose levels during pregnancy.

Benefits include:

- expense for blood glucose monitors;
- blood glucose monitoring strips for home use;
- voice-synthesizers for blood glucose monitors for use by the legally blind;

- visual magnifying aids for use by the legally blind;
- urine glucose strips;
- ketone strips;
- insulin;
- insulin syringes;
- prescribed oral diabetes medications that influence blood sugar levels;
- laboratory tests, including glycosylated hemoglobin, or HbA1C tests;
- urinary/protein/microalbumin and lipid profiles;
- insulin pumps and insulin pump supplies;
- insulin pens;
- so-called, therapeutic/molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating doctor and prescribed by a podiatrist or other qualified doctor and furnished by a podiatrist, orthotist, prosthetist or pedorthist;
- supplies and equipment approved by the FDA for the purposes for which they have been prescribed and diabetes outpatient self-management training and education, including medical nutrition therapy.

NOTE: A co-payment for a 30-day supply would apply to items payable under the prescription drug benefit.

n. Surgical Second Opinion

Charges incurred for a second surgical opinion, are as follows:

- fees of a specialist Physician for a second surgical consultation when non-Emergency or elective surgery is recommended by the Covered Person's attending Physician (The Specialist Physician rendering the second opinion regarding the Medical Necessity of such surgery must be board certified in the medical field relating to the surgical procedure being proposed; and
- Covered Charges will include expenses for required x-rays and diagnostic tests done in connection with that consultation.

o. Habilitative Services Expense

Habilitative services that are delivered through early intervention or school services are not covered.

For purposes of this benefit "Habilitative services" means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function.

For purposes of this benefit, "congenital or genetic birth defect" means a defect existing at or from birth, including a hereditary defect. "Congenital or genetic birth defect" includes, but is not limited to:

- Autism or an autism spectrum disorder;
- Cerebral palsy;
- Intellectual disability;
- Down syndrome;
- Spina bifida;
- Hydroencephalocele; and
- Congenital or genetic developmental disabilities.

p. Hearing Aid Expense

Covered Medical Expenses include charges for hearing aids only when prescribed, fitted and dispensed by a licensed audiologist. Hearing aid means a device is (a) of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by the Covered Person and (b) non-disposable. This benefit is limited to one hearing aid for each impaired ear every 36 months.

q. Hearing Screening for Newborns

Covered charges for hearing screening service rendered to a dependent child performed before the newborn infant is discharged from the Hospital or birthing center.

r. Home Health Care

Covered Charges include Medically Necessary expenses incurred by a Covered Person for Home Health Services in accordance with a Home Health Care Plan (HHCP) written by the treating Physician.

Such expenses will only be covered if:

- Services are furnished by, arranged by, or under the direction of a licensed Home Health Agency.
- Services are rendered under a HHCP. The plan must be established by the written order of the attending Physician. Such plan must be reviewed by the attending Physician every sixty (60) days. Such Physician must certify that the proper treatment of the condition would require inpatient confinement in a Hospital or Skilled Nursing Facility if the services and supplies were not provided under the Home Health Care Plan. The attending Physician must examine the Covered Person at least once a month.
- Unless specifically provided in the plan, services are to be delivered in the Covered Person's place of residence on a part-time, intermittent visiting basis.
- Services must be provided by a certified professional operating within the scope of their license.
- Each visit that last for a period of four (4) hours or less is treated as one (1) visit.

No benefits will be provided for services and supplies:

- Not included in the Home Health Plan;
- Services of any social worker, transportation services, Custodial Care and housekeeping;
- Dialysis treatment, purchase or rental of dialysis equipment, food or home delivered services; or
- For services of a person who ordinarily resides in the home of the Covered Person, or is a close relative of the Covered Person.

s. Hospice Care

Hospice care benefits are provided to a terminally-ill Covered Person with a life expectancy of less than six (6) months; Benefits are limited to:

- Inpatient Care in a Hospital or Hospice facility;
- Ancillary charges furnished by the facility while the patient is confined therein, including rental of durable medical equipment which is used solely for treating an Injury or Illness;
- Medical supplies, drugs, and medicines prescribed by the attending Physician, but only to the extent that such items are necessary for pain control and management of the terminal condition;

- Services and/or nursing care by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or a Licensed Vocational Nurse (L.V.N.), on a part time basis (up to 8 hours in one (1) day);
- Home Health aide services;
- Medical social services by licensed or trained social workers, psychologists, or counselors under the direction of a physician, including the assessment of the person's social, emotional, medical and dietary needs and assessment of the home and family situation;
- Identification of available community resources and assistance in obtaining those resources as noted in the covered person's assessed needs;
- Nutrition services provided by a licensed dietitian;
- Respite care for up to 5 days in any 30 day period; and
- Bereavement counseling.

Bereavement counseling is a support service provided to Covered Person's immediate family both prior to and after the death of the Covered Person. Such visits are to assist in adjusting to the death. Benefits will be payable provided:

- On the date immediately before his or her death, the terminally-ill person was in a Hospice Plan of Care program and was a Covered Person under the SHIP; and
- Charges for such services are incurred by the Covered Person(s) within three (3) months of the terminally-ill person's death.

The term immediate family means: parents, spouse (or domestic partner) and children of the terminally-ill Covered Person.

Bereavement Counseling does not include: funeral arrangements; financial or legal counseling; or homemaker or caretaker services (not otherwise provided in the Home Health Care Plan).

t. Hypodermic Needles

Covered charges include coverage for Medically Necessary Hypodermic needles and syringes.

u. Infertility

Benefits will be payable for infertility procedures including diagnostic evaluation and testing to determine the cause of infertility. Benefits are also available to Covered Persons for services and supplies related to the treatment of infertility or which assist in achieving pregnancy, including infertility counseling, drugs (including but not limited to hormone therapy), and tests. Benefits for infertility treatment are available to all covered members who meet the definition of infertility as outlined below and in the Definitions section.

‘‘Infertility’’ is a disease, condition, or status characterized by any of the following:

a. The inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.
b. The need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner.
c. In patients having regular, unprotected intercourse and without any known etiology for either partner suggestive of impaired reproductive ability, evaluation should be initiated at 12 months when the female partner is under 35 years of age and at 6 months when the female partner is 35 years of age or older.

Nothing in this definition shall be used to deny or delay treatment to any individual, regardless of relationship status or sexual orientation.

The following assisted reproductive technology procedures are covered with or without the use of donor egg, sperm or embryos: artificial insemination (AI), intra-uterine insemination (IUI), in vitro fertilization (IVF) including reciprocal IVF, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT). Freezing (cryopreservation), storage up to 12 months, and thawing of eggs, sperm, and embryos (with or without donor tissue) are covered as part of approved fertility treatment cycles. Genetic carrier screenings, chromosome analysis, and preimplantation genetic testing (PGT-A, PGT-M, and PGT-SR) are also covered. Carrier screenings, chromosome analysis, PGT-M and PGT-SR require medical necessity.

