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5814 Reed Road Fort Wayne, IN 46835

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STUDENT HEALTH INSURANCE
OUTLINE OF COVERAGE

(1) Read Your Policy Carefully — This outline provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provision will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) Student Medical Expense Coverage — Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out of hospital care, subject to any deductibles, copayment provisions, or other limitations which may be set forth in the policy. *Comprehensive* hospital and medical insurance coverage is provided.

(3) The benefits, as selected by the Policyholder under this policy, are summarized below:
Preventive Services:
The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of the Maximum Allowance.

Medical Deductible per Policy Year:

Individual:	$0

Out-of-Pocket Maximum:

Individual:	$6,350
Family:	$12,700

Coinsurance Amount*:

90% of the Maximum Allowance for Covered Medical Expenses after satisfying the Deductible, unless otherwise noted below.

***NOTICE**: Your actual expenses for Covered Medical Expenses may exceed the stated Coinsurance percentage because Actual Charges may not be used to determine Your payment obligations. If You obtain care from providers who charge more than the Maximum Allowance, You will be responsible for the difference between the Maximum Allowance and the Actual Charges.

Pre-Certification Requirement:
What types of Inpatient and Outpatient services or supplies require Pre-Certification?
Pre-Certification is required for the following :

1. All Inpatient admissions, including length of stay, to a Hospital, Skilled Nursing Facility, a facility established primarily for the Treatment of a Substance Use Disorder, or a residential Treatment facility, surgical procedures;
2. All Inpatient maternity care after the initial 48/96 hours;

3. Home Health Care;
4. Durable Medical Equipment over $500 per item;
5. Outpatient Surgical Procedures;
6. Transplant Services;
7. Diagnostic Testing and Radiology services listed at www.wellfleetstudent.com/providers/. See Prior Authorization Requirements section;
8. Complex Imaging ;
9. Biomarker Testing
10. Chemotherapy/Radiation;
11. Cochlear devices;
12. Infusions/Injectables;
13. Botox Injections;
14. Genetic Testing, except for BRCA;
15. Orthotics/Prosthetics;
16. Non-emergency air Ambulance (fixed wing)

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

Pre-Certification is not a guarantee that benefits will be paid.

This Certificate does not use a participating provider organization (PPO) network. You can go to any provider You choose.

Balance Billing
This Certificate pays claims based on the Maximum Allowance. Some Physicians and Hospitals will accept the Maximum Allowance as payment in full. Other Physicians and Hospitals may bill You for the difference between the Maximum Allowance and the Actual Charges. This is known as balance billing. Balance billing is legal in many states, and We have no control over Physicians and Hospitals that engage in balance billing practices.

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

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

You can also print cost estimate results.

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

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. UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE WILL ALWAYS APPLY;
4. UNLESS SPECIFIED BELOW, ANY APPLICABLE COPAYMENTS ARE APPLIED AFTER DEDUCTIBLE IS MET.

BENEFITS FOR COVERED INJURY/SICKNESS	BENEFIT AMOUNT PAYABLE
INPATIENT SERVICES	
Hospital Care Includes Hospital Room and Board Expenses and Hospital Miscellaneous Expenses. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Certification Required	90% of the Maximum Allowance for Covered Medical Expenses
Preadmission Testing	90% of the Maximum Allowance for Covered Medical Expenses
Physician's Visits while Confined	90% of the Maximum Allowance for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Certification Required	90% of the Maximum Allowance for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	90% of the Maximum Allowance for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	90% of the Maximum Allowance for Covered Medical Expenses
MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER BENEFITS In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, and any Pre-Certification requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness. Day or visit limits do not apply to Mental Health Disorder and Substance Use Disorder Benefits.	
Inpatient Mental Health Disorder and Substance Use Disorder Benefits Pre-Certification Required	90% of the Maximum Allowance for Covered Medical Expenses
Outpatient Mental Health Disorder and Substance Use Disorder Benefits Physician's Office Visits including, but not limited to, Physician visits; individual and group therapy; medication management All Other Outpatient Services (All Other Outpatient Services does not include Emergency Services in an emergency department, Urgent Care Centers, and Emergency Ambulance Service and Prescription Drugs. Refer	90% of the Maximum Allowance for Covered Medical Expenses 90% of the Maximum Allowance for Covered Medical Expenses

