

WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

STUDENT HEALTH CERTIFICATE OF COVERAGE

POLICYHOLDER: BATES COLLEGE
(Policyholder)
POLICY NUMBER: WI2627MESHPTC01
POLICY EFFECTIVE DATE: August 15, 2026
POLICY TERMINATION DATE: August 14, 2027
STATE OF ISSUE: Maine

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Policy between Wellfleet Insurance Company (hereinafter referred to as "We", "Us" or "Our") and the Policyholder. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

INSURING AGREEMENTS

COVERAGE: Benefits are provided to cover the expenses incurred due to a Covered Sickness or a Covered Injury which results in Covered Medical Expenses.

We will pay the benefits under the terms of the Policy in consideration of:

1. The application for the Policy; and
2. The payment of all Premiums as set forth in the Policy.

This Certificate takes effect on the Policy Effective Date at 12:00 a.m. local time at the Policyholder's address. We must receive the Policyholder's signed application and the initial Premium for it to take place.

Termination of the Certificate

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

Right to examine and return policy - The Policyholder may return the Policy within at least ten (10) days of delivery for a full refund of all Premiums paid; and any coverage returned for a refund of Premium will be null and void from its inception.

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

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

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

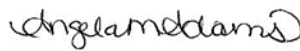
Non-Participating One Year Term Insurance

This Certificate pays Covered Medical Expenses pursuant to the Maximum Allowance as defined in this Certificate. **You are responsible for any amounts determined to be in excess of the Maximum Allowance** and the Usual, Customary, and Reasonable amount.

For claims subject to the No Surprises Act, if an initial payment under the Plan is challenged and no negotiation and/or settlement occurs resulting in a negotiated rate, the Maximum Allowance will be the amount deemed payable by a certified independent dispute resolution entity as outlined in applicable law.



President
Andrew M. DiGiorgio



Secretary
Angela Adams

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

Administrator: Wellfleet Group, LLC
P.O. Box 15369
Springfield, MA 01115-5369
877-657-5030

RIGHTS AND RESPONSIBILITIES

The responsibilities of an Insured Person include:

1. Carrying the Insured Person's identification card with them and presenting it prior to receiving health care services.
2. Paying all Deductibles, Coinsurance and Copayment amounts, if any, when due.
3. Reading the Policy, knowing their coverage, and following the procedures outlined in the Policy to receive maximum benefits.
4. Informing Us of any other health insurance the Insured Person might have.
5. Preventing the dishonest or false use of the Insured Person's identification card by people not eligible for coverage, and immediately reporting any such use to Us.
6. Informing Us of any change in the Insured Person's address or a Qualifying Life Event that may affect benefits for the Insured Person.

The rights of an Insured Person include:

1. Simple information and explanations from the Insured Person's health plan to help them understand what is covered and what is not covered.
2. Emergency care at any Hospital for a condition the Insured Person believes threatens their life or seriously affects their health subject to protection for Surprise Billing.
3. Information about steps the Insured Person can take if they think that their health insurance plan has denied them coverage of a Treatment they believe is covered.

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SCHEDULE OF BENEFITS

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*:

100% 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. Chemotherapy/Radiation;
10. Cochlear devices;
11. Infusion Therapy;
12. Botox Injections;
13. Genetic Testing, except for BRCA;
14. Orthotics/Prosthetics;
15. 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.

The Insured Person is only responsible for the applicable Coinsurance amounts, Deductibles and Copayments up to the Out-of-Pocket Maximum. If an Insured Person receives a balance bill for a Covered Medical Expense, please follow the instructions on the Wellfleet Student App or contact Us at the number on Your ID card. We provide balance billing protection to the Insured Person. Once notified of a balance bill, We will take full responsibility for managing negotiations with the provider to reach a resolution. The Insured Person will not be assessed any additional cost share based on these negotiations.

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 toll-free 877-657-5030, TTY 711.

You have the right to obtain the estimated maximum allowable charge for a covered service before You receive the service. Contact Us at 877-657-5030, TTY 711 or visit www.wellfleetstudent.com for this information.

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	100% of the Maximum Allowance for Covered Medical Expenses

PROFESSIONAL AND OUTPATIENT SERVICES	
<i>Surgical Expenses</i>	
Inpatient and Outpatient Surgery includes: Pre-Certification Required for surgery only Surgeon Services Anesthetist Assistant Surgeon	100% 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	100% of the Maximum Allowance for Covered Medical Expenses
Abortion Expense	100% of the Maximum Allowance for Covered Medical Expenses Deductible Waived, if applicable
Bariatric Surgery Pre-Certification Required	100% 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	100% of the Maximum Allowance for Covered Medical Expenses
Human Leukocyte Antigen Testing	100% of Maximum Allowance for Covered Medical Expenses. Deductible Waived, if applicable. Subject to once per lifetime for Antigen testing laboratory fees
Reconstructive Surgery Pre-Certification Required	100% of the Maximum Allowance for Covered Medical Expenses
<i>Other Professional Services</i>	
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	100% of the Maximum Allowance for Covered Medical Expenses
Hospice Care Coverage	100% of the Maximum Allowance for Covered Medical Expenses
<i>Office Visits</i>	
Physician's Office Visits including Specialists/Consultants	\$10 Copayment per visit then the plan pays 100% of the Maximum Allowance for Covered Medical Expenses
Telemedicine or Telehealth Services Benefit	100% of the Maximum Allowance for Covered Medical Expenses
Acupuncture Services (Medically Necessary Treatment only)	100% of the Maximum Allowance for Covered Medical Expenses
Acupuncture Services Maximum visits per Policy Year	30
Allergy Testing and Treatment, including injections	100% of the Maximum Allowance for Covered Medical Expenses

Chiropractic Care Benefit	100% 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)	100% 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 100% of the Maximum Allowance for Covered Medical Expenses Copayment waived if admitted
Urgent Care Centers for non-life-threatening conditions	\$10 Copayment per visit then the plan pays 100% of the Maximum Allowance for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	100% 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)	100% of the Maximum Allowance for Covered Medical Expenses
DIAGNOSTIC LABORATORY, RADIOLOGY, TESTING AND IMAGING SERVICES	
Diagnostic Complex Imaging Services Pre-Certification Required	100% 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/ .	100% of the Maximum Allowance for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	100% of the Maximum Allowance for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	100% of the Maximum Allowance for Covered Medical Expenses
REHABILITATION AND HABILITATION THERAPIES	
Cardiac Rehabilitation	100% of the Maximum Allowance for Covered Medical Expenses
Cardiac Rehabilitation Maximum Visits per Policy Year	60
Pulmonary Rehabilitation	100% 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	100% 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	100% 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.	100% of the Maximum Allowance for Covered Medical Expenses
Dialysis Treatment	100% of the Maximum Allowance for Covered Medical Expenses
Durable Medical Equipment Pre-Certification Required	100% 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.	100% of the Maximum Allowance for Covered Medical Expenses
Hearing Aids One hearing aid per affected ear every 36 months	100% of the Maximum Allowance for Covered Medical Expenses
Infertility Treatment Benefit	100% of the Maximum Allowance for Covered Medical Expenses
Fertility Preservation Benefit	100% of the Maximum Allowance for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness
Prosthetic and Orthotic Devices Pre-Certification Required	100% of the Maximum Allowance for Covered Medical Expenses
Prosthetic Devices (Arm and Leg) Pre-Certification Required	100% of the Maximum Allowance for Covered Medical Expenses
Pediatric Autoimmune Neuropsychiatric Disorders (PANS and PANDA)	Covered the same as any other Sickness
Accidental Injury Dental Treatment	100% of the Maximum Allowance for Covered Medical Expenses
Sickness Dental Expense Benefit	100% of the Maximum Allowance for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	100% of the Maximum Allowance for Covered Medical Expenses
Anesthesia and Facility Charges for Dental Procedures	100% of the Maximum Allowance for Covered Medical Expenses
Dental Care for Cancer Patients	100% of the Maximum Allowance for Covered Medical Expenses

Sports Accident Expense Benefit - incurred as the result of the play or practice of club sports	100% of the Maximum Allowance for Covered Medical Expenses
Non-emergency Care While Traveling Outside of the United States	100% 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, unless considered a Preventive Service
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.	

SECTION I - ELIGIBILITY

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

Except in the case of withdrawal from School due to Sickness or Injury, any student who withdraws from the Policyholder's School during the first 31-Unlimited days of the period for which he or she is enrolled shall not be covered under the insurance plan. A full refund of Premium will be made, minus the cost of any claim benefits paid by the Certificate. A student who graduates or withdraws after such 31 days of the period for which he or she is enrolled will remain covered under this Certificate for the term purchased and no refund will be allowed.

A student withdrawing due to a medical withdrawal due to a Sickness or Injury, must submit documentation or certification of the medical withdrawal to Us at least 30 days prior to the medical leave of absence from the School, if the medical reason for the absence and the absence are foreseeable, or 30 days after the date of the medical leave from School. The student withdrawing due to a medical withdrawal due to a Sickness or Injury will remain covered under the Certificate for the term purchased and no refund will be allowed.

All International Students are required to have a J-1, F-1, or M-1 and their eligible Dependents (who are not U.S. citizens) are required to have a J-2, F-2, or M-2 Visa to be eligible for this insurance plan.

