UNIVERSITY OF ST. THOMAS

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2020/2021

DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

UNIVERSITY OF ST. THOMAS INTERNATIONAL

Houston, TX

("the Policyholder")

Policy Number: WI2021TXSHIP16
Group Number: ST1528SH
Effective: 8/8/2020 – 8/7/2021

UNDERWRITTEN BY:

Wellfleet Insurance Company | Fort Wayne, IN

("the Company")

ADMINISTERED BY:

Wellfleet Group, LLC

WELLFLEET STUDENT

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Welcome Students…

We are pleased to provide you with this summary of the 2020 – 2021 Student Health Insurance Plan ("Plan"), which is fully compliant with the Affordable Care Act. "Benefits at a Glance" includes effective dates and costs of coverage, as well as other helpful information. For additional details about the Plan, please consult the Plan Certificate and other materials at **stthomintl.myahpcare.com/**. For questions about medical benefits or claims, please call Wellfleet Student at (877) 657-5030, TTY 711.

Where to Find Help

For Questions About:	Please Contact:
Servicing Agent **Enrollment** **Waivers**	**Academic HealthPlans** **stthomintl.myahpcare.com**
Insurance Benefits **Claims Processing** **ID Cards** **Preferred Provider Listings**	**Wellfleet Group, LLC** **PO Box 15369** **Springfield, Massachusetts 01115-5369** **(877) 657-5030, TTY 711** **www.wellfleetstudent.com**
Preferred PPO Provider Listings **Cigna Claims**	**stthomintl.myahpcare.com** or **www.cigna.com** **Send Cigna claims to:** **CIGNA** **PO Box 188061** **Chattanooga, TN 37422 – 8061** **Electronic Payor ID: 62308**
Prescription Drug Provider	**For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit www.wellfleetstudent.com** **Your plan includes Wellfleet Rx – offering over 40 generics at a $0 copay. Please ask your health care provider to review our formulary to see if these medications are right for you. Click here http://wellfleetrx.com/students/formularies/ for more information.**

Am I Eligible?

All registered international students taking 1 or more credit hours are required to enrolled in the Student Health Insurance Plan and charged premium unless proof of comparable coverage is provided. Domestic students are not eligible to enroll in the Student Health Insurance Plan.

Insured Students who are enrolled in the Student Health Plan may also enroll their eligible dependents.

How Do I Waive/Enroll?

To Waive:

- Go to **stthomintl.myahpcare.com**
- Click the waiver tab and proceed as directed. You must fill in all of the required information on the waiver form. If any information is missing, your waiver will not be accepted.
- Click submit and review the information being provided is accurate.
- When your online waiver form is successfully submitted you will receive a confirmation e-mail.
- You must submit a waiver for each semester.

To Purchase coverage and Enroll eligible dependents:

- Go to **stthomintl.myahpcare.com**
- Click the "Enroll" tab and proceed as directed to enroll in and purchase the student health insurance plan.
- You must enroll your dependent each semester along with your enrollment.

Effective Dates & Costs

All time periods begin at 12:00 A.M. local time and end at 11:59 P.M. local time at the Policyholder's address.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Fall	08/08/2020	12/31/2020	08/31/2020
Spring/Summer	01/01/2021	08/10/2021	01/25/2021
Summer	05/19/2021	08/10/2021	06/04/2021

Plan Costs for International Students and their Dependents

	Fall	Spring/Summer	Summer
Student*	$841	$841	$387
Spouse*	$841	$841	$387
Each Child*	$841	$841	$387
2 or more Children*	$1,682	$1,682	$774

***The above plan costs include an administrative service fee.**
The plan costs for Dependents are in addition to the plan costs for student.

Preferred Provider Organization (PPO) Network

…providing access to quality health care at discounted costs!

By enrolling in this Student Health Plan, you have the Cigna PPO Network of participating Providers. To find a complete listing of the Network's participating Providers, go to **www.cigna.com** or contact Wellfleet Student toll-free at (877) 657-5030, TTY 711, or **www.wellfleetstudent.com** for assistance.

University of Saint Thomas International Schedule of Benefits

This is only a brief description of coverage available under Certificate form TX SHIP CERT (2019). The Certificate will contain full details of coverage, coinsurance, limitations, exclusions, and termination provisions. If there are any conflicts between this document and the Certificate, the Certificate governs in all cases.

UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE (IF APPLICABLE) WILL ALWAYS APPLY.

SCHEDULE OF BENEFITS

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

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

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

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

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

Out-of-Pocket Maximum:	In-Network Provider	Individual:	$6,350
		Family	$12,700
	Out-of-Network Provider	Individual	$12,700
		Family	$25,400

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

Coinsurance Amounts:

In-Network Provider:	80% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below.
Out-of-Network Provider:	60% of the Usual and Customary Charge (U&C) for Covered Medical Expenses unless otherwise stated below.
Student Health Center	100% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below.

***Student Health Center Benefits:**
When Treatment is rendered at the Student Health Center, the Deductible, Coinsurance and Copayments will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred

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

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

Preferred Provider Organization:
To locate an In-Network Provider in Your area, consult Your Provider Directory or call toll free 1-877-657-5030, TTY 711 or visit Our website at **www.wellfleetstudent.com**

THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:

1. **THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
3. **DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY AN IN-NETWORK OR OUT-OF-NETWORK PROVIDER.**
4. **UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE WILL ALWAYS APPLY.**

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Inpatient Benefits		
Hospital Care Includes hospital room & board expenses and miscellaneous services and supplies. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Physician's Visits while Confined: Limited to 1 visit per day of Confinement per provider	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Surgery: Pre-Authorization Required		
Surgeon Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Anesthetist	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Assistant Surgeon	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Registered Nurse Services for private duty nursing while Confined	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Maximum days per Policy Year	25	25
Inpatient Rehabilitation Facility Expense Benefit Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
INPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
Mental Health Disorder and Substance Use Disorder Benefit Pre-Authorization Required In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-Authorization requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Outpatient Benefits		
Outpatient Surgery: Pre-Authorization Required		
Surgeon Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Anesthetist	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Assistant Surgeon	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Surgery Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Office Visits including specialists and consultants	$30 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telemedicine or Telehealth Services	Payable the same as any other Physician or Specialist Office Visit	
Cardiac Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maximum Visits per Policy Year for Physical Therapy, Occupational Therapy and Speech Therapy Combined	35	35
Habilitative Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Care Services	$150 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Charge.

Urgent Care Centers	$30 Copayment per visit then the plan pays 100% of the Negotiated health Charge after Deductible for Covered Medical Expenses	100% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diagnostic Imaging Services Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	$40 Copayment per visit then the plan pays 80% of the Negotiated Charge for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Pre-Certification required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hospice Care Coverage	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
OUTPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
Mental Health Disorder and Substance Use Disorder Benefit Pre-Authorization Required except for office visits In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-Authorization requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy You will not be required to pay more for a prescription drug than the lesser of the applicable copayment, the allowable claim amount or the amount You would pay if purchasing without health benefits or discounts.		

TIER 1 (Including Enteral Formulas) For each fill up to a 30-day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual charge after Deductible for Covered Medical Expenses
More than a 30-day supply but less than a 61- day supply filled at a Retail pharmacy	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual charge after Deductible for Covered Medical Expenses
More than a 60-day supply filled at a Retail pharmacy	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual charge after Deductible for Covered Medical Expenses
TIER 2 (Including Enteral Formulas) For each fill up to a 30- day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual charge after Deductible for Covered Medical Expenses
More than a 30- day supply but less than a 61- day supply filled at a Retail pharmacy	$80 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual charge after Deductible for Covered Medical Expenses
More than a 60- day supply filled at a Retail pharmacy	$120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual charge after Deductible for Covered Medical Expenses

TIER 3 (Including Enteral Formulas) For each fill up to a 30- day supply filled at a Retail Pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual charge after Deductible for Covered Medical Expenses
More than a 30- day supply but less than a 61-day supply filled at a Retail pharmacy	$120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual charge after Deductible for Covered Medical Expenses
More than a 60-day supply filled at a Retail pharmacy	$180 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual charge after Deductible for Covered Medical Expenses
Zero Cost Generics		
Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	100% of Actual charge for Covered Medical Expenses Deductible Waived
Specialty Prescription Drugs		
Specialty Prescription Drugs For each fill up to a 30- day supply Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual charge after Deductible for Covered Medical Expenses
More than a 30- day supply but less than a 61day supply	$120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual charge after Deductible for Covered Medical Expenses
More than a 60-day supply	$180 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual charge after Deductible for Covered Medical Expenses