to the Emergency Services, Ambulance and Non-Emergency Services, and Prescription Drugs sections of this Certificate for benefit information.) Pre-Certification may be required for certain All Other Outpatient Services. To see if Pre-Certification is required, refer to the Pre-Certification Requirement listing and specific benefit listed in this Schedule of Benefits	
PROFESSIONAL AND OUTPATIENT SERVICES	
Surgical Expenses	
Inpatient and Outpatient Surgery includes: Pre-Certification Required for surgery only Surgeon Services Anesthetist Assistant Surgeon	90% of the Maximum Allowance for Covered Medical Expenses
Outpatient Surgical Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	90% of the Maximum Allowance for Covered Medical Expenses
Abortion Expense	100% of the Maximum Allowance Deductible Waived, if applicable
Bariatric Surgery Pre-Certification Required	90% of the Maximum Allowance 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-Certification Required	90% of the Maximum Allowance for Covered Medical Expenses
Human Leukocyte Antigen Testing	Paid at 100% of Maximum Allowance. Deductible Waived. Subject to once per lifetime for Antigen testing laboratory fees
Reconstructive Surgery Pre-Certification Required	90% of the Maximum Allowance for Covered Medical Expenses
Other Professional Services	
Gender Affirming Services Benefit Pre-Certification Required for gender affirming surgery	Same as any other Mental Health Disorder

Home Health Care Expenses Pre-Certification required	90% of the Maximum Allowance for Covered Medical Expenses
Hospice Care Coverage	90% of the Maximum Allowance for Covered Medical Expenses
Office Visits	
Physician's Office Visits including Specialists/Consultants	90% of the Maximum Allowance for Covered Medical Expenses
Telemedicine or Telehealth Services Benefit	90% of the Maximum Allowance for Covered Medical Expenses
Acupuncture Services (Medically Necessary Treatment only)	90% of the Maximum Allowance for Covered Medical Expenses
Acupuncture Services Maximum visits per Policy Year	30
Allergy Testing and Treatment, including injections	90% of the Maximum Allowance for Covered Medical Expenses
Chiropractic Care Benefit	90% of the Maximum Allowance for Covered Medical Expenses
Chiropractic Care Benefit Maximum visits per Policy Year	40
Tuberculosis screening (TB), Titers, QuantiFERON B tests including shots (other than covered under Preventive Services)	90% of the Maximum Allowance for Covered Medical Expenses
EMERGENCY SERVICES, AMBULANCE AND NON-EMERGENCY SERVICES	
Emergency Services in an emergency department for Emergency Medical Conditions.	$75 Copayment per visit then the plan pays 90% of the Maximum Allowance for Covered Medical Expenses Copayment waived if admitted
Urgent Care Centers for non-life-threatening conditions	90% of the Maximum Allowance for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	90% of the Maximum Allowance for Covered Medical Expenses
Non-Emergency Ambulance Expenses ground and/or air (fixed wing) transportation Pre-Certification Required for non-emergency air Ambulance (fixed wing)	90% of the Maximum Allowance for Covered Medical Expenses
DIAGNOSTIC LABORATORY, RADIOLOGY TESTING AND IMAGING SERVICES	
Diagnostic Complex Imaging Services Pre-Certification Required	90% of the Maximum Allowance for Covered Medical Expenses
Diagnostic Laboratory Radiological Services and Testing (Outpatient) Pre-Certification may be required. See Prior Authorization Requirements section listed at www.wellfleetstudent.com/providers/.	90% of the Maximum Allowance for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	90% of the Maximum Allowance for Covered Medical Expenses

Infusion Therapy Pre-Certification Required	90% of the Maximum Allowance for Covered Medical Expenses
REHABILITATION AND HABILITATION THERAPIES	
Cardiac Rehabilitation	90% of the Maximum Allowance for Covered Medical Expenses
Cardiac Rehabilitation Maximum Visits per Policy Year	60
Pulmonary Rehabilitation	90% of the Maximum Allowance for Covered Medical Expenses
Pulmonary Rehabilitation Maximum Visits per Policy Year	60
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy	90% of the Maximum Allowance for Covered Medical Expenses
Rehabilitation Therapy Maximum Visits for each therapy per Policy Year for Physical Therapy, and Occupational Therapy and Speech Therapy Combined with Habilitation Services Therapy	30
Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy	90% of the Maximum Allowance for Covered Medical Expenses
Habilitation Services Maximum Visits for each therapy per Policy Year for Physical Therapy, and Occupational Therapy and Speech Therapy Combined with Rehabilitation Therapy	30
OTHER SERVICES AND SUPPLIES	
Covered Clinical Trials	Same as any other Covered Sickness
Diabetic Services and Supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	90% of the Maximum Allowance for Covered Medical Expenses
Dialysis Treatment	90% of the Maximum Allowance for Covered Medical Expenses
Durable Medical Equipment Pre-Certification Required	90% of the Maximum Allowance for Covered Medical Expenses
Enteral Formulas and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	90% of the Maximum Allowance for Covered Medical Expenses
Hearing Aids	90% of the Maximum Allowance for Covered Medical Expenses