We maintain the right to investigate eligibility status and attendance records to verify that the Certificate eligibility requirements have been and continue to be met. If We discover that the Certificate eligibility requirements have not been

met, Our only obligation is refund of Premium less any claims paid. Eligibility requirements must be met each time Premium is paid to continue coverage.

If the Insured Student or the Insured Student's Dependent has performed an act that constitutes fraud; or the Insured Student has made an intentional misrepresentation of material fact during their enrollment under this insurance plan in order to obtain coverage for a service, coverage will be terminated. We will provide 30 days prior written notice of termination delivered by Us to the Insured Student and/or the Insured Student's Dependent, as applicable. If termination is a result of the Insured Student's action, coverage will terminate for the Insured Student and the Insured Student's Dependents. If termination is a result of the Insured Student's Dependent's action, coverage will terminate for the Insured Student's Dependent.

Who is Eligible

Class	Description of Class(es)
1	All international students and scholars of the Policyholder enrolled in (1) or more classes.
2	All full-time domestic students of the Policyholder enrolled in three (3) or more classes.

Class 1: All students, as determined by the Policyholder, are eligible for coverage under the Policy. Eligible Students are required to have health insurance coverage and will be automatically enrolled in the Student Health Insurance Plan and the Premium will be added to the student's tuition fees and they do not have the option to waive coverage.

Class2: All students, as determined by the Policyholder, are eligible for coverage under the Policy. Eligible Students are required to have health insurance coverage and will be required to enroll in the Student Health Insurance Plan and the Premium will be added to the student's tuition fees unless proof of comparable coverage is provided by completing the waiver.

Who is Not Eligible

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

Dependent Eligibility

Dependents are eligible for coverage under this plan.

The Insured Student's Dependent may become eligible for coverage under this Certificate only when the Insured Student becomes eligible; or within 60 days of a Qualifying Life Event.

SECTION II – EFFECTIVE AND TERMINATION DATES

Effective Dates

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

1. The Policy Effective Date;
2. The beginning date of the term of coverage for which Premium has been paid;
3. The day after Enrollment (if applicable) and Premium payment is received by Us, Our authorized agent or the School;
4. The day after the date of postmark if the Enrollment Form is mailed; or
5. For International Students or scholars, the departure date to his or her Home Country to travel to the Country of Assignment. The scheduled arrival in the Country of Assignment must be not more than 48 hours later than the departure from the Home Country.

Dependent's coverage, becomes effective on the later of:

1. The date the Insured Student's coverage becomes effective; or
2. The date the Insured Student's Dependent is enrolled for coverage, provided Premium is paid when due.
3. The day after the date of postmark if the Enrollment Form is mailed; or
4. The beginning date of the term of coverage for which Premium has been paid; or
5. The day after the date the required individual Enrollment Form and Premium payment are received by Us or Our authorized agent. This applies only when Premium payment is made within 31 days of the Insured Student's enrollment in the School's insurance plan; or
6. The Policy Effective Date.

Special Enrollment – Qualifying Life Event

The Insured Student, and the Insured Student's Spouse or Child can also enroll for coverage within 60 days of the loss of coverage in another health plan if coverage was terminated because the Insured Student, the Insured Student's Spouse or Child are no longer eligible for coverage under the other health plan due to:

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

The Insured Student, the Insured Student's Spouse or Child can also enroll 60 days from exhaustion of the Insured Student's COBRA or continuation coverage or if the Insured Student gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption.

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

In addition, the Insured Student, and the Insured Student's Spouse or Child can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. The Insured Student or the Insured Student's Spouse or Child loses eligibility for Medicaid or a state child health plan.
2. The Insured Student or the Insured Student's Spouse or Child becomes eligible for Medicaid or a state child health plan.

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

Termination Dates

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

1. The date this Certificate terminates; or
2. The end of the term of coverage for which Premium has been paid; or
3. The date the Insured Student ceases to be eligible for the insurance; or
4. The date the Insured Student enters military service; or
5. For International Students, the date the Insured Student ceases to meet Visa requirements; or

6. For International Students, the date the Insured Student departs the Country of Assignment for their Home Country (except for scheduled School breaks); or
7. On any Premium due date the Policyholder fails to pay the required Premium for the Insured Student except as the result of an inadvertent error and subject to any Grace Period provision.

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

1. The date the Insured Student's insurance ends; or
2. The date the Insured Student's Dependent ceases to be eligible for the insurance; or
3. The end of the term of coverage for which Premium has been paid.

Dependent Child Coverage

Newly Born Children

A newly born child of the Insured Person will be covered from the moment of birth. Such newborn child will be covered for Covered Injury or Covered Sickness for an initial period of 31 days. This includes the necessary care and Treatment of medically diagnosed congenital defects and birth abnormalities from the moment of birth. If additional Premium is required, to continue coverage beyond this initial 31-day period, the Insured Student must notify Us of the birth so We can generate an updated Premium bill so a timely Premium payment is made. If an additional Premium is not required, We request that the Insured Student notify Us of the birth to ensure proper claims adjudication.

Adopted Children

Dependent Child coverage also applies to any child adopted or placed for adoption irrespective of whether the adoption has become final.

We must receive:

1. Notification of a child's placement for adoption within 31 days of the placement; and
2. Any Premium required for the child.

We will provide coverage for the child placed for adoption as long as the Insured Student:

1. Has custody of the child;
2. The Insured Student's coverage under this Certificate remains in effect; and
3. The required Premiums are furnished to Us.

As it pertains to this provision:

Child means, in connection with an adoption or placement for adoption, an individual who has not attained the age of 18 as of the date of the adoption or placement for adoption.

Placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of a child. The child's placement with a person terminates upon the termination of the legal obligation.

Disabled Children

If:

1. There is Dependent coverage; and
2. This Certificate provides that coverage of a Dependent child will terminate upon attainment of a specified age, We will not terminate the coverage of such child due to attainment of that age while the child is and continues to be both:
 1. Incapable of self-sustaining employment by reason of developmental or physical disability, mental illness or disorder; and

2. Chiefly dependent upon the Insured Student for support and maintenance.

Proof of such incapacity and dependence shall be furnished to Us within 31 days of the child's attainment of the limiting age. Upon request, We may require proof satisfactory to Us of the continuance of such incapacity and dependency. We may not request this more frequently than annually after the 2-year period following the child's attainment of the limiting age.

Medically Necessary leave of absence if:

A Dependent child who is a full time college student takes a Medically Necessary leave of absence from school, coverage for that Dependent will continue for a period of 12 months or until the date on which the coverage is scheduled to terminate pursuant to the Policy, whichever comes first. The period of coverage under this section shall commence on the first day of the medical leave of absence from the School or on the date the Physician determines the Injury or Sickness prevented the Dependent child from attending School, whichever comes first. Documents or certification of the medical leave of absence from School shall be submitted to Us at least 30 days prior to the medical leave of absence from the School, if the medical reason for the absence and the absence are foreseeable, or 30 days after the start date of the medical leave of absence from School.

Extension of Benefits

Coverage under this Certificate ceases on the Termination Date of Your insurance coverage. However, coverage for You will be extended as follows:

1. If You are Hospital Confined for a Covered Injury or Covered Sickness on the date Your insurance coverage terminates, We will continue to pay benefits for that Covered Injury or Covered Sickness for up to 90 days from the Termination Date while such Confinement continues; or
2. If You are Totally Disabled due to a Covered Injury or Covered Sickness, the coverage for that condition will be extended for up to 90 days from the Termination Date of Your insurance coverage while such Total Disability continues.

Dependents that are newly acquired during Your Extension of Benefits period are not eligible for benefits under this provision.

Notice of cancellation

In the event this Certificate is cancelled for not paying the Premium, We will send You and the Policyholder a notice of cancellation. You have the right to designate another person to receive notice of cancellation if it is due to non-payment of Premium. To designate or change the person You designate to receive the notice You must notify Us in writing. We will send the notice to the last address You provided Us at least 60 Calendar days before cancellation. Within 90 days after cancellation due to nonpayment of Premium, this Certificate may be reinstated if it was cancelled due to an Insured Person's cognitive impairment or functional incapacity. We may require medical evidence to support such incapacity at time of the cancellation. If a request for reinstatement of coverage because of cognitive impairment or functional incapacity is denied, We will provide a notice of denial to You and, if applicable, Your representative. You may request a hearing before the Maine Superintendent for up to 30 days following receipt of the notice of denial.

Reinstatement Of Reservist After Release From Active Duty

If the Insured Student's insurance or an eligible Dependent's insurance ends due to the Insured Student being called or ordered to active duty, such insurance will be reinstated without any waiting period when the student returns to School and satisfies the eligibility requirements defined by the School.

Refund of Premium

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

1. If a student ceases to be eligible for the insurance and coverage is terminated prior to the next Premium due date, a pro rata refund of Premium (less any claims paid) will be made for such person. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.