Medical fertility treatment and laboratory services (such as embryology) provided to the member which utilizes any combination of donor eggs, sperm, and/or embryos are covered under the plan. Cost for purchase and procurement of donor gametes and embryos is excluded under the plan, which includes (but is not limited to) agency fees, donor medical costs, donor compensation, and shipping costs.

Notwithstanding anything herein to the contrary, medical necessity shall not be required for: frozen embryo transfers; freeze all cycles; storage of semen and embryos as part of IVF treatment; donor semen, eggs, and embryos prior to use. These benefits shall be approved if the Covered Person is approved for IVF.

Benefits are available for cryopreservation, storage up to 12 months, and thawing of eggs, sperm, and embryos (with or without donor tissue) related to infertility treatment for Covered Persons with iatrogenic infertility (including gender affirming treatment).

Outpatient In Vitro Fertilization Expense

Benefits shall include all outpatient expenses arising from in vitro fertilization procedures incurred by a covered person or a covered person’s spouse or domestic partner.

Lifetime maximum benefit of medical and prescription (Rx) benefits combined shall be $100,000.

v. Fertility Preservation Procedures

Benefits are payable for standard fertility preservation procedures provided for a Covered Person or a Covered Person’s Spouse or Domestic Partner, who at the time the expenses were incurred, was at least 18 years old, to the extent the expenses are Medically Necessary to preserve fertility for the Covered Person due to a need for medical treatment that may directly or indirectly cause iatrogenic infertility.

For purposes of this benefit:

- Iatrogenic infertility means an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment affecting the reproductive organs or processes including gender affirming treatment.
- Medical treatment that may directly or indirectly cause iatrogenic infertility means medical treatment with a likely side effect of infertility as established by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology.
- Standard fertility preservation procedures means procedures to preserve fertility that are consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology, as may be amended from time to time, including sperm and oocyte cryopreservation, including but not limited to; laboratory assessments; medications; and treatments associated with sperm and oocyte cryopreservation. Standard fertility preservation procedures include the cryopreservation, storage, and thawing of sperm or oocytes, provided that coverage for preservation procedures is limited to a storage period of no longer than 12 months.

w. Licensed Nurse

Covered Charges include charges incurred by a covered person who is confined in an Inpatient basis and requires the Medically Necessary services of a registered nurse or licensed practical nurse, provided that the nurse is not an immediate family member or resides in the Covered Person's home.

x. Mammography

In addition to the Wellness/Preventive and Immunization benefits, coverage is provided in accordance with the latest cancer screening guidelines issued by the American Cancer Society.

y. Medical Evacuation and Repatriation

TravelGuard services are a comprehensive program providing You with 24/7 emergency medical and travel assistance services including emergency security or political evacuation, repatriation services and other travel assistance services when you are outside Your home country or 100 or more miles away from your permanent residence. Travel Guard is your key to travel security.

Medical Evacuation

If the Covered Learner cannot continue his/her academic program because he/she sustains an Injury or becomes ill while Covered under the Plan we will pay for the Reasonable and Customary Charges incurred for a medical evacuation of the Covered Person to or back to the Covered Person's home country or country of regular domicile, subject to the Coinsurance, Deductible, Copayment, maximums and limits as stated in the Schedule of Benefits and subject to the Exclusions and Limitations provisions. No payment will be made under this provision unless the evacuation follows a Hospital Confinement of at least five (5) days. Before we make any payment, we require written certification by the Doctor that the evacuation is Medically Necessary. Any expense for medical evacuation requires Our prior approval and coordination. For International Learners once evacuation is made outside the country, Coverage terminates.

Medical Repatriation

If the Covered Person dies while Covered under the Plan, We will pay for the Reasonable and Customary Charge incurred for embalming, and/or cremation and returning the body to his place of residence in his/her home country or country of regular domicile, subject to the Coinsurance, Deductible, Copayment, maximums and limits as stated in the Schedule of Benefits and subject to the Exclusions and Limitations provision. Expenses for repatriation of remains require the Policyholder's and Our prior approval. If you are a United States citizen, your home country is the United States.

For general inquiries regarding the travel access assistance services coverage, please call Wellfleet at 877-657-5044.

If you have a medical, security, or travel problem, simply call Travel Guard for assistance and provide your name, school name, the group number shown on your ID card, and a description of your situation. If you are in North America, call the Assistance Center toll-free at: 1-877-305-1966 or if you are in a foreign country, call collect at: 1-715-295-9311.

If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center. Travel Guard will then take the appropriate action to assist You and monitor Your care until the situation is resolved.

z. Medical Foods and Modified Food Products

aa. Non-Prescription Enteral Formula

Covered Charges include Non-Prescription Enteral formulas for which a Physician has issued a written order. Such formulas must be Medically Necessary for the treatment of malabsorption caused by:

- Ulcerative Colitis,
- Chronic intestinal pseudo-obstruction,
- Crohn's disease,
- Gastroesophageal motility problems,
- Gastroesophageal reflux, and
- Inherited diseases of amino acids and organic acids (including food products modified to be low protein).

bb. Outpatient Contraceptive Drugs, Devices and Services

Covered Charges include:

- Charges incurred for Contraceptive drugs and devices that have been approved by the FDA and legally require a Physician's prescription.
- Related Outpatient services such as: consultations, exams, procedures, and other contraceptive related services and supplies.
- Additional contraceptive packs are covered when Medically Necessary.

Covered Charges do not include:

- Charges incurred while confined on an Inpatient basis; and
- Charges incurred for duplicate, lost, stolen, or damaged contraceptive devices.

NOTE: Necessary surgical procedures incidental to providing a wellness benefit required by the SHIP's voluntarily compliance with HHS guidelines will be covered at the same rate as any other Wellness expense. Surgical procedures not required under HHS regulations, such as vasectomies, will be paid as any other Covered Medical Expense.

cc. Pediatric Preventive Care

Includes covered charges for physical examination history measurements sensory screening neuropsychiatric evaluation and developmental screening, and assessment of dependent children of the covered person from birth through age six (6). Services shall include hereditary and metabolic disease(s) screening at birth, appropriate immunizations and tests recommended by the physician.

dd. Podiatric

Covered Charges include Medically Necessary Outpatient Podiatric services.

ee. Prescription Drug Benefit

This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered condition. Prescription drugs include:

- "Off-label" drugs for the treatment of HIV/AIDS or cancer, will not be excluded on the grounds that the drug has not be approved by the U.S. FDA for that indication, if such drug is recognized for the treatment of such indication in one (1) of the standard reference compendia, in medical literature.
- Services associated with the administration of a Prescription drug are covered as any other Medically Necessary service when recommended by the treating Physician as part of the Prescription.