One hearing aid per affected ear every 36 months	
Infertility Treatment Benefit Pre-Certification Required	90% of the Maximum Allowance for Covered Medical Expenses
Fertility Preservation Benefit	90% of the Maximum Allowance for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness
Prosthetic and Orthotic Devices Pre-Certification Required	90% of the Maximum Allowance for Covered Medical Expenses
Prosthetic Devices (Arm and Leg) Pre-Certification Required	90% of the Maximum Allowance for Covered Medical Expenses
Accidental Injury Dental Treatment	90% of the Maximum Allowance for Covered Medical Expenses
Sickness Dental Expense Benefit	90% of the Maximum Allowance for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	90% of the Maximum Allowance for Covered Medical Expenses
Anesthesia and Facility Charges for Dental Procedures	90% of the Maximum Allowance for Covered Medical Expenses
Dental Care for Cancer Patients	90% of the Maximum Allowance for Covered Medical Expenses
Sports Accident Expense Benefit - incurred as the result of the play or practice of club sports	90% of the Maximum Allowance for Covered Medical Expenses
Non-emergency Care While Traveling Outside of the United States	70% of Actual Charge for Covered Medical Expenses Subject to $10,000 maximum per Policy Year
Bedside Visits (International Students and their Dependents)	100% of Actual Charge for Covered Expenses Subject to $5,000 maximum per Policy Year
Medical Evacuation Expense	100% of Actual Charge for Covered Medical Expenses
Repatriation Expense	100% of Actual Charge for Covered Medical Expenses
MANDATED BENEFITS	
Breast Reduction/Varicose Vein Surgery	Same as any other Covered Sickness
Children's Early Intervention	Same as any other Covered Sickness
Prostate Cancer Screening	Same as any other Covered Sickness, unless considered a Preventive Service
Diagnostic Breast Examination	100% of the Maximum Allowance. If applicable, Deductible waived
COVID-19 Screening, Testing, and Immunizations Benefits	100% of the Maximum Allowance. If applicable, Deductible waived
Accidental Death and Dismemberment	

Principal Sum	$10,000

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

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

PEDIATRIC DENTAL CARE	
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)	See the Dental Care Schedule of Benefits below and Pediatric Dental Care Benefits description for further information.
Type A – Basic Services Preventive Dental Care Limited to 1 dental exam every 6 months	100% of Usual and Customary Charge for Covered Medical Expenses
The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care:	
Type B – Intermediate Services	50%of Usual and Customary Charge for Covered Medical Expenses
Type C – Major Services	50% of Usual and Customary Charge for Covered Medical Expenses
Type D: Medically Necessary Orthodontic Services	50% of Usual and Customary Charge for Covered Medical Expenses
General Services	50% of Usual and Customary Charge for Covered Medical Expenses
Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	

Dental Care Schedule of Benefits

Type A – Basic Services

<u>Diagnostic and Treatment Services</u>

Periodic oral evaluation - Limited to 1 every 6 months
Limited oral evaluation - problem focused - Limited to 1 every 6 months
Comprehensive oral evaluation - Limited to 1 every 6 months
Comprehensive periodontal evaluation - Limited to 1 every 6 months
Intraoral – complete set of radiographic images including bitewings - 1 every 60 (sixty) months
Intraoral - periapical radiographic image
Intraoral - additional periapical image
Intraoral - occlusal radiographic image
Extraoral – Each Additional Radiographic Image
Bitewing - single image Adult - 1 set every calendar year/Children - 1 set every 6 months
Bitewings - two images - Adult - 1 set every calendar year/Children - 1 set every 6 months

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

Preventive Services
Prophylaxis – Adult - Limited to 1 every 6 months
Prophylaxis – Child - Limited to 1 every 6 months
Topical Fluoride – Varnish -1 in 12 months for adults, 2 every 12 months for dependent children based on age limits
Topical application of fluoride (excluding prophylaxis) - 2 every 12 months for dependent children based on age limits
Sealant - per tooth – unrestored permanent molars - Less than age 19 - 1 sealant per tooth every 36 months
Preventative resin restorations in a moderate to high caries risk patient - permanent tooth - 1 sealant per tooth every 36 months
Sealant Repair –Per tooth-Permanent tooth-1 every 36 months
Interim Caries Medicament-Permanent teeth 1 per tooth every 36 months (Molars/Bicuspids excluding Wisdom Teeth)
Caries preventive medicament application – per tooth - 1 every 36 months
Space maintainer – fixed – unilateral - Limited to children under age 19
Space Maintainer- Fixed-bilateral, Maxillary-Limited to children under age 19
Space Maintainer- Fixed-bilateral, mandibular-Limited to children under age 19
Space maintainer - removable – unilateral - Limited to children under age 19
Space Maintainer removable-bilateral, maxillary-Limited to children under age 19
Space Maintainer Removable bilateral, mandibular-Limited to children under age 19
Re-cement or re-bond bilateral space maintainer-maxillary
Re-cement or re-bond bilateral space maintainer-mandibular
Re-cement or re-bond unilateral space maintainer-per quadrant
Distal space maintainer fixed