2. For any student who withdraws from School during the first 31 days of the period for which he or she is enrolled for a reason other than withdrawal due to Sickness or Injury. Such a student will not be covered under this Certificate and a full refund of the Premium will be made (less any claims paid) when written request is made within 90 days of withdrawal from School. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.
3. For an Insured Student entering the Armed Forces of any country. Such a student will not be covered under this Certificate as of the date of his/her entry into the service. A pro rata refund of Premium (less any claims paid) will be made upon written request received by Us within 90 days of withdrawal from School. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.
4. For an Insured International Student, Scholar, Visiting Faculty member departing School to return to his or her Home Country on a permanent basis. We will refund a pro rata refund of Premium (less any claims paid) when written request and proof from the Policyholder that the student is no longer an eligible person is received by Us within 60 days of such departure. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.

SECTION III – DEFINITIONS

These are key words used in this Certificate. They are used to describe the Policyholder's rights as well as Ours. Reference should be made to these words as the Certificate is read.

Accident means a sudden, unforeseeable event which directly and from no other cause, results in an Injury.

Actual Charge means the charge for the Treatment by the provider who furnishes it.

Ambulance means any conveyance designed and constructed or modified and equipped to be used, maintained, or operated to transport individuals who are sick, wounded, or otherwise incapacitated.

Ambulance Service means transportation to or from a Hospital by a licensed Ambulance whether ground, air or water Ambulance, in a Medical Emergency.

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

1. Is equipped and operated to provide medical care and Treatment by a Physician;
2. Does not provide services or accommodations for overnight stays, unless the expected duration of services is less than 24 hours;
3. Has a medical staff that is supervised full-time by a Physician;
4. Has full-time services of a licensed registered Nurse at all times when patients are in the facility;
5. Has at least one operating room and one recovery room and is equipped to support any surgery performed;
6. Has x-ray and laboratory diagnostic facilities;
7. Maintains a medical record for each patient; and
8. Has a written agreement with at least one Hospital for the immediate transfer of patients who develop complications or need Confinement.

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

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

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

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

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

Complications of Pregnancy also include non-elective cesarean section, termination of an ectopic pregnancy, and spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.)

Complications of Pregnancy do not include false labor, occasional spotting or Physician prescribed rest during the period of pregnancy, morning Sickness, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.

Confinement/Confined means an uninterrupted stay following admission to a health care facility. The readmission to a health care facility for the same or related condition, within a 7 day period, will be considered a continuation of the Confinement. Confinement does not include Observation Services, which is a review or assessment of 48 hours or less, of a condition that does not result in admission to a Hospital or health care facility.

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

Country of Assignment means the country in which an Eligible International Student, scholar or visiting faculty member is:

1. Temporarily residing; and
2. Actively engaged in education or educational research related activities sponsored by the National Association for Foreign Student Affairs or its Member Organizations.

Covered Injury/Injury means a bodily injury due to an unforeseeable, external event which results independently of disease, bodily infirmity or any other cause. All injuries sustained in any one Accident, all related conditions and recurrent symptoms of these injuries are considered a single Injury.

Covered Medical Expense means those Medically Necessary charges for any Treatment, service, and/or supplies referenced in the Covered Medical Expense provision that are:

1. Not in excess of the Maximum Allowance;
2. Not in excess of the amount You are personally responsible for paying pursuant to the Hospital's financial assistance policy;
3. Not in excess of the Usual, Customary, and Reasonable amount;
4. Not in excess of the amount that would have been paid in the absence of this Certificate;
5. Not more than the rates or fees established as payable pursuant to a direct contract; and
6. Incurred while this Certificate is in force, except with respect to any expenses payable under the Extension of Benefits Provision.

All charges are subject to all Exclusions, Limitations, and other provisions of this Certificate.

Covered Sickness/Sickness means an illness, disease or condition, including pregnancy and Complications of Pregnancy, that impairs Your normal function of mind or body and which is not the direct result of an Injury which results in Covered Medical Expenses. Covered Sickness includes Mental Health Disorders and Substance Use Disorders.

Custodial Care means care that is mainly for the purpose of meeting non-medical personal needs. This includes help with activities of daily living and taking medications. Activities of daily living include: bathing, dressing or grooming, eating, toileting, walking and getting in and out of bed. Custodial Care can usually be provided by someone without professional and medical skills or training.

Deductible means the dollar amount of Covered Medical Expenses You must incur before benefits are payable under this Certificate. The amount of the Deductible, if any, will be shown in the Schedule of Benefits. Expenses that are not eligible or amounts above any maximum benefit do not apply toward the Deductible.

Dependent means:

1. An Insured Student's lawful Spouse, or lawful Domestic Partner;
2. An Insured Student's dependent biological or adopted child or stepchild under age 26; and
3. An Insured Student's unmarried biological or adopted child or stepchild who has reached age 26 and who is:
 - a. primarily dependent upon the Insured Student for support and maintenance; and
 - b. incapable of self-sustaining employment by reason of developmental or physical disability, mental illness or disorder.

Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when an Insured Student enrolls a new disabled child under the plan.

Domestic Partner means the partner of an Insured Student who:

1. Is a mentally competent adult as is the Insured Student;
2. Has been legally domiciled with the Insured Student for at least 12 months;
3. Is not legally married to or legally separated from another individual;
4. Is the sole partner of the Insured Student and expects to remain so; and
5. Is jointly responsible with the Insured Student for each other's common welfare as evidenced by joint living arrangements, joint financial arrangements or joint ownership of real or personal property.

Durable Medical Equipment means a device which:

1. Is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of Sickness or Injury and is able to withstand repeated use;
2. Is used exclusively by You;
3. Is not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment;
4. Is suited for use in the home;
5. Can be expected to make a meaningful contribution to treating Your Sickness or Injury; and
6. Is prescribed by a Physician and the device is Medically Necessary for Rehabilitation.

Durable Medical Equipment does not include:

1. Comfort and convenience items;
2. Equipment that can be used by Immediate Family Members other than You;
3. Health exercise equipment; and
4. Equipment that may increase the value of Your residence.

Effective Date means the date coverage becomes effective.

Elective Surgery or Elective Treatment means those health care services or supplies not Medically Necessary for the care and Treatment of an Injury or Sickness. Elective surgery does not include Plastic, Cosmetic, or Reconstructive Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

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

Emergency Medical Condition means the sudden and, at the time, unexpected onset of a physical or mental health condition, including severe pain, manifesting itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe the absence of immediate medical attention to result in any of the following:

1. Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions, that there is:

1. Inadequate time to effect a safe transfer of the woman to another Hospital before delivery; or
2. A threat to the health or safety of the woman or unborn child if the woman were to be transferred to another Hospital.

Emergency Services means, with respect to an Emergency Medical Condition: transportation services, including but not limited to Ambulance Services, a medical screening examination that is within the capability of the emergency department, including ancillary services routinely available to the emergency department, and covered inpatient and outpatient services furnished by a Hospital, independent freestanding emergency department, or Physician qualified to furnish those services that are needed to evaluate or Stabilize an Emergency Medical Condition.

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

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

Experimental and Investigational services are medical procedures, equipment, medications, and cosmetic procedures that are not Medically Necessary and are not covered. These services are considered experimental and investigational if they meet any of the following criteria:

- The service does not have unrestricted market approval from the Food and Drug Administration (FDA) or final approval from any other governmental regulatory body.
- There is insufficient or inconclusive medical and scientific evidence to evaluate the service's therapeutic value.
- The service is not Medically Necessary and there is a safe and medically accepted alternative available.
- The service is a medical device established by the FDA as Category A, which are generally not covered because their safety and effectiveness have not yet been established.

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

Home Country means the Insured Student's country of citizenship. If the Insured Student has dual citizenship, the Insured Student's Home Country is the country of the passport the Insured Student used to enter the United States. The Insured Student's Home Country is considered the Home Country for any International Dependent of the Insured Student while insured under this Certificate.

Home Health Care Agency means an agency that:

1. Is constituted, licensed and operated under the provision of Title XVIII of the Federal Social Security Act, or qualified to be so operated if application was made, and certified by the jurisdiction in which the Home Health Care plan is established; and

2. Is engaged primarily in providing Skilled Nursing Facility services and other therapeutic services in Your home under the supervision of a Physician or a Nurse; and
3. Maintains clinical records on all patients.

Home Health Care means the continued care and Treatment if:

1. Your institutionalization would have been required if Home Health Care was not provided; and
2. Your Physician establishes and approves in writing the plan of Treatment covering the Home Health Care service; and
3. Home Health Care is provided by:
 - a. a Hospital that has a valid operating certificate and is certified to provide Home Health Care services; or
 - b. a public or private health service or agency that is licensed as a Home Health Care Agency under title 19, subtitle 4 of the General Health Article to provide coordinated Home Health Care.

Hospice: means a coordinated plan of home and inpatient care which treats the terminally ill patient and family as a unit. It provides care to meet the special needs of a family unit during the final stages of a terminal illness and during the bereavement. Care is provided by a team of: trained medical personnel, homemakers, and counselors. The team acts under an independent Hospice administration. It helps the family unit cope with: physical, psychological, spiritual, social, and economic stresses.