Orally administered anti-cancer prescription drugs (including specialty drugs)		
Benefit	Greater of: • Chemotherapy Benefit; or • Infusion Therapy Benefit	
Diabetic Supplies (for Prescription supplies purchased at a pharmacy)		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill	
Other Benefits		
Allergy Testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Allergy Injections/Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Ambulance Service ground and/or air, water transportation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Covered Clinical Trials	Same as any other Covered Sickness	
Durable Medical Equipment Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diabetic services and supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hearing Aids and Cochlear Implants Limited to 1 hearing aid per ear per 3-year period; and one cochlear implant in each ear with internal replacement as medically or audiologically necessary	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
Enteral Formulas and Nutritional Supplement See the Prescription Drug section of this Schedule when purchased at a pharmacy.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Prosthetic and Orthotic Devices Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Reconstructive Surgery Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)		
Type A services: Diagnostic and Preventive care	100% of Usual and Customary Charge	
Type B services: Basic Restorative Care	50% of Usual and Customary Charge	

Type C services: Major Restorative care	50% of Usual and Customary Charge
Orthodontic services	50% of Usual and Customary Charge
Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	

PREVENTIVE AND DIAGNOSTIC SERVICES (TYPE A)
Diagnostic and Treatment Services:
D0120 Periodic oral evaluation- Limited to 1 every 6 months
D0140 Limited oral evaluation- problem focused- Limited to 1 every 6 months
D0150 Comprehensive oral evaluation- Limited to 1 every 6 months
D0180 Comprehensive periodontal evaluation- Limited to 1 every 6 months
D0210 Intraoral-complete series (including bitewings) 1 every 60 (sixty) months film
D0220 Intraoral- periapical first
D0230 Intraoral- periapical - each additional film
D0240 Intraoral- occlusal film
D0270 Bitewing- single film 1 set every 6 months
D0272 Bitewings -two films 1 set every 6 months
D0274 Bitewings - four films 1 set every 6 months
D0277 Vertical bitewings-7 to 8 films 1 set every 6 months
D0330 Panoramic film-1 film every 60 (sixty) months
D0340 Cephalometric x-ray
D0350 Oral/ Facial Photographic Images
D0391 Interpretation of Diagnostic Image
D0470 Diagnostic Models
Preventative Services:
D1120 Prophylaxis-Child- Limited to 1 every 6 months
D1206 Topical fluoride varnish- 2 in 12 months
D1208 Topical application of fluoride (excluding prophylaxis)- 2 every 12 months
D1351 Sealant- per tooth- unrestored permanent molars - 1 sealant per tooth every 36 months
D1352 Preventative resin restorations in a moderate to high caries risk patient- permanent tooth- 1 sealant per tooth every 36 months
D1510 Space maintainer-fixed -unilateral
D1515 Space maintainer-fixed- bilateral
D1520 Space maintainer-removable-unilateral
D1525 Space maintainer-removable-bilateral
D1550 Re-cementation of space maintainer
Additional Procedures covered as Preventive and Diagnostic:
D9110 Palliative treatment of dental pain- minor procedure
BASIC RESTORATIVE SERVICES (TYPE B)
Minor Restorative Services:
D2140 Amalgam- one surface, primary or permanent
D2150 Amalgam- two surfaces, primary or permanent
D2160 Amalgam- three surfaces, primary or permanent
D2161 Amalgam- four or more surfaces, primary or permanent
D2330 Resin-based composite - one surface, anterior
D2331 Resin-based composite -two surfaces, anterior
D2332 Resin-based composite -three surfaces, anterior
D2335 Resin-based composite- four or more surfaces or involving incisal angle (anterior)
D2910 Re-cement inlay
D2920 Re-cement crown
D2930 Prefabricated stainless steel crown· primary tooth - Limited to I per tooth in 60 months
D2931 Prefabricated stainless steel crown - permanent tooth - Limited to I per tooth in 60 months
D2940 Protective Restoration
D2951 Pin retention per tooth, in addition to restoration