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

Type B – Intermediate Services

Minor Restorative Services
Amalgam - one surface, primary or permanent
Amalgam - two surfaces, primary or permanent
Amalgam - three surfaces, primary or permanent
Amalgam - four or more surfaces, primary or permanent
Resin–based composite - one surface, anterior
Resin-based composite - two surfaces, anterior
Resin-based composite - three surfaces, anterior

Resin-based composite - four or more surfaces or involving incisal angle (anterior)
Resin Crown-1 every 60 months
Porcelain Inlay-1 every 60 months
2 Surface Porcelain Inlay-1 every 60 months
3 or More Surf. Porcelain Onlay-1 every 60 months
Re-cement inlay or re-bond inlay, onlay veneer or partial coverage restoration
Re-cement or re-bond indirectly fabricated or prefabricated post and core
Re-cement or re-bond crown
Reattachment of Tooth Fragment
Prefabricated porcelain crown - primary - Limited to 1 every 60 months
Prefabricated stainless steel crown - primary tooth – Under age 15 - Limited to 1 per tooth in 60 months
Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth in 60 months
Protective Restoration
Pin retention - per tooth, in addition to restoration

Endodontic Services

Therapeutic pulpotomy (excluding final restoration) - *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.*
Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development - *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.*
Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - *Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.*
Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue treatment. - *Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.*
Pulpal regeneration – initial visit - Limited to 1 per lifetime
Pulpal regeneration – interim medication replacement - Limited to 1 per lifetime
Pulpal regeneration – completion of treatment - Limited to 1 per lifetime

Periodontal Services

Periodontal scaling and root planning-four or more teeth per quadrant – Limited to 1 every 24 months
Periodontal scaling and root planning-one to three teeth, per quadrant – Limited to 1 every 24 months
Scaling gingival inflammation - Limited to 1 every 6 months combined with prophylasis and periodontal maintenance
Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
Periodontal maintenance – 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy

Prosthodontic Services

Adjust complete denture – maxillary
Adjust complete denture – mandibular
Adjust partial denture – maxillary
Adjust partial denture - mandibular
Repair broken complete denture base-mandibular
Repair broken complete denture base-maxillary
Replace missing or broken teeth - complete denture (each tooth)
Repair resin partial denture base-mandibular
Repair resin partial denture base-maxillary
Repair cast partial framework-mandibular
Repair cast partial framework-maxillary

Repair or replace broken clasp
Replace broken teeth - per tooth
Add tooth to existing partial denture
Add clasp to existing partial denture
Rebase complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
Rebase maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
Rebase mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
Rebase hybrid prosthesis-Replacing the base material connected to the framework-Limited to a 1 in a 36-month period 6 months after the initial installation
Reline complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
Reline complete mandibular denture - Limited to 1 in a 36-month period 6 months after the initial installation
Reline maxillary partial denture - Limited to 1in a 36-month period 6 months after the initial installation
Reline mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
Reline maxillary partial denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
Reline mandibular partial denture (laboratory) Rebase/Reline - Limited to 1 in a 36-month period 6 months after the initial installation
Soft liner for complete or partial removable denture-indirect-A discrete procedure provided when the dentist determines placement of the soft liner is clinically indicated-Limited to a 1 in 36-month period 6 months after the initial installation
Tissue conditioning (maxillary)
Tissue conditioning (mandibular)
Recement fixed partial denture
Fixed partial denture repair, by report

Oral Surgery
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
Removal of impacted tooth - soft tissue
Removal of impacted tooth – partially bony
Removal of impacted tooth - completely bony
Removal of impacted tooth - completely bony with unusual surgical complications
Surgical removal of residual tooth roots (cutting procedure)
Coronectomy - intentional partial tooth removal
Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
Surgical access of an unerupted tooth
Alveoloplasty in conjunction with extractions - per quadrant
Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
Alveoloplasty not in conjunction with extractions - per quadrant
Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
Removal of exostosis
Incision and drainage of abscess - intraoral soft tissue
Suture of recent small wounds up to 5 cm
Collect-Apply Autologous Product-1 every 36 months
Bone replacement graft for ridge preservation-per site
Buccal/Labial Frenectomy
Lingual Frenectomy