Hospital: A facility which provides diagnosis, Treatment, and care of persons who need acute inpatient Hospital care under the supervision of Physicians and provides 24-hour nursing service by Registered Nurses on duty or call. It must be licensed as a general acute care Hospital according to state and local laws. Hospital shall also include a psychiatric health facility for the Treatment of mental or psychoneurotic disorders. Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital also includes an Ambulatory Surgical Center or ambulatory medical center; and a birthing facility certified and licensed as such under the laws where located. It shall also include an Inpatient Rehabilitation Facility if such is specifically required for Treatment of physical disability.

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

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

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

Insured Person means an Insured Student or Dependent of an Insured Student while insured under this Certificate.

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

International Student means an international student:

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

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

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

Maximum Allowance is the maximum amount payable for a Covered Medical Expense. You are responsible for all amounts above what is considered the Maximum Allowance, as well as Your Deductible, Copayments and Coinsurance pursuant to the terms of this Certificate.

The Maximum Allowance for Inpatient and Outpatient Facility (Hospital/Ambulatory Surgical Centers) Covered Medical Expenses will be based upon the average of 150% of the Medicare allowable amount for the Covered Medical Expense and 135% of the cost of the Covered Medical Expense; provided, however, that any such Maximum Allowance based on the cost shall be limited to an amount not to exceed 175% of the Medicare allowable amount or the Usual, Customary, and Reasonable amount for the Covered Medical Expense.

The Maximum Allowance for the Treatment, service, and/or supply of Covered Medical Services other than Inpatient and Outpatient Facility Covered Medical Expenses will be paid as follows:

- Professional services - 125% of the Medicare allowable amount
- Specialist services - 140% of the Medicare allowable amount
- Diagnostic, Labs, Testing, and Imaging services - 100% of the Medicare allowable amount
- Immunizations/Vaccines, Durable Medical Equipment- 100% of the Medicare allowable amount

If a Medicare Allowable Amount does not exist for the Treatment, service, and/or supply, We will determine the Maximum Allowance based on the Usual, Customary, and Reasonable amount for the Covered Medical Expense.

In the event the Maximum Allowance exceeds the Actual Charge(s), We will pay the Actual Charge(s).

If a negotiated rate exists, the Maximum Allowance will be the negotiated rate.

Medically Necessary or Medical Necessity means health care services or products provided to the Insured Person for the purpose of preventing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

1. Consistent with “generally accepted standards of medical practice”;
2. Clinically appropriate in terms of type, frequency, extent, site and duration;
3. Demonstrated through scientific evidence to be effective in improving health outcomes;
4. Representative of “best practices” in the medical profession; and
5. Not primarily for the convenience of an Insured Person, Physician or other health care provider and not more costly than an alternative setting, service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or Treatment of an Insured Person’s illness, Injury or disease.

Mental Health Disorder Benefits means benefits, with respect to items or services for Mental Health Disorders, which include all conditions covered under the plan, except for Substance Use Disorders, that fall under any of the diagnostic categories listed in the mental, behavioral, and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the ICD or that are listed in the most current version of the DSM.

Mental Health Professionals will include services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker as Medically Necessary.

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

1. Is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and

2. Provides medical services which are within the scope of the Nurse's license or certificate who does not ordinarily reside in Your home or is not related to You by blood or marriage.

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

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

Out-of-Pocket Maximum means the most You will incur during a Policy Year before Your coverage begins to pay 100% of the Maximum Allowance for Covered Medical Expenses. Refer to the Out-of-Pocket Maximum in the Description of Benefits section for details on how the Out-of-Pocket Maximum applies.

The following expenses may not count toward the Out-of-Pocket Maximum and will not be paid at 100%, even when the Out-of-Pocket Maximum has been met:

- Premium
- Charges in excess of the Maximum Allowance;
- Charges in excess of the Usual, Customary, and Reasonable amount;
- Expenses incurred for non-covered services; and
- Pre-certification Penalties.

Physical Therapy means any form of the following:

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

Physician means a health care professional including, but not limited to, naturopathic doctors, Pastoral counselors, marriage and family therapists, licensed clinical social workers, certified nurse practitioner, certified midwife, certified nurse midwife, clinical counseling professionals, psychologist, psychiatric nurses, dentist, independent practice dental hygienists, dental hygiene therapist, registered nurse first assistant, and certified registered nurse anesthetists, practicing within the scope of his or her license and is duly licensed by the appropriate state regulatory agency to perform a particular service which is covered under this Certificate, and who is not:

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

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

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

Qualifying Life Event means an event that qualifies a student to apply for coverage for him/herself or for the Insured Student's Dependent due to a Qualifying Life Event under this Certificate.

Rehabilitation means the process of restoring Your ability to live and work after a disabling condition by:

1. Helping You achieve the maximum possible physical and psychological fitness;
2. Helping You regain the ability to care for Yourself;
3. Offering assistance with relearning skills needed in everyday activities, with occupational training and guidance with psychological readjustment.

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

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

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

1. Mainly provides inpatient care and Treatment for persons who are recovering from a Sickness or Injury;
2. Provides care supervised by a Physician;
3. Provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. Is not a place primarily for the care of the aged, Custodial or Domiciliary Care, or Treatment of alcohol or drug dependency; and
5. Is not a rest, educational, or custodial facility or similar place.

Sound, Natural Teeth means natural teeth. The major portion of a tooth must be present, regardless of fillings, and not carious, abscessed or defective. Sound, Natural Teeth will not include capped teeth.

Spouse means an eligible individual who is legally married to the Insured Student under the laws of the state or jurisdiction in which the marriage was performed. A Spouse also includes the Insured Student's domestic partner with whom an affidavit of domestic partnership has been established, attesting to the relationship with another person.

Stabilize/Stabilization means, with respect to an Emergency Medical Condition, to provide such medical Treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Substance Use Disorder Benefits means benefits, with respect to items or services for Substance Use Disorders, which include all disorders covered under the plan that fall under any of the diagnostic categories listed as a mental or behavioral disorder due to psychoactive substance use (or equivalent category) in the mental, behavioral and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the ICD or that are listed as a Substance Related and Addictive Disorder (or equivalent category) in the most current version of the DSM.

Surgeon means a Physician who actually performs surgical procedures.

Telemedicine or Telehealth means the practice of health care delivery, diagnosis, consultation, Treatment, transfer of medical data, and education using interactive audio, video, or data communications involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information. Neither a telephone conversation nor an electronic messaging between a Physician and You constitutes "Telemedicine".

Total Disability or Totally Disabled, as it applies to the Extension of Benefits provision, means:

- 1) Your complete inability to engage in the everyday duties involved in the daily activities You performed prior to Your Covered Injury or Covered Sickness (work, school, housekeeping, etc.);
- 2) With care and Treatment by a Physician for the Covered Injury or Covered Sickness causing the disability.

Treatment means the medical care of a Covered Injury or Covered Sickness by a Physician who is operating within the scope of his or her license. Such care includes diagnostic, medical, surgical or therapeutic services, medical advice, consultation, recommendation, and/or the taking of drugs or medicines or the prescriptions thereof.

Urgent Care means short-term medical care performed in an Urgent Care Center for non-life-threatening conditions that can be mitigated or require care within 48 hours of onset.

Urgent Care Center is a category of walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency department. Urgent Care Centers primarily treat non-life-threatening conditions that require immediate care but are not serious enough to require an emergency department visit.

Usual, Customary, and Reasonable means eligible Covered Medical Expenses identified by Us to be the Usual, Customary, and Reasonable amount payable for the Treatment, service, and/or supply taking into consideration the fee(s) which the Hospital or Physician most frequently charges and/or accepts as payment for the Treatment, service, and/or supply from the majority of its patients, the cost to the Hospital or Physician for providing the Treatment, service, and/or supply, the prevailing range of fees charged and/or accepted for the Treatment, service, and/or supply by a Hospital or Physician of similar training and experience in the same geographic locale or area, the Medicare reimbursement rates for the Treatment, service, and/or supply, the method CMS uses to set Medicare rates, and the Medicare cost data as reflected in the applicable provider's cost report(s).

The term(s) "same geographic locale" and/or "area" mean a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of persons or organizations rendering such Treatment, service and/or supplies for which a specific charge is made or for which a reimbursement is accepted. To be Usual, Customary, and Reasonable, fee(s) must be in compliance with generally accepted billing practices for unbundling, multiple procedures, and not otherwise excluded under the terms of this Certificate.

You, or Your(s) means an Insured Person, Insured Student, or Dependent of an Insured Student while insured under this Certificate.

Visa means the document issued by the United States Government that permits an individual to participate in the educational activities of a college, university or other institution of higher learning either as a student or in another academic capacity. An International Student must have and maintain a valid Visa, either an F-1 (Academic), J-1 (Exchange) or M-1(Vocational) in order to continue as a student in the United States.

We, Us, or Our means Wellfleet Insurance Company or its authorized agent. Also referred to as the Company.

SECTION IV – HOW THE PLAN WORKS AND DESCRIPTION OF BENEFITS

Schedule of Benefits

The following are shown in the Schedule of Benefits:

- Deductible;
- Any specified benefit maximums;
- Coinsurance percentages;
- Copayment amounts; and
- Out-of-Pocket Maximums.