Endodontic Services:
D3220 Therapeutic pulpotomy (excluding final restoration)- *If a root canal is within 45 days of the pulpotomy, the Pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.*
D3222 Partial pulpotomy for apexogenesis- permanent tooth with incomplete root development *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal Procedure and benefits are not payable separately.*
D3230 Pulpal therapy (resorbable filling)- anterior, primary tooth (excluding final restoration)
D3240 Pulpal therapy (resorbable filling)- posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when treatment is discontinued.
Periodontal Services:
D4341 Periodontal scaling and root planing-four or more teeth per quadrant- Limited to 1 every 24 months
D4342 Periodontal scaling and root planing-one to three teeth, per quadrant- Limited to 1 every 24 months
D4910 Periodontal maintenance- 4 in 12 months combined with adult prophylaxis after the completion of active Periodontal therapy.
Prosthodontic Services:
D5410 Adjust complete denture-maxillary
D5411 Adjust complete denture-mandibular
D5421 Adjust partial denture-maxillary
D5422 Adjust partial denture-mandibular
D5510 Repair broken complete denture base
D5520 Replace missing or broken teeth complete denture (each tooth)
D5610 Repair resin denture base
D5620 Repair cast framework
D5630 Repair or replace broken clasp
D5640 Replace broken teeth- per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture
D5710 Rebase complete maxillary denture- Limited to 1 in a 36-month period 6 months after the initial installation
D5720 Rebase maxillary partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
D5721 Rebase mandibular partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
D5730 Reline complete maxillary denture -Limited to 1 in a 36-month Period 6 months after the initial installation
D5731 Reline complete mandibular denture -Limited to l in a 36-month period 6 months after the initial installation
D5740 Reline maxillary partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
D5741 Reline mandibular partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
D5750 Reline complete maxillary denture (laboratory) -Limited to 1 in a 36-month period 6 months after the initial
D5751 Reline complete mandibular denture (laboratory)- Limited to 1 in a 36-month period 6 months after the initial
D5760 Reline maxillary partial denture (laboratory)·Limited to 1 in a 36-month period 6 months after the initial
D5761 Reline mandibular partial denture (laboratory) Rebase/Reline- Limited to 1 in a 36-month period 6 months after the initial installation
D5850 Tissue conditioning (maxillary)
D5851 Tissue conditioning (mandibular)
D6930 Re-cement fixed partial denture
D6980 Fixed partial denture repair, by report
Oral Surgery:
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of Tooth
D7220 Removal of impacted tooth - soft tissue
D7230 Removal of impacted tooth- partially bony
D7240 Removal of impacted tooth - completely bony
D7241 Removal of impacted tooth - completely bony with unusual surgical complications
D7250 Surgical removal of residual tooth roots (cutting procedure)
D7251 Coronectomy- intentional partial tooth removal
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Surgical access of an unerupted tooth