Excision of pericoronal gingiva

Type C – Major Services

Major Restorative Services

Detailed and extensive oral evaluation - problem focused, by report
Inlay - metallic – one surface – An alternate benefit will be provided
Inlay - metallic – two surfaces – An alternate benefit will be provided
Inlay - metallic – three surfaces – An alternate benefit will be provided
Onlay - metallic - two surfaces – Limited to 1 per tooth every 60 months
Onlay - metallic - three surfaces – Limited to 1 per tooth every 60 months
Onlay - metallic - four or more surfaces – Limited to 1 per tooth every 60 months
Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 months
Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 months
Crown - porcelain fused to predominately base metal – Limited to 1 per tooth every 60 months
Crown - porcelain fused to noble metal – Limited to 1 per tooth every 60 months
Crown - porcelain fused to titanium and titanium alloys - Limited to 1 per tooth every 60 months
Crown - 3/4 cast high noble metal – Limited to 1 per tooth every 60 months
Crown - 3/4 cast predominately base metal – Limited to 1 per tooth every 60 months
Crown - 3/4 porcelain/ceramic – Limited to 1 per tooth every 60 months
Crown - full cast high noble metal– Limited to 1 per tooth every 60 months
Crown - full cast predominately base metal – Limited to 1 per tooth every 60 months
Crown - full cast noble metal– Limited to 1 per tooth every 60 months
Crown – titanium– Limited to 1 per tooth every 60 months
Prefabricated porcelain/ceramic crown – permanent tooth - limited to 1 per tooth every 60 months
Resin crown - Limited to 1 per tooth every 60 months
Core buildup, including any pins– Limited to 1 per tooth every 60 months
Post and core-limited to 1 per tooth every 60 months
Prefabricated post and core, in addition to crown– Limited to 1 per tooth every 60 months
Crown repair, by report
Inlay Repair
Onlay Repair
Veneer Repair
Resin infiltration/smooth surface - Limited to 1 in 36 months

Endodontic Services

Anterior root canal (excluding final restoration)
Bicuspid root canal (excluding final restoration)
Molar root canal (excluding final restoration)
Retreatment of previous root canal therapy-anterior
Retreatment of previous root canal therapy-bicuspid
Retreatment of previous root canal therapy-molar
Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration
Apicoectomy/periradicular surgery - anterior

Apicoectomy/periradicular surgery - bicuspid (first root)
Apicoectomy/periradicular surgery - molar (first root)
Apicoectomy/periradicular surgery (each additional root)
Root amputation - per root
Surgical repair of root resorption - anterior
Surgical repair of root resorption – premolar
Surgical repair of root resorption – molar
Surg Exp of Root-Anterior
Surg Exp of Root-Premolar
Surg Exp of Root-Molar
Hemisection (including any root removal) - not including root canal therapy
Intentional removal of coronal tooth structure for preservation of the root and surrounding bone

Periodontal Services

Gingivectomy or gingivoplasty – four or more teeth - Limited to 1 every 36 months
Gingivectomy or gingivoplasty – one to three teeth - Limited to 1 every 36 months
Gingivectomy or gingivoplasty - with restorative procedures, per tooth - Limited to 1 every 36 months
Gingival flap procedure, four or more teeth – Limited to 1 every 36 months
Gingival flap procedure, including root planning - one to three contiguous teeth or tooth bounded spaces per quadrant – Limited to 1 every 36 months
Clinical crown lengthening-hard tissue
Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months
Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months
Bone replacement graft - first site in quadrant - Limited to 1 every 36 months
Pedicle soft tissue graft procedure
Autogenous connective tissue graft procedures (including donor site surgery)
Non-Autogenous connective tissue graft - Limited to 1 every 36 months
Free soft tissue graft 1st tooth
Free soft tissue graft-additional teeth
Subepithelial tissue graft/each additional contingous tooth, implant or edentulous tooth position in same graft site
Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material)-each additional contiguos tooth, implant or edentulous tooth position in same graft site-Limited to 1 every 36 months
Full mouth debridement to enable comprehensive evaluation and diagnosis– Limited to 1 per lifetime