How the Deductible Works

Medical Deductible

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

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

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

How Your Out-of-Pocket Maximum Works

The Out-of-Pocket Maximums are shown in the Schedule of Benefits. The Out-of-Pocket Maximum is the amount of

Covered Medical Expenses the Insured Person has to incur before Covered Medical Expense will be paid at 100% for the remainder of the Policy Year, subject to any benefit maximums or limits that may apply. Any applicable Coinsurance amounts, Deductibles, and Copayments will apply toward the Out-of-Pocket Maximum.

Expenses that are not Covered Medical Expenses:

- Premium;
- Charges in excess of the Maximum Allowance;
- Charges in excess of the Usual, Customary, and Reasonable amount;
- Expenses incurred for non-covered services.

do not count toward meeting the Out-of-Pocket Maximum.

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

Individual

Once the amount of the Copayments, Coinsurance, and Deductibles the Insured Student and the Insured Student's covered Dependents have incurred for Covered Medical Expenses during the Policy Year meets the individual Out-of-Pocket Maximum, this plan will pay 100% of the Maximum Allowance for Covered Medical Expenses that apply towards the limits for the rest of the Policy Year for that covered individual.

Family

Once the amount of the Copayments, Coinsurance, and Deductibles the Insured Student and the Insured Student's covered Dependents have incurred for Covered Medical Expenses during the Policy Year meets the family Out-of-Pocket Maximum, this plan will pay 100% of the Maximum Allowance for Covered Medical Expenses that apply towards the limits for the rest of the Policy Year for all covered family members.

To satisfy this family Out-of-Pocket Maximum for the rest of the Policy Year, the following must happen:

- The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all covered family members. The family Out-of-Pocket Maximum can be met by a combination of covered family members with no single individual within the family contributing more than the individual Out-of-Pocket Maximum amount in a Policy Year.

The Out-of-Pocket Maximum is the maximum amount of Covered Medical Expenses the Insured Person is responsible to incur during the Policy Year. This plan has an individual and family Out-of-Pocket Maximum.

Essential Health Benefits

Essential Health Benefits are not subject to annual or lifetime dollar limits. If additional specific care, Treatment or services are added to the list of Essential Health Benefits by a governing authority, the Certificate benefits will be amended to comply with such changes.

Treatment of Covered Injury and Covered Sickness Benefit

If:

1. You incur expenses as the result of Covered Injury or Covered Sickness, then
2. We will pay the benefits stated in the Schedule of Benefits for the services, Treatments, and supplies described in the Covered Medical Expenses provision below.

Payment will be made, subject to the Coinsurance, Deductible, Copayment, maximums, and limits as stated in the Schedule of Benefits:

1. For the Maximum Allowance for Covered Medical Expenses that are incurred as the result of a Covered Injury or Covered Sickness; and
2. Subject to the Exclusions and Limitations provision.

Pre-Certification Process

The Schedule of Benefits identifies Covered Medical Expenses which must be Pre-Certified by Us. Notifying Us before these Covered Medical Expenses are received, allows Us to determine Medical Necessity and medical appropriateness.

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

For a list of services or supplies requiring Pre-Certification please refer to the Schedule of Benefits.

Initial Determinations: The Insured Person's and their Physician will be notified of Our decision as follows:

1. Requests by a provider for prior authorization of a nonemergency service must be answered by Us within 72 hours or 2 business days, whichever is less. If We do not grant or deny a request for prior authorization within these timeframes, the request is granted.
2. Both the provider and the Insured Person, on whose behalf the authorization was requested, will be notified of Our decision by telephone and/or in writing.
3. If the information submitted is insufficient to make a decision, We will notify the provider within 2 business days of the additional information necessary to render a decision.

Urgent Care:

1. We will make a determination (whether adverse or not), and notify the Insured Person no later than 24 hours after receiving all necessary information. We must notify the Insured Person, the Insured Person's designee if applicable, and the provider of Our coverage decision
2. We shall make a good faith effort to obtain all necessary information expeditiously and will be responsible for expeditious retrieval of necessary information.

Concurrent review determinations:

1. We will make a determination within 1 working day after obtaining all necessary information.
2. For a Certification of Extended stay or additional services: We shall notify the Insured Person and the provider rendering the service within 1 working day. Written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.
3. For an Adverse Benefit Determination of concurrent We shall notify the Insured Person and the provider rendering the service within 1 working day. The provider shall continue the service without liability to the Insured Person until the Insured Person has been notified of the determination.

Notice of an Adverse Determination made by Our agent will be in writing and will include:

1. the principal reason or reasons for the decision;
2. reference to the specific plan provisions on which the decision is based;
3. information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount if applicable), and a statement that the diagnosis code and its corresponding meaning, and the Treatment code and its corresponding meaning, will be provided upon request;
4. a description of any additional material or information necessary for the Insured Person to perfect the claim and an explanation as to why such material or information is necessary;
5. the instructions and time limits for initiating an appeal or reconsideration of the decision;

6. if the adverse health care Treatment decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the plan to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
7. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse health care Treatment decision, either the specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse decision and explaining that a copy will be provided free of charge to the Insured Person upon request;
8. a phone number the Insured Person may call for information on and assistance with initiating an appeal or reconsideration and/or requesting clinical rationale and review criteria;
9. a description of the expedited review process applicable to claims involving Urgent Care;
10. the availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act;
11. notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under a carrier's internal review process. In addition, an explanation of benefits (EOB) must comply with the requirements of 24-A M.R.S.A. §4303(13) and any rules adopted pursuant thereto; and
12. any other information required pursuant to the federal Affordable Care Act.

Language and culture. All notices to applicants, enrollees and policyholders or certificate holders subject to the requirements of the federal Affordable Care Act must be provided in a culturally and linguistically appropriate manner consistent with the requirements of the federal Affordable Care Act. Please consult phone number listed on Your ID card for assistance.

When Pre-Certification is approved, Your Physician will be notified of Our decision as follows:

1. For elective (non-emergency) admissions to a health care facility, We will notify the Physician and the health care facility by telephone and/or in writing of the number of inpatient days, if any, approved;
2. For Confinement in a health care facility longer than the originally approved number of days, the treating Physician or the health care facility must contact Us before the last approved day. We will review the request for continued stay to determine Medical Necessity and notify the Physician or the health care facility of Our decision by telephone and in writing;
3. For any other covered services requiring Pre-Certification, We will contact the Provider in writing or by telephone regarding Our decision.

For newly Insured Persons with a previously approved Pre-Certification, We will accept the approved Pre-Certification with documentation from the health care provider for at least 60 days.

If Pre-Certification is not approved, notification of Our decision will be provided by telephone, by fax to a verified number, or by electronic mail to a secure electronic mailbox to the attending health care professional and Hospital or Physician's office as applicable. Written notification will also be sent if notification occurred by telephone.

The Insured Person will be notified in writing regarding Our decision.

Failure by Our agent to make a determination within the time periods prescribed shall be deemed to be an Adverse Benefit Determination subject to an appeal.

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

Covered Medical Expenses

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

Preventive Services

The following services shall be covered without regard to any Deductible, Coinsurance, or Copayment requirement that would otherwise apply.

1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. Immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
4. With respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
5. Outpatient/office contraceptive services are covered, provided that the services are related to the use of FDA approved contraceptives. Examples of covered contraceptive services are: office visits, consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referral, counseling, and services related to the use of federal legend oral contraception or IUD insertion, diaphragm fitting, vasectomy or contraceptive injections. Please note that prescription and nonprescription contraceptive drugs and devices (such as oral contraceptives, IUDs, diaphragms, and contraceptive injections) are covered under the Prescription Drug Benefit. See Prescription Drugs for information on those services and devices.

A list of Preventive Services can be found at: [Preventive health services | HealthCare.gov](https://www.healthcare.gov/preventive-health-services/)

If the covered Preventive Service is provided during a Physician’s Office Visit and it is billed separately from the office visit, You may be responsible for any Deductible, Coinsurance and/or Copayment applicable to the Physician’s Office Visit only. If the Physician’s Office Visit and the covered Preventive Service are billed together and the primary purpose of the visit was not the Preventive Service, You may be responsible for any Deductible, Coinsurance and/or Copayment applicable to the Physician’s Office Visit, including the covered Preventive Service.

Important Notes:

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

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

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

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

Inpatient Services

1. Hospital Care - Covered Medical Expenses include the following:

- Room and Board Expenses, including general nursing care. Benefits may not exceed the daily semi-private room rate unless intensive care unit is required.
- Intensive Care Unit, including 24-hour nursing care.
- Hospital Miscellaneous Expenses, while Hospital Confined or as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as:
 - a. The cost for use of an operating room;
 - b. Prescribed medicines (excluding take-home drugs);
 - c. Laboratory tests;
 - d. Therapeutic services;
 - e. X-ray examinations;
 - f. Casts and temporary surgical appliances;
 - g. Oxygen, oxygen tent; and
 - h. Blood and blood plasma.

2. Preadmission Testing for routine tests performed as a preliminary to Your being admitted to a Hospital. These tests must be performed within 5 working days prior to admission. This benefit is limited to routine tests such as complete blood count, urinalysis, and chest x-rays. Unless otherwise payable under this Certificate, We will pay for major diagnostic procedures under the Hospital Miscellaneous Expenses benefit. This includes tests such as CAT scans, cardiac catheterization, MRI's, NMR's, and blood chemistries.