D7310 Alveoloplasty in conjunction with extractions - per quadrant
D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions- per quadrant
D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7471 Removal of exostosis
D7510 Incision and drainage of abscess intraoral soft tissue
D7910 Suture of recent small wounds up to *5* cm
D7971 Excision of pericoronal gingiva
MAJOR SERVICES (TYPE C)
Major Restorative Services:
D0160 Detailed and extensive oral evaluation- problem focused, by report
D2510 Inlay- metallic- one surface- An alternate benefit will be provided
D2520 Inlay- metallic- two surfaces -An alternate benefit will be provided
D2530 Inlay- metallic-three surfaces -An alternate benefit will be provided
D2542 Onlay- metallic- two surfaces- Limited to 1 per tooth every 60 months
D2543 Onlay - metallic- three surfaces- Limited to 1 per tooth every 60 months
D2544 Onlay - metallic- four or more surfaces- Limited to 1 per tooth every 60 months
D2740 Crown- porcelain/ceramic substrate- Limited to 1 per tooth every 60 months
D2750 Crown- porcelain fused to high noble metal- Limited to 1 per tooth every 60 months
D2751 Crown- porcelain fused to predominately base metal-Limited to 1 per tooth every 60 months
D2752 Crown- porcelain fused to noble metal-Limited to 1 per tooth every 60 months
D2780 Crown - 3/4 cast high noble metal- Limited to 1 per tooth every 60 months
D2781 Crown - 3/4 cast predominately base metal- Limited to 1 per tooth every 60 months
D2783 Crown - 3/4 porcelain/ceramic- Limited to 1 per tooth every 60 months
D2790 Crown - full cast high noble metal- Limited to 1 per tooth every 60 months
D2791 Crown- full cast predominately base metal-Limited to 1 per tooth every 60 months
D2792 Crown - full cast noble metal- Limited to I per tooth every 60 months
D2794 Crown-titanium- Limited to 1 per tooth every 60 months
D2950 Core buildup, including any pins- Limited to 1 per tooth every 60 months
D2954 Prefabricated post and core, in addition to crown- Limited to 1 per tooth every 60 months
D2980 Crown repair, by report
Endodontic Services:
D3310 Anterior root canal (excluding final restoration)
D3320 Bicuspid root canal (excluding final restoration)
D3330 Molar root canal (excluding final restoration)
D3346 Retreatment of previous root canal therapy-anterior
D3347 Retreatment of previous root canal therapy-bicuspid
D3348 Retreatment of previous root canal therapy-molar
D3351 Apexification/recalcification- initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352 Apexification/recalcification- interim medication replacement (apical closure/calcific repair of perforations,
D3353 Apexification/recalcification- final visit (includes completed root canal therapy, apical closure/calcific repair of perforations. root resorption. etc.)
D3354 Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration
D3410 Apicoectomy/periradicular surgery- anterior
D3421 Apicoectomy/periradicular surgery- bicuspid (first root)
D3425 Apicoectomy/periradicular surgery -molar (first root)
D3426 Apicoectomy/periradicular surgery (each additional root)
D3450 Root amputation- per root
D3920 Hemisection (including any root removal)- not including root canal therapy
Periodontal Services:
D4210 Gingivectomy or gingivoplasty- four or more teeth-Limited to 1 every 36 months
D4211 Gingivectomy or gingivoplasty-one to three teeth
D4240 Gingival flap procedure, four or more teeth-Limited to 1 every 36 months
D4249 Clinical crown lengthening-hard tissue
D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant- Limited to 1 every 36 months

D4261 Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant- Limited to 1 every 36 months
D4270 Pedicle soft tissue graft procedure
D4273 Subepithelial connective tissue graft procedures (including donor site surgery)
D4277 Free soft tissue graft procedure (including donor site surgery)
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis
Prosthodontic Services:
D5110 Complete denture - maxillary-Limited to 1 every 60 months
D5120 Complete denture- mandibular-Limited to 1 every 60 months
D5130 Immediate denture- maxillary-Limited to 1 every 60 months
D5140 Immediate denture- mandibular-Limited to 1 every 60 months
D5211 Maxillary partial denture- resin base (including any conventional clasps, rests and teeth)- Limited to 1 every 60 months
D5212 Mandibular partial denture- resin base (including any conventional clasps, rests and teeth)-Limited to 1 every 60 months
D5213 Maxillary partial denture- cast metal framework with resin denture base (including any conventional clasps, Rests and teeth)-Limited to 1 every 60 months
D5214 Mandibular partial denture- cast metal framework with resin denture base (including any conventional clasps, Rests and teeth)-Limited to 1 every 60 months
D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth)-Limited to 1 every 60 months
D6010 Endosteal Implant- 1 every 60 months
D6012 Surgical Placement of Interim Implant Body- 1 every 60 months
D6040 Eposteal Implant- 1 every 60 months
D6050 Transosteal Implant. Including Hardware- 1 every 60 months
D6053 Implant supported complete denture
D6054 Implant supported partial denture
D6055 Connecting Bar-implant or abutment supported- 1 every 60 months
D6056 Prefabricated Abutment- 1 every 60 months
D6057 Custom Abutment – 1 every 60 months
D6058 Abutment supported porcelain ceramic crown - 1 every 60 months
D6059 Abutment supported porcelain fused to high noble metal- 1 every 60 months
D6060 Abutment supported porcelain fused to predominately base metal crown- 1 every 60 months
D6061 Abutment supported porcelain fused to noble metal crown 1 every 60 months
D6062 Abutment supported cast high noble metal crown - 1 every 60 months
D6063 Abutment supported cast predominately base metal crown – 1 every 60 months
D6064 Abutment supported Cast noble metal crown 1 every 60 months
D6065 Implant supported porcelain/ceramic crown- 1 every 60 months
D6066 Implant supported porcelain fused to high metal crown - 1 every 60 months
D6067 Implant supported metal crown- 1 every 60 months
D6068 Abutment supported retainer for porcelain/ceramic fixed partial denture- 1 every 60 months
D6069 Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
D6070 Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months
D6071 Abutment supported retainer for porcelain fused to noble metal fixed partial denture- 1 every 60 months
D6072 Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months
D6073 Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months
D6074 Abutment supported retainer for cast noble metal fixed partial denture- 1 every 60 months
D6075 Implant supported retainer for ceramic fixed Partial denture- 1 every 60 months
D6076 Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
D6077 Implant supported retainer for cast metal fixed partial denture - 1 every 60 months
D6078 Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months
D6079 Implant/abutment supported fixed partial denture for partially edentulous arch- 1 every 60 months
D6080 Implant Maintenance Procedures -1 every 60 months
D6090 Repair Implant Prosthesis -1 every 60 months
D6091 Replacement of Semi-Precision or Precision Attachment- 1 every 60 months