Prosthodontic Services

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

Immediate mandibluar partial denture-resin base (including any conventional clasps, rests and teeth)-Limited to 1 every 60 months
Immediate maxillary partial denture-cast metal framework with resin denture base (including any conventional clasps, rests amd teeth)-Limited to 1 every 60 months
Immediate mandibular partial denture-cast metal framework with resin denture base (including any conventional clasps, rests amd teeth)-Limited to 1 every 60 months
Immediate maxillary partial denture-flexible base (including any clasps, rests and teeth)-Limited to 1 every 60 months
Immediate mandibular partial denture-flexible base (including clasps, rests and teeth)-Limited to 1 every 60 months
Removable Unilateral Partial denture-one piece cast metal (including clasps and teeth), maxillary-Limited to 1 every 60 months
Removable Unilateral partial denture-one piece cast metal (including clasps and teeth), mandibular-Limited to 1 every 60 months
Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant - Limited to 1 every 60 months
Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant - Limited to 1 every 60 months
Add metal substructure to acrylic full denture (per arch)-Limit 1 every 60 months.
Endosteal Implant - 1 every 60 months
Surgical Placement of Interim Implant Body - 1 every 60 months
Eposteal Implant – 1 every 60 months
Transosteal Implant, Including Hardware – 1 every 60 months
Connecting Bar – implant or abutment supported - 1 every 60 months
Prefabricated Abutment – 1 every 60 months
Custom Abutment - 1 every 60 months
Abutment supported porcelain ceramic crown -1 every 60 months
Abutment supported porcelain fused to high noble metal - 1 every 60 months
Abutment supported porcelain fused to predominately base metal crown - 1 every 60 months
Abutment supported porcelain fused to noble metal crown - 1 every 60 months
Abutment supported cast high noble metal crown - 1 every 60 months
Abutment supported cast predominately base metal crown - 1 every 60 months
Abutment supported cast noble metal crown - 1 every 60 months
Implant supported porcelain/ceramic crown - 1 every 60 months
Implant supported porcelain fused to high metal crown - 1 every 60 months
Implant supported metal crown - 1 every 60 months
Abutment supported retainer for porcelain/ceramic fixed partial denture - 1 every 60 months
Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months
Abutment supported retainer for porcelain fused to noble metal fixed partial denture - 1 every 60 months
Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months
Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months
Abutment supported retainer for cast noble metal fixed partial denture - 1 every 60 months
Implant supported retainer for ceramic fixed partial denture - 1 every 60 months
Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
Implant supported retainer for cast metal fixed partial denture - 1 every 60 months
Implant Maintenance Procedures -1 every 60 months
Scaling and debridement implant-1 every 60 months
Implant supported crown – porcelain fused to predominantly base alloys - 1 every 60 months
Implant supported crown – porcelain fused to noble alloys - 1 every 60 months
Implant supported crown – porcelain fused to titanium and titanium alloys - 1 every 60 months
Implant supported crown – predominantly base alloys - 1 every 60 months

Implant supported crown – noble alloys - 1 every 60 months
Implant supported crown – titanium and titanium alloys - 1 every 60 months
Repair Implant Prosthesis -1 every 60 months
Replacement of Semi-Precision or Precision Attachment -1 every 60 months
Repair Implant Abutment - 1 every 60 months
Remove broken implant retaining screw-1 every 12 months
Abutment supported crown – porcelain fused to titanium and titanium alloy - 1 every 60 months
Implant supported retainer – porcelain fused to predominantly base alloys - 1 every 60 months
Implant supported retainer for FPD – porcelain fused to noble alloys - 1 every 60 months
Implant Removal - 1 every 60 months
Debridement periimplant defect - Limited to 1 every 60 months
Debridement and osseous periimpant defect - Limited to 1 every 60 months
Bone graft periimplant defect
Bone graft implant replacement
Implant/abutment supported removable denture for edentulous arch-maxillary- 1 every 60 months
Implant/abutment supported removable denture for edentulous arch-mandibular- 1every 60 months
Implant/abutment supported removable denture for partially edentulous arch-maxillary- 1 every 60 months
Implant/abutment supported removable denture for partially edentulous arch-mandibular- 1every 60 months
Implant/abutment supported fixed denture for edentulous arch-maxillary- 1 every 60 months
Implant/abutment supported fixed denture for edentulous arch-mandibular- 1 every 60 months
Implant/abutment supported fixed denture for partially edentulous arch-maxillary- 1 every 60 months
Implant/abutment supported fixed denture for partially edentulous arch-mandibular- 1 every 60 months
Implant supported retainer – porcelain fused to titanium and titaniumalloys - 1 every 60 months
Implant supported retainer for metal FPD – predominantly base alloys - 1 every 60 months
Implant supported retainer for metal FPD – noble alloys - 1 every 60 months
Implant supported retainer for metal FPD – titanium and titanium alloys - 1 every 60 months
Implant Index - 1 every 60 months
Semi-precision abutment – placement - 1 every 60 months
Semi-precision attachment – placement - 1 every 60 months
Abutment supported retainer – porcelain fused to titanium and titanium alloys - 1 every 60 months
Pontic - cast high noble metal – Limited to 1 every 60 months
Pontic - cast predominately base metal – Limited to 1 every 60 months
Pontic - cast noble metal– Limited to 1 every 60 months
Pontic – titanium – Limited to 1 every 60 months
Pontic - porcelain fused to high noble metal – Limited to 1 every 60 months
Pontic - porcelain fused to predominately base metal – Limited to 1 every 60 months
Pontic - porcelain fused to noble metal – Limited to 1 every 60 months
Pontic – porcelain fused to titanium and titanium alloys - 1 every 60 months
Pontic - porcelain/ceramic – Limited to 1 every 60 months
Inlay/onlay – porcelain/ceramic – Limited to 1 every 60 months
Inlay – metallic – two surfaces – Limited to 1 every 60 months
Inlay – metallic – three or more surfaces - Limited to 1 every 60 months
Onlay – metallic – three surfaces - 1 every 60 months
Onlay – metallic – four or more surfaces -1 every 60 months
Retainer - cast metal for resin bonded fixed prosthesis -1 every 60 months
Retainer - porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months
Resin retainer-for resin bonded fixed prosthesis - 1 every 60 months
Crown - porcelain/ceramic - 1 every 60 months
Crown - porcelain fused to high noble metal - 1 every 60 months
Crown - porcelain fused to predominately base metal - 1 every 60 months