3. Physician's Visits while Confined. Physician's visits will be paid for either inpatient or outpatient visits when incurred on the same day, but not both. Surgeon's fees are not payable under this benefit.

4. Skilled Nursing Facility Benefit for services received in a licensed Skilled Nursing Facility. Services must be Medically Necessary. Confinement for Custodial Care or residential care is not covered.

5. Inpatient Rehabilitation Facility Expense Benefit for the services, supplies and Treatments rendered to You in an Inpatient Rehabilitation Facility. You must enter an Inpatient Rehabilitation Facility:

- a. After being discharged from a Hospital Confinement for a Covered Sickness or Coverage Injury; and
- b. The services, supplies and Treatments rendered at the Inpatient Rehabilitation Facility must be related to the same Covered Sickness or Covered Injury.

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

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

6. Physical Therapy while Confined when prescribed by the attending Physician.

Mental Health Disorder and Substance Use Disorder Benefits

1. Inpatient and Outpatient Mental Health Disorder Benefits for Treatment of Mental Health Disorders as specified on the Schedule of Benefits. This includes:

Autism Spectrum Disorders Benefit for an Insured Person as follows:

Assessments, evaluations or tests by a licensed Physician or psychologist to diagnose whether an individual has an Autism Spectrum Disorder;

- a. Treatment of Autism Spectrum Disorders when determined by a licensed Physician or psychologist that the Treatment is Medically Necessary health care; a licensed Physician or psychologist may be required to demonstrate ongoing Medical Necessity for coverage provided at least annually;
- b. We will cover prescription drugs for the Treatment of Autism Spectrum Disorders in the same manner as coverage for prescription drugs for Treatment of any other illness or condition; and

Treatment of Autism Spectrum Disorders includes the following types of care prescribed, provided or ordered for an Insured Person diagnosed with an Autism Spectrum Disorder:

- a. Habilitative or Rehabilitative services, including Applied Behavior Analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an Insured Person to the extent possible. To be eligible for coverage, Applied Behavior Analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;
- b. Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and
- c. Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist.

As used in this benefit:

Applied Behavior Analysis means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Autism Spectrum Disorders means any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

2. **Inpatient and Outpatient Substance Use Disorder Benefits** for Treatment of Substance Use Disorders as specified on the Schedule of Benefits.

Professional and Outpatient Services

SURGICAL EXPENSES

1. **Inpatient and Outpatient Surgery including Surgeon, Anesthetist, and Assistant Surgeon Services** (including pre- and post-operative visits) as specified in the Schedule of Benefits. Covered surgical expenses will be paid under either the Inpatient Surgery benefit or the Outpatient Surgery benefit. They will not be paid under both. This benefit is not payable in addition to Physician's Visits.

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

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

- b. **Through Different Incisions.** If covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
 - For the procedure with the highest allowed amount; and
 - 50% of the amount We would otherwise pay for the other procedures.
- 2. **Outpatient Surgical Facility and Miscellaneous** expenses benefit. Benefits will be paid for services and supplies, including:
 - a. Operating room;
 - b. Therapeutic services;
 - c. Oxygen, oxygen tent; and
 - d. Blood transfusions, which include blood and blood plasma, and blood plasma expanders, and administrative costs of autologous blood pre-donations.
- 3. **Abortion Expense** for the expense of an elective, non-therapeutic, abortion.
- 4. **Bariatric Surgery** (to treat morbid obesity) when it is Medically Necessary. Surgery is limited to an intestinal bypass, gastric bypass, or gastroplasty. This benefit requires prior approval.
- 5. **Organ Transplant Surgery**
Recipient Surgery for Medically Necessary, non-Experimental and non-Investigational solid organ, bone marrow, stem-cell or tissue transplants. We will provide benefits for the Hospital and other Covered Medical Expenses when You are the recipient of an Organ Transplant.

Donor's Surgery for Medically Necessary transplant services required by the Insured Person who serves as an organ donor only if the recipient is also an Insured Person. We will not cover the transplant services of a non-Insured Person acting as a donor for an Insured Person if the non-Insured Person's expenses will be covered under another health plan or program.

Travel Expenses when the facility performing the Medically Necessary transplant is located more than 200 miles from Your residence, coverage will be provided for lodging, meals and transportation expenses (coach class only) subject to the maximum benefits shown on the Schedule of Benefits.

Non-Covered Services for transportation and lodging include, but are not limited to:

- a. Child care;
 - b. Mileage within the medical transplant facility city;
 - c. Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us;
 - d. Frequent Flyer miles;
 - e. Coupons, Vouchers, or Travel tickets;
 - f. Prepayments or deposits;
 - g. Services for a condition that is not directly related or a direct result of the transplant;
 - h. Telephone calls;
 - i. Laundry;
 - j. Postage;
 - k. Entertainment;
 - l. Interim visits to a medical care facility while waiting for the actual transplant procedure;
 - m. Travel expenses for donor companion/caregiver;
 - n. Return visits for the donor for a Treatment of condition found during the evaluation.
- 6. **Human Leukocyte Antigen Testing** for laboratory fees arising from human leukocyte antigen testing performed to establish bone marrow transplantation subject to the limits shown on the Schedule of Benefits.

7. **Reconstructive Surgery** covers all stages of reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and Treatment of physical complications for all stages of mastectomy, including lymphedemas. This benefit also covers cosmetic surgery specifically and solely for: Reconstruction due to bodily Injury, infection or other disease of the involved part; or for a congenital anomaly of a Dependent child which resulted in a functional impairment.

OTHER PROFESSIONAL SERVICES

1. **Gender Affirming Services Benefit** for Medically Necessary expenses incurred for services and supplies provided in connection with gender affirming Treatment when You have been diagnosed with gender identity disorder or gender dysphoria. Covered Medical Expenses include the following:
 - a. Counseling by qualified mental health professional;
 - b. Hormone therapy, including monitoring of such therapy;
 - c. Gender affirming surgery and procedures.
2. **Home Health Care Expenses** for Your Home Health Care when, otherwise, hospitalization or Confinement in a Skilled Nursing Facility would have been necessary. This does not include Private Duty Nursing.

Home Health Care Services will include:

- a. Visits by a Registered Nurse or licensed practical nurse to carry out Treatments prescribed, or supportive nursing care and observation as indicated.
- b. A Physician's home or office visits or both.
- c. Visits by a registered physical, speech, occupational, home infusion, inhalation or dietary therapist for services or for evaluation of, consultation with and instruction of nurses in carrying out such therapy prescribed by the attending Physician, or both.
- d. Any prescribed laboratory tests and x-ray examination using Hospital or community facilities, drugs, dressings, oxygen or medical appliances and equipment as prescribed by a Physician, but only to the extent that such charges would have been covered under the contract if the Insured had remained in the Hospital.
- e. Visits by persons who have completed a home health aide training course under the supervision of a Registered Nurse for the purpose of giving personal care to the patient and performing light household tasks as required by the plan of care, but not including services.

This does not include benefits for services or charges for custodial, domiciliary or convalescent care.

3. **Hospice Care Coverage** when, as the result of a Covered Injury or Covered Sickness, You require Hospice Care, We will pay the Covered Medical Expenses incurred for such care. You must have been diagnosed with a terminal illness by a licensed Physician. You must have elected to receive palliative rather than curative care. Any required documentation will be no greater than that required for the same services under Medicare.

Benefits include respite care. Respite care allows the person who regularly assists the Insured Person at home, either a family member, or other nonprofessional, to have personal time solely for relaxation. The Insured Person may then need a temporary replacement to provide Hospice Care.

OFFICE VISITS

1. **Physician's Office Visits.** Physician's Visits include second surgical opinions, specialists, and consultant services. Benefits will be paid for either outpatient or inpatient visits on the same day, but not both. Surgeon fees are NOT payable under this benefit. Physician office visits for a specific health concern that includes preventive health services may not be greater than the applicable cost share specified in the Schedule of Benefits. Benefits include services provided in a rural health clinic.

2. **Telemedicine or Telehealth Services Benefit** for health care delivery, diagnosis, consultation, or Treatment provided to You by a Physician.
3. **Acupuncture Services** that are Medically Necessary and provided by a Physician licensed to perform such services.
4. **Allergy Testing and Treatment, including injections.** This includes tests that You need such as PRIST, RAST, and scratch tests. Also, includes Treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications and asthma not responding to usual Treatments. This also includes the administration of allergy therapy, injections, allergy serum, and supplies used for allergy therapy.
5. **Chiropractic Care Benefit** for Treatment of a Covered Injury or Covered Sickness and performed by a Physician (including chiropractor, allopathic, or osteopathic doctor) for therapeutic, adjustive and manipulative services.
6. **Tuberculosis (TB) screening, Titers, QuantiFERON B tests including shots** (other than covered under Preventive Services) when required by the School for high risk Insured Persons.

Emergency Services, Ambulance and Non-Emergency Services

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

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

In case of a medical emergency:

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

2. **Urgent Care Centers (non-life-threatening conditions)** for services provided at an Urgent Care Center, as shown in the Schedule of Benefits. In the case of a life-threatening condition, You should go to the nearest emergency room.
3. **Emergency Ambulance Service**, with respect to an Emergency Medical Condition, for ground transportation to a Hospital by a licensed Ambulance. Transportation from a facility to Your home is not covered.