- This benefit includes: blood glucose monitoring strips, urine glucose strips, keotone strips, lancets, insulin syringes, insulin pumps and insulin pump supplies, insulin pens, insulin and oral medications. A co-payment will be required for a thirty (30) day supply.

Not all medications are covered. For more information on covered medications contact Cigna.

Specialty Prescription Drugs with Copay 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. Copay 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 Payment Assistance Program at 636-271-5280.

ff. Prosthetic Device

Covered Charges include artificial limbs, or eyes, and other non-dental prosthetic devices that are Medically Necessary as the result of an injury or illness.

Covered Charges do not include: Eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet (except as required to prevent complications from diabetes). This exclusion from Covered Charges in the preceding sentence does not apply to Routine Vision Care for Children under age 19 described in the Schedule of Benefits.

gg. Rehabilitation Facility

Covered Charges for expenses incurred by a covered person for confinement as a full time Inpatient in a Rehabilitation Facility. Confinement must follow within 24 hours of and be for the same or related cause(s) as, a period of Hospital or Skilled Nursing facility confinement.

hh. Residential Crisis Treatment

Covered Medical Expenses will include expenses incurred by a person for residential crisis services.

"Residential crisis services" means: intensive mental health and support services that are:

- Provided to a child or adult with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair their ability to function in the community,
- Designed to prevent psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of the inpatient stay,
- Provided out of the individual's residence on a short term basis in a community based residential setting, and
- Provided by entities that are licensed by the Department of Health and Mental Hygiene to provide residential crisis services.

ii. Scalp Hair Prostheses

Charges for Medically Necessary wigs and artificial hairpieces, worn for hair loss resulting from any form of cancer or leukemia treatment.

jj. Skilled Nursing Facility

Skilled Nursing/Extended Care Facilities: Inpatient confinement in a Skilled Nursing/extended care facility and/or in a rehabilitation facility/Hospital is provided if:

- Is in lieu of confinement in a hospital on a full time inpatient basis;
- Charges are incurred within twenty-four (24) hours following a Hospital confinement for the same or related cause as the confinement;
- The attending Physician certifies that twenty-four (24) hour nursing care is Medically Necessary for recuperation from the Illness or Injury which required the Hospital confinement.

kk. Special Medical Formulas

Covered charges include special medical formulas for newly born infants, adoptive children, and if Medically Necessary a pregnant women with phenylketonuria. The formulas must be approved by the Commissioner of Health for the Medically Necessary treatment of an inborn error of metabolism (such as but not limited to Homocystinuria, Methylmalonic acidemia, Maple Syrup Urine Disease, Phenylketonuria, Propionic academia, and Tyrosinemia).

ll. Speech, Hearing and Language Disorders

Covered Charges include Medically Necessary diagnosis and treatment of speech; hearing; and language disorders if the charges are made for:

- Diagnostic Services rendered to find out if- and to what extent- a covered person's ability to speak or hear is lost or impaired.
- Rehabilitative services rendered that are expected to restore or improve a covered person's ability to speak or hear.

This benefit does not include charges:

- For any ear or hearing exam to diagnose or treat a disease or injury
- For drugs or medications
- For any hearing care service or supply which is a covered expense in whole or in part under any other part of this plan or under any other group plan;
- For any hearing care service or supply which does not meet professionally accepted standards
- For hearing aids, hearing evaluation tests, hearing aid batteries, and the fitting of prescription hearing aids
- For any exam which: is required by an employer as a condition of employment; or is required to provide under a labor agreement; or is required by any law of government;
- For Special Education (including lessons in sign language) to instruct a covered person, whose ability to speak or hear is lost or impaired, to function without that ability;
- For diagnostic or rehabilitative services for treatment of speech, hearing, and language disorders that any school system, by law, must provide; or as to speech therapy, to the extent such coverage is already provided for under Early Intervention and Home Health Care Services;
- For any services unless they are provided in accordance with a specific treatment plan, which details the treatment to be rendered and the frequency and duration of the treatment; and
- That provides for ongoing services, and is renewed only if such treatment is still Medically Necessary.

mm. Transfusion or Dialysis of Blood

Covered charges for administration of infusions and transfusions (This includes the cost of unreplaced blood and blood plasma or autologuous blood and blood plasma. Expenses for storage of autologuous blood or blood plasma will not be covered.)

nn. Treatment of Morbid Obesity

Coverage is provided for surgical treatment of morbid obesity that is:

- Recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity; and
- Consistent with guidelines approved by the National Institutes of Health.

Surgical treatment of morbid obesity is covered to the same extent as for other Medically Necessary surgical procedures under the Plan.

oo. Wellness/Preventive and Immunizations

As part of the University's voluntary adoption of the U.S Department of Health and Human Services (HHS) benefit requirements for fully insured Learner health insurance plans, the LHBP will be providing wellness benefits in accordance with government guidelines as listed at www.healthcare.gov/coverage/preventive-care-benefits/ The following is a sample of the benefits considered preventive under the Affordable Care Act (ACA) as required by HHS Regulations.

"In any event, the following services and supplies are covered without cost sharing: Preventive care for adults, children and adolescents, including 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; Well-child care, including evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; Well-woman care, including evidence-informed preventive care and screenings for women provided for in comprehensive guidelines supported by the Health Resources and Services Administration; Prescription drugs, including prescribed over the counter drugs, that are included in the United States Preventive Services Task Force preventive care recommendations with a rating of A or B: Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention."

pp. Organ Transplants

All Medically Necessary non-experimental/investigational solid organ transplants, and other non-solid organ transplant procedures, are covered the same as any other condition. Please see the Travel and Lodging Policy for information about covered costs related thereto.

qq. Pulmonary Rehabilitation

Medically Necessary pulmonary rehabilitation services are covered for Covered Persons who have been diagnosed with significant pulmonary disease or who have undergone certain surgical procedures of the lung, each as determined by the Claims Administrator.

Coverage is provided to the same extent as for office visits for medical treatment.

Services must be provided at a place of service approved by the Claims Administrator that is equipped and approved to provide pulmonary rehabilitation services.

Coverage is not provided for maintenance programs. Maintenance programs consist of activities that preserve the Covered Person's level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional progress is apparent or expected to occur.