Crown - porcelain fused to noble metal - 1 every 60 months
Retainer crown – porcelain fused to titanium and titanium alloys - 1 every 60 months
Crown - 3/4 cast high noble metal - 1 every 60 months
Crown - 3/4 cast predominately base metal - 1 every 60 months
Crown - 3/4 cast noble metal - 1 every 60 months
Crown - 3/4 porcelain/ceramic - 1 every 60 months
Retainer crown ¾ titanium and titanium alloys - 1 every 60 months
Crown - full cast high noble metal - 1 every 60 months
Crown - full cast predominately base metal - 1 every 60 months
Crown - full cast noble metal - 1 every 60 months
Cleaning and inspection of removable complete denture, maxillary-1 every 6 months
Cleaning and inspection of removable complete denture, mandibular-1 every 6 months
Cleaning and inspection of removable partial denture, maxillary-1 every 6 months
Cleaning and inspection of removable partial denture, mandibular-1 every 6 months
Repair/reline occlusal guard-1 every 24 months for patients 13 and older
Occlusal guard adjustment-1 every 24 months for patients 13 and older
Occlusal guard-hard appliance, full arch - 1 in 12 months for patients 13 and older
Occlusal guard-soft appliance, full arch - 1 in 12 months for patients 13 and older
Occlusal guard-hard appliance, partial arch - 1 in 12 months for patients 13 and older

Type D – Medically Necessary Orthodontic Services

Orthodontia Services

Limited orthodontic treatment of the primary dentition
Limited orthodontic treatment of the transitional dentition
Limited orthodontic treatment of the adolescent dentition
Limited orthodontic treatment of the adult dentition
Comprehensive orthodontic treatment of the transitional dentition
Comprehensive orthodontic treatment of the adolescent dentition
Comprehensive orthodontic treatment of the adult dentition
Removable appliance therapy
Fixed appliance therapy
Pre-orthodontic treatment examination to monitor growth and development
Periodic orthodontic treatment visit (as part of contract)
Orthodontic retention (removal of appliances, construction and placement of retainer(s)

Type D – General Services

Anesthesia Services

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

Intravenous Sedation

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

Medications

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

Post Surgical Services

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

PEDIATRIC VISION CARE	
Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19) Limited to 1 vision examination per Policy Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year. 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

PRESCRIPTION DRUGS

Prescription Drugs Retail Pharmacy

No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy.

Your benefit is limited to a 30 day supply. Coverage for more than a 30 day supply only applies if the smallest package size exceeds a 30 day supply. See "Retail Pharmacy Supply Limits" section for more information.

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK	OUT-OF-NETWORK
TIER 1 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$10 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 60 day supply filled at a Retail pharmacy	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
TIER 2 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered

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	Not Covered
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	Not Covered
TIER 3 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail Pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 60 day supply filled at a Retail pharmacy	$90 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
Specialty Prescription Drugs		
For each fill up to a 30 day supply.	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 30 day supply but less than a 61 day supply	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 60 day supply	$90 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
Zero Cost Drugs		
	100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
Orally administered anti-cancer Prescription Drugs (including Specialty Drugs)		
Benefit	If the cost share for the Prescription Drug's Tier is greater than the chemotherapy Benefit or Infusion Therapy Benefit, the cost share will be calculated as follows: Greater of: • Chemotherapy Benefit; or • Infusion Therapy Benefit	

Diabetic Supplies (for prescription supplies purchased at a pharmacy)	
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill except, that the Insured Person's out-of-pocket costs for covered prescription insulin drugs will not exceed $30 per 30-day supply regardless of the amount or type of insulin that is needed to fill the Insured Person's prescription.