Your plan also covers transportation to a Hospital by professional air Ambulance or water Ambulance when:

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

4. **Non-Emergency Ambulance Expenses** for Medically Necessary transportation by a licensed Ambulance, whether by ground or air Ambulance (fixed wing) (as appropriate), when the transportation is:

- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective acute care Hospital/facility; or
- From an acute care Hospital/facility to a sub-acute setting.

Transportation from a facility to Your home is not covered.

Diagnostic Laboratory, Radiology, Testing and Imaging Services

1. Diagnostic Complex Imaging Services

Covered Medical Expenses include complex imaging services provided by a provider, including but not limited to:

- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including Magnetic resonance spectroscopy (MRS), Magnetic resonance venography (MRV) and Magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including positron emission tomography (PET) scans

2. Diagnostic Laboratory, Radiological Services and Testing (Outpatient)

Covered Medical Expenses include diagnostic radiological services (other than diagnostic complex imaging), laboratory services, and pathology services and other tests. This includes Breast Tomosynthesis testing, including digital breast related tomography and ultrasound studies. Genetic and Biomarker testing are also included.

- 3. Chemotherapy and Radiation Therapy** for chemotherapy, oral chemotherapy drugs, and radiation therapy to treat or control a serious illness.
- 4. Infusion Therapy** for the administration of antibiotics, nutrients, or other therapeutic agents by direct infusion.

Rehabilitation and Habilitation Therapies

- 1. Cardiac Rehabilitation.** Benefits are available for Outpatient cardiac Rehabilitation programs. Covered Medical Expenses include exercise and education under the direct supervision of skilled program personnel in the intensive Rehabilitation phase of the program.

No benefits are available for portions of a cardiac Rehabilitation program extending beyond the intensive Rehabilitation phase. On-going or life-long exercise and education maintenance programs intended to maintain fitness or to reinforce permanent lifestyle changes are not covered.

- 2. Pulmonary Rehabilitation.** Benefits are available for pulmonary Rehabilitation services as part of an inpatient Hospital stay if it is part of a Treatment plan ordered by a Physician. A course of outpatient pulmonary Rehabilitation may also be eligible for coverage if it is performed at a Hospital, Skilled Nursing Facility, or Physician's office, is used to treat reversible pulmonary disease states, and is part of a Treatment plan ordered by a Physician.
- 3. Rehabilitation Therapy** when prescribed by the attending Physician, limited to 1 visit per day.
- 4. Habilitation Services** when prescribed by the attending Physician, limited to 1 visit per day.

Other Services and Supplies

- 1. Covered Clinical Trials** benefits will be paid for Routine Patient Care Costs for items and services furnished in connection with participation in an Approved Clinical Trial if:
 - a. The Insured Person has a life-threatening illness for which no standard Treatment is effective;

- b. The Insured Person is eligible to participate according to the clinical trial protocol with respect to Treatment of such illness;
- c. The Insured Person's participation in the trial offers meaningful potential for significant clinical benefit; and
- d. The Insured Person's referring Physician has concluded that participation in such a trial would be appropriate based upon the satisfaction of the conditions in paragraphs a, b and c.

As used in this benefit:

Approved Clinical Trial means a clinical research study or clinical investigation approved and funded by the federal Department of Health and Human Services, National Institutes of Health or a cooperative group or center of the National Institutes of Health.

Routine Patient Care Costs means coverage for reasonable and Medically Necessary services needed to administer the drug or device under evaluation in the clinical trial. Routine Patient Care Costs include all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

- a. The investigational item or service itself;
- b. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- c. Items and services customarily provided by the research sponsors free of charge for any Insured Person in the trial.

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

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

- Insulin preparations
- Foot care to minimize the risk of infection
- Injection aids for the blind
- Diabetic test agents
- Prescribed oral medications whose primary purpose is to control blood sugar
- Injectable glucagon
- Glucagon emergency kits
- Control solutions used in blood glucose monitors
- Diabetes data management systems for management of blood glucose
- Cartridges for the visually impaired
- Disposable insulin cartridges and pen cartridges
- Insulin pumps and equipment for the use of the pump including batteries
- Insulin infusion devices
- Oral agents for treating hypoglycemia such as glucose tablets and gels
- Glucagon for injection to increase blood glucose concentration
- Other diabetes equipment and related supplies that are Medically Necessary for the Treatment of diabetes

Equipment

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

Training

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

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

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

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

3. **Dialysis Treatment** of an acute or chronic kidney ailment, provided in an Outpatient facility of a Hospital, a free-standing renal Dialysis facility or in Your home. Covered Medical Expenses for home Treatment will include equipment, training and medical supplies. Private Duty Nursing is not covered.
4. **Durable Medical Equipment** for the rental or purchase of Durable Medical Equipment, including, but not limited to, Hospital beds, wheelchairs, walkers, braces that stabilize an injured body part and braces to treat curvature of the spine. We will pay the lesser of either the rental or purchase charges, but not both. Such equipment must be prescribed by a Physician and a copy of the written prescription must accompany the claim. Durable Medical Equipment must:
 - a. Be primarily and customarily used to serve a medical, rehabilitative purpose;
 - b. Be able to withstand repeated use; and
 - c. Generally, not be useful to a person in the absence of Injury or Sickness.
5. **Enteral Formulas and Nutritional Supplements** Covered Medical Expenses prescribed by a Physician used to treat malabsorption of food caused by:
 - Crohn’s Disease
 - Ulcerative colitis
 - Gastroesophageal reflux
 - Gastrointestinal motility;
 - Chronic intestinal pseudo-obstruction
 - Phenylketonuria
 - Eosinophilic gastrointestinal disorders
 - Inherited diseases of amino acids and organic acids
 - Multiple severe food allergies
 - Branched-chain ketonuria,
 - Galactosemia
 - Homocystinuria

Covered benefits also include parenteral therapy and food products modified to be low in protein for inherited diseases of amino acids and organic acids. For purposes of this benefit, “low protein modified food product” means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary Treatment of any inherited metabolic illness. Low protein modified food products do not include foods that are naturally low in protein. Benefits include formulas for inborn errors of metabolism.

6. **Hearing Aids** Covered Medical Expenses include prescribed hearing aids and hearing aid devices as described below. Benefits are limited as shown in the Schedule of Benefits.
Hearing aid means:

- Any wearable, non-disposable instrument or device designed to aid impaired human hearing
- Parts, attachments, or accessories

Hearing aid services are:

- Audiometric hearing exam and evaluation for a hearing aid prescription performed by:
 - A physician certified as an otolaryngologist or otologist
 - An audiologist who is legally qualified in audiology, or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a prescription written during a covered hearing exam
- Any other related services necessary to access, select and adjust or fit a hearing aid.

The following are not covered under this benefit:

- Batteries or cords
- Replacement parts or repairs to a hearing aid
- Other assistive listening devices including frequency modulation systems.

7. **Infertility Treatment Benefit** for the Diagnosis and Treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease or dysfunction or a correctable medical condition otherwise covered under this Certificate.

In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, and the American Society for Reproductive Medicine. All services must be provided by Physicians who are qualified to provide such infertility services in accordance with these guidelines.

Infertility services provided to an Insured Person who is an appropriate candidate for infertility Treatment include, but are not limited to:

- Initial evaluation;
- Semen analysis;
- Evaluation of ovulatory function;
- Postcoital test;
- Endometrial biopsy;
- Pelvic ultrasound;
- Hysterosalpingogram;
- Sonohysterogram;
- Testis biopsy;
- Hormone level testing;
- Laparoscopy;
- Hysteroscopy;
- Vesiculography;
- Epididymography;
- Treatment of ovulatory dysfunction;
- Costs for an ovum donor or donor sperm;
- Ovulation induction and monitoring;
- Artificial insemination;
- Intracytoplasmic sperm injections;
- Salpingectomy (complete or partial, unilateral or bilateral)

Benefits for any combination of gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or fresh or frozen embryo transfer (FET) may be limited to two lifetime cycles.

8. Fertility Preservation Benefit

Fertility preservation is covered for iatrogenic causes. Fertility preservation involves the retrieval of mature eggs/sperm with or without the creation of embryos that are frozen for future use. Covered Medical Expenses include services for fertility preservation provided when You:

- are believed to be fertile, with or without a partner.
- have planned services or treatment that are proven to result in infertility such as:
 - Surgery, Chemotherapy or radiation therapy that is established in medical literature to result in infertility
 - Other gonadotoxic therapies
 - Removal of the uterus
 - Removal of both ovaries or testicles

Fertility preservation means procedures to preserve fertility that are consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology.

Coverage under this benefit includes the procurement and cryopreservation of embryos, eggs, sperm, and reproductive material determined not to be an experimental infertility procedure. Storage shall be covered from the time of cryopreservation for duration of the Policy Term. Storage fees are non-medical expenses that are not routinely covered.

9. Maternity Benefit for maternity charges as follows:

a. Routine prenatal care

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

Home Births are also covered when services are rendered by a licensed Nurse midwife.