Pulmonary rehabilitation services are limited to one (1) program per lifetime and must be authorized in advance by the Claims Administrator.

rr. Pediatric Dental Care

Preventive Dental Care

- Cleanings – once every six months.
- Fluoride treatments – topical fluoride varnish up to four times per year. Topical application of fluoride once per six months.
- Sealants – once per lifetime. Teeth 2-5, 12-15, 18-21, 28-31 covered only for the occlusal surfaces of posterior permanent teeth without restorations or decay.
- Space maintainers – once every two years.
- Dental examinations – once per six months.

X-Rays

- Bitewing (must be at least age 2)
- Full Mouth Panoramic (must be at least age 6)

Basic Dental Care

Fillings

- Silver amalgam.
- Tooth colored composite.

Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least 36 months.

Major Dental Care

Crowns/Tooth Caps

- Stainless steel crowns – teeth 1-32 once per 60 months per tooth. Teeth A-T once per 36 months per tooth.
- Metal (only), metal/porcelain and porcelain crowns – precertification required; once per 60 months per tooth. Pre-operative radiographs of adjacent and opposing teeth required.

Root Canals (Endodontics)

- Root canals on baby teeth (pulpotomies).
- Root canals on permanent teeth – once per lifetime per tooth. Pre-operative and fill radiograph must be maintained in patient record.
- Gum (periodontal) therapy – precertification required. Once per 24 months per quadrant.

Dentures

- Partial and complete dentures – precertification and preoperative radiographs required; once per 60 months.
- Bridges – not covered.

Oral Surgery

- Simple extractions, Surgical extractions, Care of abscesses, including palliative (emergency) treatment of dental pain
- Cleft palate treatment – precertification required, must be treatable through orthodontics
- Cancer treatment – covered under Surgical Benefits

- Treatment of fractures – may require precertification depending on the nature of the fracture
- Biopsies – copy of pathology report is required with claim.
- Treatment of jaw joint problems (TMJ) – not covered under Dental Benefits.
- Emergency room services provided by a dentist – facility and anesthesia charges are covered under Inpatient Hospitalization and Surgical Benefits.

  Dental procedures that require emergency care can be reviewed retrospectively to determine coverage under Dental Benefits.

Inpatient Hospital Services

All dental services that are to be rendered in a hospital setting require recertification.

Covered for patients requiring extensive operative procedures and who meet one or more of the following:

- classified by American Society of Anesthesiologists as medically compromised patient whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary
- medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment not medically appropriate
- documentation of psychosomatic disorders that require special treatment
- cognitively disability where patient's prior history indicates hospitalization is appropriate

Anesthesia

General anesthesia, nitrous oxide or intravenous conscious sedation – a maximum of 60 minutes of services are allowed. A narrative of Medical Necessity must be maintained in patient records.

Coverage is provided for extensive or complex oral surgical procedures such as:

- Impacted wisdom teeth
- Surgical root-recovery from maxillary antrum
- Surgical exposure of impacted or unerupted cuspids
- Radical excision of lesions in excess of 1.25 cm

Anesthesia is also covered if medically necessary due to the following medical conditions:

- Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension).
- Underlying hazardous medical condition (cerebral palsy, epilepsy, mental retardation, including Down's syndrome) which would render patient noncompliant.
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.
- Patients 3 years old and younger with extensive procedures to be accomplished.

Orthodontics

- Retainers (orthodontic) – precertification required; one set included in comprehensive orthodontia. Replacement allowed once per arch per lifetime within 24 months of date of debanding.
- Braces – precertification required; once per lifetime. Must have a set of fully erupted permanent teeth with at least 1/2 to 3/4 of the clinical crown exposed (unless the tooth is impacted or congenitally missing). Must have a severe, dysfunctional, handicapping malocclusion that meets a minimum score of 15 on the handicapping labio-lingual deviations form (HLD). Since a case must be dysfunctional to be accepted for treatment, patients whose molars and bicuspids are in good occlusion seldom qualify. Crowding

alone is usually not dysfunctional in spite of the esthetic considerations. Points are not awarded for esthetics. Specified documentation and treatment plan must be submitted.

ss. Preventive Services for Adults (a Covered Person age 19 and older)

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked.
- Alcohol misuse screening and counseling.
- Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk.
- Blood pressure screening.
- Cholesterol screening for adults of certain ages or at higher risk.
- Colorectal cancer screening for adults 45 to 75 years old.
- Depression screening.
- Type 2 diabetes screening for adults 40 to 70 years who are overweight or obese.
- Diet counseling for adults at higher risk for chronic disease.
- Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting.
- Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
- Hepatitis C screening for adults age 18 to 79 years.
- HIV screening for everyone age 15 to 65, and other ages at increased risk.
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use.
- Immunizations and vaccines for adults (doses, recommended ages, and recommended populations vary):
    - chickenpox
    - hepatitis a
    - hepatitis b
    - herpes zoster
    - human papillomavirus
    - influenza (flu shot)
    - measles, mumps, rubella
    - meningococcal
    - mumps
    - whooping cough
    - pneumococcal
    - rubella
    - tetanus, diphtheria, pertussis
    - shingles
    - varicella
- Prostate exam and routine prostate cancer screening
- Lung cancer screening for adults 50 to 80 at high risk for lung cancer because they’re heavy smokers or have quit in the past 15 years.
- Obesity screening and counseling.
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk

- Statin preventive medication for adults 40 to 75 at high risk
- Syphilis screening for adults at higher risk.
- Tobacco use screening for all adults and cessation interventions for tobacco users.
- Tuberculosis screening for certain adults without symptoms at high risk.

tt. Preventive Services for Women, including Pregnant Women

- Anemia screening on a routine basis for pregnant women.
- Bacteriuria urinary tract or other infection screening for women.
- BRCA counseling about genetic testing for women at higher risk.
- Breast cancer mammography screenings every 1 to 2 years for women over 40 years. See Mammography coverage benefit.
- Breast cancer chemoprevention counseling for women at higher risk.
- Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women.
- Cervical cancer screening for sexually active women.
- Annual chlamydia infection screening for sexually active women age 25 or younger and women at higher risk.
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.
- Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before.
- Domestic and interpersonal violence screening and counseling for all women.
- Folic acid supplements for women who may become pregnant.
- Gestational diabetes screening for women 24 weeks pregnant (or later) and those at high risk of developing gestational diabetes.
- Gonorrhea screening for all women at higher risk.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- Human papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are age 30 or older.
- Maternal depression screening for mothers at well-baby visits.
- Osteoporosis screening for women over age 60 depending on risk factors. Further, coverage is provided for bone mass measurement expenses for the prevention, diagnosis and treatment of osteoporosis when provided to a qualified individual.
- Preeclampsia prevention and screening for pregnant women with high blood pressure.
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
- Tobacco screening and interventions for all women, and expanded counseling for pregnant tobacco users.
- Sexually transmitted infections (STI) counseling for sexually active women.
- Syphilis screening.
- Well-woman visits to obtain recommended preventive services for all women.

uu. Preventive Services for Children (a Covered Person under age 19)

- Alcohol and Drug Use assessments for adolescents.
- Autism screening for children at 18 and 24 months.