(4) EXCLUSIONS AND LIMITATIONS

Exclusion Disclaimer: Any exclusion in conflict with the Patient Protection and Affordable Care Act will be administered to comply with the requirements of the Act.

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.

- **International Students Only -** Covered Medical Expenses received within Your Home Country or country of origin that are covered under Your governmental or national health plan.
- 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 Your attending Physician or dentist.
- Medical services rendered by a provider employed for or contracted with the Policyholder, including team Physicians or trainers, except as specifically provided in the Schedule of Benefits.
- Professional services rendered by an Immediate Family Member or anyone who lives with You.
- Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services covered by Student Health Fees.
- Any expenses in excess of the Maximum Allowance except as provided in the Certificate.
- Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which You are required to pay.
- Services that are duplicated when provided by both a certified Nurse midwife and a Physician.
- Expenses payable under any prior policy which was in force for the person making the claim.
- Loss resulting from war or any act of war, whether declared or not, or Loss sustained while in the armed forces of any country or international authority.
- Injury sustained as the result of Your operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle Accident takes place.
- Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
- Expenses incurred after:
  - The date insurance terminates as to an Insured Person, except as specified in the extension of benefits provision; and
  - The end of the Policy Year specified in the Policy.
- Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
- You are:
  - committing or attempting to commit a felony,
  - engaged in an illegal occupation, or
  - participating in a riot.
- Custodial Care service and supplies.
- Charges for hot or cold packs for personal use.
- Services of private duty Nurse except as provided in the Certificate.
- Expenses that are not recommended and approved by a Physician.
- Experimental or Investigational drugs, devices, Treatments or procedures.
- Routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue,

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

- Loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
- Non-chemical addictions.
- Outpatient non-physical, occupational, speech therapies (such as art, dance, drama, horticulture, music, writing, etc.).
- Modifications made to dwellings.
- General fitness, exercise programs.
- Hypnosis.
- Rolfing.
- Biofeedback.
- Sleep Disorders, except for the diagnosis and Treatment of obstructive sleep apnea including testing performed in a home or outpatient setting
- Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary because of Injury, infection or disease.

Activities Related

- Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate 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.
- Racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles).

Weight Management/Reduction

- Weight management. Weight reduction. Nutrition programs. This does not apply to nutritional counseling, or any screening or assessment specifically provided under the Preventive Services benefit, or otherwise specifically covered under the Certificate.
- Treatment for obesity except surgery for morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat.

Family Planning

- Infertility Treatment (male or female)-this includes but is not limited to:
  - Genetic counseling and genetic testing;
  - Impotence, organic or otherwise;
  - Costs for an ovum donor or donor sperm;
  - Ovulation predictor kits;
  - Reversal of tubal ligations;
  - Reversal of vasectomies;
  - Costs for and relating to surrogate motherhood if the individual is not an Insured Person under the Certificate;
  - Cloning; or
  - Medical and surgical procedures that are Experimental or Investigational, unless Our denial is overturned by an External Appeal Agent.

Hearing

- Charges for hearing exams, hearing screening, or cochlear implants except as specifically provided in the Certificate.

Cosmetic

- Treatment of Acne unless Medically Necessary.
- Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
- Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma.

Prescription Drugs

- Any drug or medicine which does not, by federal or state law, require a prescription order, i.e., over-the-counter drugs, even if a prescription is written, except as specifically provided under Preventive Services or in the Prescription Drug Benefit section of 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;
- Vitamins, and minerals, except as specifically provided under Preventive Services;
- Food supplements, dietary supplements; except as specifically provided in the Certificate;
- Cosmetic drugs or medicines including, but not limited to, products that improve the appearance of wrinkles or other skin blemishes;
- Refills in excess of the number specified or dispensed after 1 year of date of the prescription;
- Drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
- Any drug or medicine purchased after coverage under the Certificate terminates;
- Any drug or medicine consumed or administered at the place where it is dispensed;
- If the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
- Prescription digital therapeutics;
- Bulk chemicals;
- Non-insulin syringes, surgical supplies, Durable Medical Equipment/medical devices, except as specifically provided in the Prescription Drug Benefit section of the Certificate;
- Repackaged products;
- Blood components except factors;
- Medical marijuana, cannabis, or other supplies and/or services rendered at a cannabis dispensary. This does not include synthetic pharmaceutical products approved by the FDA and included on the Formulary;
- Any expenses in excess of the Usual and Customary Charge;
- Any drug or medicine for the purpose of weight control;
- Sexual enhancements drugs;
- Vision correction products.

(5) The Policy Year runs from the Policy Effective date until the Policy Termination Date. The Policy Term is the period of time selected by the Insured Student and for which premium has been paid by the Policyholder for an eligible Student.