D6095 Repair Implant Abutment -1 every 60 months
D6100 Implant Removal-1 every 60 months
D6101 Debridement periimplant defect, covered if implants are covered – Limited to 1 every 60 months
D6102 Debridement and osseous periimplant defect, covered if implants are covered – Limited to 1 every 60 months
D6103 Bone Graft periimplant defect, covered if implants are covered
D6104 Bone Graft implant replacement, covered if implants are covered
D6190 Implant Index -1 every 60 months
D6210 Pontic-cast high noble metal- Limited to 1 every 60 months
D6211 Pontic-cast predominately base metal -Limited to 1 every 60 months
D6212 Pontic-cast noble metal- Limited to 1 every 60 months
D6214 Pontic-titanium-Limited to 1 every 60 months
D6240 Pontic -porcelain fused to high noble metal-Limited to 1 every 60 months
D6241 Pontic-porcelain fused to predominately base metal-Limited to 1 every 60 months
D6242 Pontic-porcelain fused to noble metal Limited to 1 every 60 months
D6245 Pontic-porcelain/ceramic-Limited to 1 every 60 months
D6545 Retainer -cast metal for resin bonded fixed prosthesis -1 every 60 months
D6548 Retainer- porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months
D6740 Crown- porcelain/ceramic- 1 every 60 months
D6750 Crown -porcelain fused to high noble metal - 1 every 60 months
D6751 Crown- porcelain fused to predominately base metal- 1 every 60 months
D6752 Crown- porcelain fused to noble metal - 1 every 60 months
D6780 Crown -3/4 cast high noble metal - 1 every 60 months
D6781 Crown- 314 cast predominately base metal • 1 every 60 months
D6782 Crown 3/4 cast noble metal 1 every 60 months
D6783 Crown - 3/4 porcelain/ceramic- 1 every 60 months
D6790 Crown • full cast high noble metal- 1 every 60 months
D6791 Crown -full cast predominately base metal- 1 every 60 months
D6792Crown full cast noble metal 1 every 60 months
D9940 Occlusal guard, by report- 1 in 12 months
GENERAL SERVICES (TYPE C)
Anesthesia Services:
D9222 Deep sedation/general anesthesia- first 30 minutes
D9223Deep sedation/general anesthesia- each additional 15 minutes
Intravenous Sedation:
D9239 Intravenous conscious sedation/analgesia- first 30 minutes
D9243 Intravenous conscious sedation/analgesia each additional 15 minutes
Consultations:
D9310 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)
Medications:
D9610 Therapeutic drug injection, by report
Post-Surgical Services:
D9930 Treatment of complications (post-surgical) unusual circumstances, by report
MEDICALLY NECESSARY ORTHODONTIA SERVICES (TYPE D)
Orthodontic Services -covered for persons with severe and handicapping malocclusion
D8010 Limited orthodontic treatment of the primary dentition
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8050 Interceptive orthodontic treatment of the primary dentition
D8060 Interceptive orthodontic treatment of the transitional dentition
D8070Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8670 Periodic orthodontic treatment visits (as part of contract)
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)
D8681 Removable appliance therapy