- Behavioral assessments for children of all ages (up to age 18).
- Bilirubin concentration screening for newborns
- Blood Pressure screening for children (up to age 18).
- Blood screening for newborns
- Cervical Dysplasia screening for sexually active females.
- Congenital Hypothyroidism screening for newborns.
- Depression screening for adolescents beginning routinely at age 12.
- Developmental screening for children under age 3, and surveillance throughout childhood.
- Dyslipidemia screening for children at higher risk of lipid disorders (up to age 18).
- Fluoride chemoprevention supplements for children without fluoride in their water source.
- Fluoride varnish for all infants and children as soon as teeth are present
- Gonorrhea preventive medication for the eyes of all newborns.
- Hearing screening for all newborns and regular screenings for children and adolescents as recommended by their provider.
- Height, weight and body mass index measurements for children.
- Hematocrit or hemoglobin screening for children.
- Hemoglobinopathies or sickle cell screening for newborns.
- Hepatitis B screening for adolescents at higher risk
- HIV screening for adolescents at higher risk.
- Immunizations and vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary) including:
    - chickenpox
    - diphtheria, tetanus, pertussis
    - haemophilus influenzae type b
    - hepatitis a
    - hepatitis b
    - human papillomavirus
    - inactivated poliovirus
    - influenza (flu shot)
    - measles, mumps, rubella
    - meningococcal
    - mumps
    - pneumococcal
    - rubella
    - rotavirus
    - varicella
- Iron supplements for children ages 6 to 12 months at risk for anemia.
- Lead screening for children at risk of exposure.
- Medical history for all children throughout development. (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)
- Obesity screening and counseling.
- Oral health risk assessment for young children (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years).

- Phenylketonuria (PKU) screening for this genetic disorder in newborns.
- Sexually transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk.
- Tuberculin testing for children at higher risk of tuberculosis (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, and 15 to 17 years).
- Vision screening for all children.
- Well-baby and well-child visits.

In addition, Coverage will be provided for Annual chlamydia and gonorrhea Screenings for men, which include the mouth, urethra and rectum as indicated.

Notwithstanding any provision herein to the contrary, the In-Network reimbursement rates set forth on Schedule A shall apply to any Out-of-Network provider who provides a Benefit set forth on Schedule A to a Covered Learner or Dependent at an In-Network facility.

Travel and Lodging

The Plan provides Covered Persons with a travel and lodging allowance to receive Medically Necessary services, including Gender Affirming Services, that are not available in the Covered Person's primary state of residence, but are available and legally permissible in the state wherein the services are provided.

The Plan provides an allowance for reasonable travel and lodging expenses for a Covered Person and one travel companion when the Covered Person must travel at least 50 miles, but no more than 300 miles, from such Covered Person's primary residence, as reflected in our records, to another state to receive the services described above. The Plan will not cover any travel and lodging expenses incurred for travel in excess of 300 miles from the Covered Person's primary residence. In the event the Covered Person receiving the services provided above is a "child" as defined by the Plan, two travel companions (one of whom must not be a "child") may accompany the child.

This Plan provides an allowance for incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available to the Covered Person. The allowance is up to $10,000 per Plan Year, and will be provided for travel and lodging expenses incurred as a part of the services described above. Lodging expenses for Covered Persons and a travel companion are subject to IRS annual limits.

Please remember to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding travel and lodging, you may contact us at 877-657-5044 or the telephone number on your ID card.

Preadmission/Precertification / Case Management

Pre-certification simply means contacting the service provider designated by the Plan Administrator, currently, Cigna, prior to treatment to obtain approval for a medical procedure or service. This may be done for you by your doctor, a hospital administrator, or one of your relatives (if they possess a written Protected Health Information (PHI) letter granting access to your health information). All requests for certification must be obtained by contacting Cigna.

If you do not secure pre-certification for a non-emergency inpatient admission or provide notification for an emergency admission within one (1) business day you will be subject to a charge of $200 per admission. This per admission charge cannot be used to satisfy co-payments, deductibles, or out-of-pocket maximums described herein.

Pre-certification is required for the following inpatient or outpatient services or supplies:

- All inpatient admissions to a hospital, convalescent facility, skilled nursing facility, residential treatment facility, and facility established primarily for the treatment of substance abuse. Documentation must include projected length of stay. In the event the number of days of hospitalization exceeds the number of pre-certified days, the

additional days will not be an eligible expense under the provisions of this SHIP, unless certified as Medically Necessary care by the Plan Administrator.

- Inpatient maternity care lasting longer than the initial 48 hours for a vaginal delivery or no longer than 96 hours for a cesarean delivery. Documentation must be provided as to expected extension of stay.
- All partial hospitalization in a hospital, residential treatment facility, or facility established primarily for the treatment of substance abuse.

Pre-certification does not guarantee the payment of benefit for your inpatient admission. Each claim is subject to review in accordance with the exclusions and limitations contained in the Plan, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the Learner Health Benefits Plan.

Pre-certification of Non-Emergency Inpatient Admissions, Partial Hospitalization and Home Health Services must take place at least three (3) business days prior the planned admission or date the services are scheduled to begin.

In the case of an Emergency Admission, the Covered Person, their physician, representative, or care center must contact the Claim Administrator within one (1) business day following the Emergency Admission. If the Covered Person is confined to the Hospital's observation area for more than 24 hours, it is necessary that the Covered Person contact the Claim Administrator within 48 hours after an admission or on the first business day following admission. If authorization is not obtained, the reduction in benefits described above applies.

Case Management Provision for Alternate Treatment

In cases where a Covered Person's condition is, or is expected to be, of a serious nature, the Plan Administrator may arrange for review and/or case management services from a professional qualified agency. This service involves the cost-effective voluntary management of a potentially high-cost claim for a high-risk or long-term medical condition. The intention of the service is to plan necessary, quality care in the most cost-effective manner with the approval of the Covered Person, the family of the Covered Person, and the Primary Care Physician (PCP).

In the event a Covered Person is identified as a candidate for case management a treatment plan is developed and implemented. Such plan is created and approved with input from the Primary Care Physician, the Covered Person, and the Case Management Agency. If either the Primary Care Physician and/or the Covered Person do not wish to follow the developed plan, treatments will continue and benefits will be paid according to the SHIP.