Pediatric Vision Care Benefit (including low vision services) (to the end of the month in which the Insured Person turns age 19) Limited to 1 visit(s) per Policy Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of Usual and Customary Charge for Covered Medical Expenses per Policy Year	
Accidental Injury Dental Treatment for Insured Person's over age 18 maximum $1,000 per Policy Year	80% of the Negotiated Charge after Deductible for Covered Medical Expenses Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Oral Surgery and Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Organ Transplant Surgery travel and lodging expenses a maximum of $2,000 per Policy Year or $250 per day, whichever is less while at the transplant facility. Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Shots and Injections unless considered Preventive Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Tuberculosis screening, Titers, Quantiferon B tests including shots (other than covered under preventive services)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses Health Center Referred
Non-emergency Care While Traveling Outside of the United States	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived Subject to $10,000 maximum per Policy Year	
Student Health Center/Infirmary Expense	100% of the Usual and Customary Charge for Covered Medical Expenses Deductible Waived	

Mandated Benefits	
Acquired Brain Injury	Same as any other Covered Sickness
Autism Spectrum Disorder	Same as any other Covered Sickness, unless considered a Preventive Service
Cervical and Ovarian Cancer Screening	Same as any other Covered Sickness, unless considered a Preventive Service
Colorectal Cancer Screening	Same as any other Covered Sickness, unless considered a Preventive Service
Contraceptive Drugs and Devices and Related Services	Same as any other Covered Sickness, unless considered a Preventive Service
Early Detection of Cardiovascular Disease	Same as any other Covered Sickness, subject to the limitations described in the Benefit
Mammography	Same as any other Covered Sickness, unless considered a Preventive Service
Minimum Stay for Mastectomy and Lymph Node Dissection	Same as any other Covered Sickness, subject to the limitations described in the Benefit
Osteoporosis Detection and Prevention	Same as any other Covered Sickness
Prostate Cancer Screening	Same as any other Preventive Service
Reconstructive Breast Surgery	Same as any other Covered Sickness, subject to the limitations described in the Benefit
Reconstructive Surgery for Craniofacial Abnormalities	Same as any other Covered Sickness, subject to the limitations described in the Benefit

Preauthorization

Preauthorization is required for inpatient hospital, surgery and selected outpatient services. Pre-Authorization is not required for an Emergency Medical Condition or for a Life Threatening Condition or Urgent Care or Hospital Confinement for the initial 48/96 hours of maternity care. Additionally, no authorization requirement will apply to obstetrical or gynecological care provided by In-Network Providers.

Exclusions and Limitations

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

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

1. **International Students Only -** Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible.
2. Treatment, service or supply which is not Medically Necessary for the diagnosis, care or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended or approved by the Student Health Center or by Your attending Physician or dentist.
3. Medical services rendered by a provider employed for or contracted with the Policyholder, including team physicians or trainers, except as specifically provided in the Schedule of Benefits or as part of the Student Health Center benefits provided by this plan.
4. Professional services rendered by an Immediate Family Member or anyone who lives with You. This exclusion does not apply to Dental services.
5. Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary because of Injury, infection or disease.
6. Infertility treatment (male or female)-this includes but is not limited to:

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

7. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
8. Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services covered by Student Health Fees.
9. Any expenses in excess of Usual and Customary Rate except as provided in the Certificate.
10. Loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
11. Loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority.
12. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate or club sports for which benefits are paid under another Sports Accident policy issued to the Policyholder; or for which coverage is provided by the National Collegiate Athletic Association (NCAA), National Association of Intercollegiate Athletic (NAIA) or any other sports association
13. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
14. Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which You are required to pay.
15. Services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
16. Expenses payable under any prior policy which was in force for the person making the claim.
17. Injury sustained as the result of Your operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.
18. Expenses incurred after:
    - The date insurance terminates as to an Insured Person, except as specified in the extension of benefits provision; and
    - The end of the Policy Year specified in the Policy.
19. Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
20. Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
21. Weight management. Weight reduction. Nutrition programs. This does not apply to nutritional counseling or any screening or assessment specifically provided under the Preventive Services benefit, or otherwise specifically covered under the Certificate.

22. Treatment for obesity. Surgery for removal of excess skin or fat.
23. Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
24. Expenses for radial keratotomy.
25. Adult Vision unless specifically provided in the Certificate.
26. Charges for office visit exam for the fitting of prescription contact lenses, duplicate spare eyeglasses, lenses or frames, non-prescription lenses or contact lenses that are for cosmetic purposes.
27. Racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles) or other hazardous sport or hobby.
28. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma.
29. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
30. You are:
    - committing or attempting to commit a felony,
    - engaged in an illegal occupation, or
    - participating in a riot.
31. Elective abortions.
32. Custodial Care service and supplies.
33. Charges for hot or cold packs for personal use.
34. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
35. Services of private duty Nurse except as provided in the Certificate.
36. Expenses that are not recommended and approved by a Physician.
37. Routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal.
38. Cosmetic procedures related to Gender Reassignment including but not limited to rhinoplasty, face lift, facial bone reduction, lip enhancement or reduction, blepharoplasty, breast augmentation, body contouring, reduction thyroid chondroplasty, hair removal, voice modification surgery, skin resurfacing, chin implants, nose implants.
39. Sleep Disorders, except for the diagnosis and treatment of obstructive sleep apnea..
40. Treatment of Acne unless Medically Necessary.
41. Experimental or Investigational drugs, devices, treatments or procedures unless otherwise covered under Covered Clinical Trials or covered under clinical trials (routine patient costs). See the Other Benefits section for more information.
42. Under the Prescription Drug Benefit shown in the Schedule of Benefits:
    - any drug or medicine which does not, by federal or state law, require a prescription order, i.e. over-the-counter drugs, even if a prescription is written, except as specifically provided under Preventive Services or in the Prescription Drug Benefit section of the Certificate. Insulin and OTC preventive medications required under ACA are exempt from this exclusion;
    - drugs with over-the-counter equivalents except as specifically provided under Preventive Services;
    - allergy sera and extracts administered via injection;
    - any drug or medicine for the purpose of weight control;
    - fertility drugs;
    - sexual enhancements drugs;
    - vitamins, and minerals, except as specifically provided under Preventive Services;
    - food supplements, dietary supplements; except as specifically provided in the Certificate;
    - cosmetic drugs or medicines, including but not limited to, products that improve the appearance of wrinkles or other skin blemishes;
    - refills in excess of the number specified or dispensed after 1 year of date of the prescription;
    - drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
    - any drug or medicine purchased after coverage under the Certificate terminates;
    - any drug or medicine consumed or administered at the place where it is dispensed;
    - if the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;

- bulk chemicals;
- non-insulin syringes, surgical supplies, durable medical equipment/medical devices, except as specifically provided in the Prescription Drug Benefit section of the Certificate;
- repackaged products;
- blood components except factors;
- immunology products.

43. Non-chemical addictions.
44. Non-physical, occupational, speech therapies (art, dance, etc.).
45. Modifications made to dwellings.
46. General fitness, exercise programs.
47. Hypnosis.
48. Rolfing.
49. Biofeedback.

Value Added Services

The following are not affiliated with Wellfleet Insurance Company and the services are not part of the Plan Underwritten by Wellfleet Insurance Company. These value-added options are provided by Wellfleet Student.

VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:

www.wellfleetstudent.com

24 HOUR NURSELINE

Students who enroll and maintain medical coverage in this insurance plan have access to the *24 Hour Nurseline*. This *24-Hour Nurseline* program provides:

- Phone-based, reliable health information in response to health concerns and questions; and
- Assistance in decisions on the appropriate level of care for an injury or sickness.

Appropriate care may include self-care at home, a call to a physician, or a visit to the emergency room.

Calls are answered 24 hours a day, 365 days a year by experienced registered nurses who have been specifically trained to handle telephone health inquiries.

This program is not a substitute for doctor visits or emergency response systems. The *Nurseline* does not answer health plan benefit questions. Health benefit questions should be referred to the Plan Administrator. The *24 Hour Nurseline* toll free number will be on the ID card.

(800) 634-7629

CareConnect

Integrated Behavioral Health from Wellfleet Student

With CareConnect from Wellfleet Student, students have 24/7 access to professional assistance to help manage personal concerns, emotional issues, transition and adjustment concerns, academic stress, career development, and the demands of daily and family obligations.

Members in need of assistance simply call the behavioral health hotline on their ID card, **(888) 857-5462**, or via the Wellfleet Student mobile app for immediate access to a masters-level mental health professional. Students are run through a clinical assessment to determine if CareConnect counseling, health center referral, or other treatment is necessary. To access mobile features, students simply download their school's app in their device's app store.