Most of the time, large case management treatment will contain options regularly covered under the SHIP. However, in certain cases, the most medically appropriate and cost-effective care may be in a setting or manner not usually covered by the SHIP. In such cases, all Medically Necessary aspects of the approved treatment will be covered under the terms of the SHIP. Such exceptions will be determined on a case-by-case basis. In no way will an exception be considered as setting a precedent or creating a future liability for any Covered Person. All regular SHIP provisions would still apply.

Exclusions

In addition to any other services, procedures, or treatments excluded from coverage elsewhere in this Brochure or the Plan document, the Plan shall not provide benefits for any of the following expenses:

1. Expenses incurred as a result of dental treatment, except for treatment resulting from injury to sound natural teeth, dental abscesses, for the extraction of impacted wisdom teeth and as provided elsewhere in this Brochure or the Plan. This exclusion does not apply to Dental Care for Children under age 19 described in the Schedule of Benefits.

2. Expenses incurred for services normally provided without charge by the Student Health & Well-Being Primary Care Clinic and its health care providers.
3. Expenses incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aid, or prescriptions or examinations except as required for repair caused by a covered Injury. This exclusion does not apply to a newborn hearing screening test to be performed before the newborn infant is discharged from the Hospital or birthing center to the care of the parent or guardian. This exclusion does not apply to Routine Vision Care for Children under age 19 described in the Schedule of Benefits.
4. Expenses incurred as a result of an Injury due to participation in a riot or attempt to or commission of a felony. “Participation in a riot” means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order. “Riot” means a public and violent disturbance of the peace by three (3) or more persons assembled together.
5. Expenses incurred due to an accident as a consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a commercial airline maintaining regular published schedules on a regularly established route.
6. Expenses incurred due to an injury or illness as a result of working for wage or profit, or for which benefits are payable under any Worker’s Compensation or Occupational Disease Law, Public Assistance Program, or Occupational Benefit Plans.
7. Expenses incurred as the result of an illness contracted or injury sustained while in service of the Uniformed Services of any country. Upon the covered person entering the Uniformed Services of any country a Covered Person may terminate their participation in this plan and request a pro-rated refund of premium.
8. Expenses incurred in a government hospital unless there is a legal obligation to pay.
9. Expenses incurred for care or services to the extent the charge would have been covered under Medicare Part A or B even though the covered person is eligible, but did not enroll in Part B.
10. Expenses incurred by a Covered Person who is not a citizen of the United States for services performed within the home country of that Covered Person, if the covered person’s home country has a socialized medicine program and the covered person is eligible to participate in that program.
11. Expenses incurred for surgery or related services for cosmetic purposes to improve appearance, but this exclusion does not apply to the extent needed to restore bodily function or correct deformity resulting from disease, trauma, congenital, or developmental anomalies.
12. Expenses incurred by a covered person after the date coverage terminates, except as may be specifically provided in the extension of benefits provision.
13. Expenses incurred for services rendered: by a person or individual acting beyond the scope or his or her legal authority; a member of the Covered Person’s Immediate Family; or anyone who lived with the Covered Person.
14. Expenses incurred for an injury sustained while a.) participating in any intercollegiate or professional sport, contest or competition; b.) traveling to or from such sport, contest, or competition; c.) while participating in any supervised practice or conditioning program for such sport, contest, or competition; (participation in club or intramural athletic activities is not specifically excluded). Notwithstanding the preceding, when combined with the benefits provided by the athletic department, intercollegiate athletes will not incur out of pocket expenses resulting from the practice or play of National Collegiate Athletic Association (NCAA) or National Association of Intercollegiate Athletics (NAIA) sanctioned intercollegiate

sports that are substantially different from the benefits provided by this plan. This exclusion also does not apply to the extent that a learner has incurred medical expenses that are not covered due to either: (1) the maximum per injury limits of insurance coverage provided by the NCAA or the NAIA; or (2) a specific limitation or exclusion in such NCAA or NAIA coverage, or any other coverage provided by the athletic department for medical expenses incurred in the play or practice of intercollegiate sports, for an expense that is otherwise eligible under this plan.

15. Expenses incurred for procedures that are determined to be experimental or investigational.
16. Custodial Care; Care provided in a: rest home, home for the aged, halfway house, health resort, college infirmary or any similar facility for domiciliary or Custodial Care, or that provides twenty-four (24) hour non-medical residential care or day care (except as provided for Hospice Care).
17. Expenses incurred for the removal of an organ from a Covered Person for the purpose of donating or selling the organ to any person or organization. This limitation does not apply to donation by a Covered Person to a spouse, child, brother, sister or parent.
18. Expense for services or supplies provided for the treatment of obesity and/or weight control, except for morbid obesity unless specifically provided for in this Plan.
19. Expenses incurred for gynecomastia (male breasts).
20. Expenses incurred for sinus surgery except for Medically Necessary surgery and purulent sinusitis.
21. Expenses incurred to rent or buy personal hygiene/convenience items (such as air conditioners, humidifiers, hot tubs, whirlpools, general exercise equipment, telephones, TV, radio, extra bed/cot, guest meal, take home items, motorized transportation equipment, escalators or elevators in private homes, swimming pools or related supplies); telephone consolations; standby charges of a physician; charges for missed appointments; photocopies of medical records; completion of forms; or expenses not Medically Necessary to diagnose or treat an Injury or Illness including but not limited to services related to the activities of daily living.
22. Expenses incurred that were: not recommended by the attending physician; non-medical in nature; not required for the care and treatment of a covered injury or illness; in excess of Reasonable and Customary.
23. Expenses incurred for the treatment of Covered learners who specialize in the mental health care field, who receive treatment as part of their training in that field.
24. Expenses incurred for legend vitamins, food supplements, biological sera, blood plasma, drugs to promote or stimulate hair growth, experimental drugs, drugs dispensed in a rest home or hospital for take home usage, except as specifically provided.
25. Expenses incurred for injury or sickness resulting from declared or undeclared war or any act thereof.
26. Expenses for charges for or related to artificial insemination; elective sterilization or its reversal unless specifically provided for in this Plan.
27. Expenses for alternative, holistic medicine, and or therapy; including but not limited to yoga and hypnotherapy.
28. Expenses for massage therapy.
29. Expenses incurred for elective treatment or elective surgery except as specifically provided elsewhere in the Plan.
30. Expenses incurred for services normally provided without charge by the school and covered by the school fee for services.
31. Expenses incurred for which no member of the covered person’s immediate family has any legal obligation for payment. However, this does not exclude charges made by hospitals and other institutions of the Maryland State or local governments.

32. Expenses incurred for a treatment, service, or supply which is not Medically Necessary for the diagnosis care or treatment of the sickness or injury involved.
33. Expenses relating to the services of or treatment of surrogates (traditional and gestational).
34. Expenses relating to any service, treatment, or drug that is not permitted under applicable state or local law, unless the Covered Person travels to a state or locality without such restriction to receive such service or item.

Coordination of Benefits

A. Maximum Benefits Under All Plans

If any Covered Person covered under the SHIP is also covered under one or more Other Plan(s), and the sum of the benefits payable under all the plans exceeds the Covered Person's eligible charges during any claim determination period, then the benefits payable under all the plans involved will not exceed the eligible charges for such period as determined under the SHIP. Benefits payable under another plan are included, whether or not a claim has been made. The first $10,000 in eligible medical expenses will be paid as primary, and each dollar above $10,000 will be paid in accordance with Section D(1), below. For these purposes,

(1) claim determination period means a Plan Year; and

(2) eligible charge means any necessary, Reasonable and Customary item of which at least a portion is covered under the SHIP, but does not include charges specifically excluded from benefits under the SHIP that may also be eligible under any Other Plans covering the Covered Person for whom the claim is made.

B. Other Plans

Other Plan means the following plans providing benefits or services for medical and dental care or treatment and include:

(1) group insurance or any other arrangement for coverage for Covered Persons in a group, whether on an insured or uninsured basis;

(2) Blue Cross, Blue Shield, or any other prepayment coverage, including health maintenance organizations (HMOs), Medicare, or Medicaid; or

(3) no-fault automobile insurance (for purposes of the SHIP, in states with compulsory no-fault automobile insurance laws, each Covered Person will be deemed to have full no-fault coverage to the maximum available in that state. The SHIP will coordinate benefits with no-fault coverage as defined in the state of residence, whether or not the Covered Person is in compliance with the law, or whether or not the maximum coverage is carried).

C. Determining Order of Payment

If a Covered Person is covered under two or more plans, the order in which benefits will be determined is as follows.

(1) The plan covering the Covered Person as a subscriber pays benefits first. The plan covering the Covered Person as an Eligible Dependent pays benefits second.

(2) If no plan is determined to have primary benefit payment responsibility under (1) above, then the plan that covered the Covered Person for the longest period has the primary responsibility.

(3) A plan that has no Coordination of Benefits provision will be deemed to have primary benefit payment responsibility.

(4) The plan covering the parent of the Eligible Dependent child pays first if the parent's birthday (month and day of birth, not year) falls earlier in the calendar year. The plan covering the parent of an Eligible Dependent child pays second if the parent's birthday falls later in the calendar year.

(5) In the event that the parents of the Eligible Dependent child are divorced or separated, the following order of benefit determination applies:

   (a) the plan covering the parent with custody pays benefits first;

   (b) if the parent with custody has not remarried, then the plan covering the parent without custody pays benefits second;

   (c) if the parent with custody has remarried, then the plan covering the step-parent pays benefits second, and the plan covering the parent without custody pays benefits third; and

   (d) if a divorce decree or other order of a court of competent jurisdiction places the financial responsibility for the child's health care expenses on one of the parents, then the plan covering that parent pays benefits first.

D. Facilitation of Coordination

For the purpose of Coordination of Benefits, the Claims Administrator:

(1) may release to, or obtain from, any other insurance company or other organization or individual any claim information, and any Covered Person claiming benefits under the SHIP must furnish any information that the Plan Administrator may require. Notwithstanding the foregoing, Claims Administrator will request other insurance information for those payment amounts exceeding $10,000;

(2) may recover on behalf of the SHIP any benefit overpayment from any other individual, insurance company, or organization; and

(3) has the right to pay to any other organization an amount it will determine to be warranted, if payments that should have been made by the SHIP have been made by such organization.

Definitions

The following are terms used in this Schedule A. To the extent any terms defined below are inconsistent with the same term defined in the Plan document, the term defined below shall control with regard to matters relating to this Schedule A and the term defined in the Plan will control with regard to matters relating to Plan provisions.

Accident

Means a sudden specific event that is unforeseen, caused by an external force not due in whole or in part to a sickness or disease of any kind that is the direct cause of a physical injury occurring while the SHIP is in force as to the Covered Person.

Maximum Benefit

Means the greatest amount of benefit that will be paid under the SHIP for a Covered Medical Expense incurred by a Covered Person during a Plan Year.

Appeal

Means a request that a decision to deny benefits or a claim be reviewed. Such review would include consideration of any relevant information.

Biologically-Based Mental Disorders

Means a biological disorder of the brain; as defined in the most recent edition of the American Psychiatric Associations' Diagnostic and Statistical Manual of Mental Disorders (DSM) that substantially limits the functioning of the person with the condition up to and including:

- Affective disorders
- Autism (see Autism Spectrum Disorder Benefit);
- Bipolar Disorder;
- Delirium;
- Dementia
- Eating Disorders;
- Major depressive Disorder
- Obsessive-Compulsive Disorder;
- Panic Disorder
- Paranoia and other psychotic disorders;
- Post-Traumatic Stress Disorder;
- Schizoaffective Disorder;
- Schizophrenia;
- Substance Abuse Disorders; and
- any Biologically-Based Mental Disorders appearing in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association that are scientifically recognized and approved by the commissioner of the department of mental health in consultation with the commissioner of the division of insurance.

Coinsurance

Means the out-of-pocket expenses to be paid by the Covered Person as a percentage of the Covered Medical Expenses as show in the Schedule of Medical Benefits.

Co-payment (Co-pay)

Means a fee charged to the Covered Person at the point the service is rendered or prescription is dispensed.

Covered Medical Expense

Means charges for Medically Necessary treatment, services, or supplies received by an individual while enrolled in this plan. Covered charges may not be in excess of Preferred Allowance, Negotiated Fee, Reasonable and Customary expenses or in excess of charges that would be made in the absence of this insurance. Such expenses will be subject to the terms listed in the schedule of benefits and detailed in the covered benefits section.

Covered Person

Means an individual that is covered under this Plan as either the Covered Learner or as an eligible Dependent of the Covered Learner.

Covered Learner

Means a learner of the Plan Sponsor who has paid the applicable premium for coverage and is enrolled in the SHIP.

Deductible

Means the dollar amount of Covered Medical Expenses that the Covered Person must incur as an out-of-pocket expense each Policy Year before benefits are payable under this Policy. The Deductible amount, as shown in the Schedule of Medical Benefits, may be reduced or waived under certain conditions. Most of such conditions are specified in the Schedule of Medical Benefits.

Eligible Dependent

Means one of the following persons:

(1) A child of the Covered Learner who has not attained 26 years of age;
(2) A person who is the lawful spouse of the Covered Learner;
(3) A person for whom the covered learner has completed and signed a “declaration of domestic partnership”;
(4) An unmarried child of the Covered Learner who is age 26 or older and is permanently and totally disabled (under Internal Revenue code Section 22 (e)(B)).

For purposes of determining eligibility, the term “child” means:

- any person under age 26 for whom the Covered Learner must provide coverage under a child support order;
- any person who resides with the Covered Learner for more than half the taxable year and for whom the Covered Learner is appointed legal guardian by a court of competent jurisdiction
- a Covered Learner’s step-child, biological child, legally adopted child or child placed with the Covered Learner for adoption; or
- any child of the Covered Learner’s Domestic Partner who would otherwise qualify as a Child of the Covered Learner under this section if the Domestic Partner and the Learner were legally married to each other; provided, however, that the Child must reside with the Learner or Domestic Partner Covered Person.

Elective Treatment

Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Covered Person’s effective date of coverage. Elective treatment includes; but is not limited to:

- vasectomy;
- breast reduction;
- submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis;
- treatment for weight reduction;
- learning disabilities;
- temporomandibular joint dysfunction (TMJ).

Emergency Medical Condition

Means medical condition that manifests itself by symptoms of sufficient severity, that could lead a reasonably prudent layperson with an average knowledge of health and medicine, to believe that lack of prompt medical attention could place the health of a Covered Person in serious jeopardy, serious impairment to body function, serious dysfunction of any body organ or part, or, with respect to a pregnant woman, may cause distress to the fetus.

Filing

Means the earlier of (a) 5 days after the date of mailing or (b) the date of receipt.

Hospital

Means a health care facility that:

- Primarily engaged to provide in-patient services for a fee for the treatment of Injured and sick people;
- Has established facilities for diagnosis and major surgery under the supervision of a physician(s) who is(are) legally licensed to practice medicine;
- Is licensed and run as a hospital according to the laws and regulations applicable to the location/jurisdiction including the Joint Commission on Accreditation of Health Care Organizations, and accredited by the Commission of Accreditation of Rehabilitation Facilities.

Hospital Confinement

Means a stay of eighteen (18) or more hours in a row of care as a patient in a hospital.

Illness

Means a disorder or disease either or the body or a mental nervous disorder including reoccurring symptoms of the same illness. In this document the term Illness and Sickness are used interchangeably. All conditions due to the same or related illness are considered one illness. The term Illness/Sickness includes pregnancy, and complications of pregnancy.

Infertility

Is a disease, condition, or status characterized by any of the following:

a. The inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.
b. The need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner.
c. In patients having regular, unprotected intercourse and without any known etiology for either partner suggestive of impaired reproductive ability, evaluation should be initiated at 12 months when the female partner is under 35 years of age and at 6 months when the female partner is 35 years of age or older.

Nothing in this definition shall be used to deny or delay treatment to any individual, regardless of relationship status or sexual orientation.

Injury/Injuries

Means physical harm to the body due to an accident, trauma, or damage that includes complications arising from an injury due to an accident but is independent of all other causes including illnesses.

In-Network

Means an organization, Hospital, Physician, Practitioner, or other Provider that has agreed to participate in the Preferred Provider Network and accept a Negotiated Charge for their services.

That negotiated charge, known as the preferred provider amount (PA), is the maximum charged a provider in the network for their service or supply under this plan.

Johns Hopkins University Counseling Center

A clinic operated; maintained; and supported by the school that provides counseling services to enrolled learners.

Johns Hopkins University Student Heath & Well-Being Primary Care

Clinics operated; maintained; and supported by the school that provides health care services to enrolled students & learners.

Medically Necessary

Means a service or supply that is not experimental or investigational and is necessary and appropriate for the diagnosis or treatment of an Injury or Illness based on generally accepted current medical practices. For a treatment, service or supply to be considered “medically necessary”, the service or supply must, without creating a negative impact on the overall health of the Covered Person, be:

- Care or treatment likely to produce a significant positive outcome both to the sickness or injury involved and to the overall health of the Covered Person without being more costly than any other comparable care or treatment; or
- A diagnostic procedure likely to result in producing information that could affect the course of treatment in a way other less costly diagnostic procedures could not do; and
- Ordered by a treating physician; safe and effective in treating the condition for which it is ordered; of the proper quantity, frequency, and duration for the treatment of the condition for which it is ordered; and applied according to practices generally accepted by the American Medical Community.

In determining if a service or supply is appropriate under the circumstance, the Claim Administrator will take all pertinent information into account such as:

- Information relating to the health status of the Covered Person;
- Reports in peer reviewed medical literature;
- Reports and guidelines, including scientific data, published by nationally recognized health care organizations;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis care or treatment; and
- The opinion of health care professional in the generally recognized health field specifically involved.

Medically Necessary will never include: services that do not require the technical skills of a medical, mental health or dental professional; or service furnished mainly for the personal comfort or convenience of the Covered Person or any person who is caring for the Covered Person; services furnished solely because the person was inpatient on a day which there person’s covered medical condition could safely and adequately be diagnosed or treated on an outpatient basis or other less costly setting.

Out-of-Pocket

Means the most You will pay during a Policy Year before your coverage pays at 100%. This includes deductibles, copayments (medical and prescription) and any coinsurance paid by You. This does not include non-covered medical expenses and elective services.

Out-of-Network

Means an organization, Hospital, Physician, Practitioner, or other Provider that has not agreed to participate in the Preferred Provider Network.

Physician

Means a practitioner of the healing arts that is legally qualified and recognized by the state in which he or she practices. Such practitioners include but are not limited to: Doctor of Medicine (M.D.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Licensed Anesthesiologist, Doctor of Podiatry Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Certified Nurse Midwife (C.N.M.), Certified Registered Nurse Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Psychologist (Ph.D., Ed. D., Psy.D., MA), Registered Nurse (R.N.), Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), Speech Therapist, Occupational Therapist, Physician's Assistant, Registered Respiratory Therapist, Nutritionist, Nurse Practitioner (A.R.N.P.), or Naturopath (N.D.).

Reasonable and Customary Charges (R&C)

Means most common charge for similar professional service, procedures, drugs, devices, supplies or treatment within the geographical area where the covered medical expense was incurred. The most common charge means the lesser of:

- The actual amount charged by the provider; or
- The negotiated rate; or
- The charge which would have been made by the provider (Doctor, Hospital, etc.) for a comparable service or supply made by other providers in the same Geographic Area, as reasonable determined by us for the same service or supply.

As used in this plan: "Geographic Area" means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

Sickness

Means either a disorder or disease of the body including reoccurring symptoms of the same illness. In this document the term Illness and Sickness are used interchangeably. All conditions due to the same or related sicknesses are considered one sickness. The term Illness/Sickness includes pregnancy, and complications of pregnancy.

We, Our or Us

Means the Claim Administrator on behalf of the Johns Hopkins University SHIP.

You, Your, Yours

Means the Covered Person. Male pronouns whenever used include female pronouns.