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

- c. Inpatient Physician charges or Surgeon charges** will be covered the same as for any other Covered Sickness for both mother and newborn child.

d. Physician-directed Follow-up Care including:

1. Physician assessment of the mother and newborn;
2. Parent education;
3. Assistance and training in breast or bottle feeding;
4. Assessment of the home support system;
5. Performance of any prescribed clinical tests; and
6. Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric obstetrical and nursing professionals.

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

- e. **Outpatient Physician’s visits** will be covered the same as for any other Covered Sickness.
 - f. **Pasteurized Donated Human Breast Milk:** We will pay benefits for Medically Necessary expenses incurred for pasteurized donated human breast milk provided to an infant eligible for coverage under this Certificate, if a Physician, licensed Physician assistant, or licensed advanced practice registered nurse signs an order that the infant is medically or physically unable to receive maternal breast milk or participate in breastfeeding or the infant's parent is medically or physically unable to produce maternal breast milk in quantities sufficient for the infant
- 10. **Prosthetic and Orthotic Devices** to replace all or part of a body organ, or replace all or part of the function of a permanently inoperative, absent, or malfunctioning body part when Medically Necessary and prescribed by a Physician.
 - 11. **Prosthetic Devices (Arm and Leg)** includes external devices that replace a missing arm or leg when Medically Necessary and prescribed by a Physician. This includes coverage of a prosthetic device for an Insured Person under age 18 for recreational purposes to maximize the ability to ambulate, run, bike and swim to maximize upper limb function.
 - 12. **Pediatric Autoimmune Neuropsychiatric Disorders (PANS and PANDA)** coverage includes Medically Necessary diagnosis, evaluation, and treatment of pediatric autoimmune neuropsychiatric disorders (PANDAS) associated with streptococcal infections; and pediatric acute onset neuropsychiatric syndrome (PANS), including off-label use drug treatment and use of intravenous immunoglobulin therapy (IVIG).
 - 13. **Accidental Injury Dental Treatment** as the result of Injury to Sound, Natural Teeth. Routine dental care and Treatment are not payable under this benefit. Damage to teeth due to chewing or biting is not deemed an accidental Injury and is not covered.
 - 14. **Sickness Dental Expense Benefit** when, by reason of Sickness, You require Treatment for impacted wisdom teeth or dental abscesses, We will pay the Covered Medical Expenses incurred for the Treatment.
 - 15. **Treatment for Temporomandibular Joint (TMJ) Disorders** for Treatment provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.
 - 16. **Anesthesia and Facility Charges for Dental Procedures** for general anesthesia and facility charges for dental procedures rendered in a Hospital when the clinical status or underlying medical condition of the Insured Person required dental procedures that ordinarily would not require general anesthesia to be rendered in a Hospital. This benefit is payable only for the following:
 - Insured Persons, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental Treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental Treatment under general anesthesia can be expected to produce a superior result;

- Insured Persons demonstrating dental Treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy;
- Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs or such magnitude that Treatment should not be postponed or deferred and for whom lack of Treatment can be expected to result in dental or oral pain or infection, Loss of teeth or other increased oral or dental morbidity; and
- Insured Persons who have sustained extensive oral-facial or dental trauma for which Treatment under local anesthesia would be ineffective or compromised.

This benefit does NOT include the cost of the actual dental procedures or dentist's fees. If an Insured Person is also eligible for coverage for general anesthesia and associated facility charges under a dental insurance policy or contract, the contract providing such care will be the primary payer responsible for those charges. We will be considered the secondary payer of such expenses.

17. Dental Care for Cancer Patients. Benefits will be paid for Medically Necessary dental procedures, laboratory assessments, medications and Treatment for an Insured Person who has been diagnosed with cancer. Covered Medical Expenses includes:

- Fluoride treatment and dental procedures to reduce the risk of infection or eliminate infection or to treat tooth loss or decay prior to beginning cancer Treatment, including chemotherapy, biological therapy or radiation therapy treatment; and
- Dental procedures to reduce the risk of infection or eliminate infection or to treat tooth loss or decay that are the direct or indirect result of cancer Treatment, including chemotherapy, biological therapy or radiation therapy treatment.

18. Pediatric Dental and Vision Services. Benefits are payable as specified in the attached Pediatric Dental Services Benefit and Pediatric Vision Care Services Benefit provisions. See Additional Benefits Section of this Certificate.

19. Sports Accident Expense Benefit for an Insured Student as the result of covered sports Accident while at play or practice of club sports as shown in the Schedule of Benefits.

20. Non-emergency Care While Traveling Outside of the United States for Medically Necessary Treatment when You are traveling outside of the United States.

21. Bedside Visits (International Students and their Dependents Only) when You are Hospital Confined for more than 7 continuous days as the result of a Covered Injury or Covered Sickness, We will pay for the cost of an economy round-trip airfare for an individual to travel to Your Hospital bedside. The benefit will not exceed the amount shown in the Schedule of Benefits. This individual must be designated by You and the trip must be approved by Us. No more than one trip may be made during any one Policy Year.

22. Medical Evacuation Expense

The maximum benefit for Medical Evacuation, if any, is shown in the Schedule of Benefits.

If You are unable to continue Your academic program as the result of a Covered Injury or Covered Sickness that occurs while You are covered under this Certificate, We will pay the necessary Actual Charges for evacuation to another medical facility or Your Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

Payment of this benefit is subject to the following conditions:

- a. You must have been in a Hospital due to a Covered Injury or Covered Sickness for a Confinement of 5 or more consecutive days immediately prior to medical evacuation;

- b. Prior to the medical evacuation occurring, the attending Physician must have recommended, and We must have approved, the medical evacuation;
- c. We must approve the expenses incurred prior to the medical evacuation occurring, if applicable;
- d. No benefits are payable for expenses after the date Your insurance terminates. However, if on the date of termination, You are in the Hospital, this benefit continues in force until the earlier of the date the Confinement ends or 31 days after the date of termination;
- e. Evacuation to Your Home Country terminates any further insurance coverage under this Certificate for You; and
- f. Transportation must be by the most direct and economical route.

23. Repatriation Expense

The maximum benefit for Repatriation, if any, is shown in the Schedule of Benefits.

If You die while You are traveling 100 or more miles from Your place of residence and/or outside Your Home Country, We will pay a benefit. The benefit will be the necessary charges for preparation, including cremation, and transportation of the remains to Your place of residence or Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

Mandated Benefits for Maine

Mandate Disclaimer: If any Preventive Services Benefit is subject to the mandated benefits required by state law, they will be administered under the federal or state guideline, whichever is more favorable to the Insured Person.

1. **Breast Reduction/Varicose Vein Surgery** for breast reduction surgery and symptomatic varicose vein surgery determined to be Medically Necessary. We cover such charges the same way We treat any other Covered Sickness as shown in the Schedule of Benefits.
2. **Children's Early Intervention Benefit** Covered Medical expenses include early intervention services for Dependent child from ages birth to 36 months of age with an identified developmental disability or delay. A referral from the child's provider is required.
3. **Prostate Cancer Screening** for an examination for prostate cancer for men who are fifty (50) years of age or older until the age of seventy-two (72), at least once per year, if prescribed by a Physician.
4. **Diagnostic Breast Examination:** We will pay benefits for Medically Necessary expenses incurred for diagnostic mammography, magnetic resonance imaging, ultrasound or supplemental breast examination used to evaluate an abnormality seen or suspected by an imaging test or other means.
5. **COVID-19 Screening, Testing, and Immunizations Benefits** (including all associated costs for administration), except when such screening and testing is part of a surveillance testing program. Surveillance testing program means a structured program of asymptomatic testing at a community or population level to understand the incidence or prevalence of COVID-19 in a group. Surveillance testing program does not include a program of testing that occurs less often than once per month per individual.

SECTION V - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

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

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

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

SECTION VI - EXCLUSIONS AND LIMITATIONS

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

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

General Exclusions

- **International Students Only** - 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.
- Any routine services such as physical exams, vaccinations, or laboratory testing required for employment, school, camp, sports participation, travel, insurance enrollment, or licensing, as well as for joining a sport or recreational activity, except as specifically provided under Preventive Services, or otherwise specifically covered under the Certificate.
- Services provided by a Doula.

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;
 - 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.

Third Party Refund:

When:

1. You are injured through the negligent act or omission of another person (the "third party"); and
2. Benefits are paid under this Certificate as a result of that Injury,

We are entitled to a refund by You of all Certificate benefits paid as a result of the Injury minus the apportioned cost for:

1. Legal defenses: Questions of liability and comparative negligence or other legal defenses;
2. Exigencies of trial: Exigencies of trial that reduce a settlement or award in order to resolve the claim; and
3. Limits of coverage: Limits on the amount of applicable insurance coverage that reduce the claim to an amount recoverable by the insured.

In the event of a dispute as to the application of any such provision or the amount available for payment to those claiming payment for services or reimbursement, the dispute shall be determined if the action is pending, before the court in which it is pending; or if no action is pending, by filing an action in any court for determination of the dispute.

Coordination Of Benefits

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one (1) Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Maximum Allowance.

DEFINITIONS

1. A Plan is any of the following that provides benefits or services for medical or dental care or Treatment. If separate policies are used to provide coordinated coverage for members of a group, the separate policies are considered parts of the same plan and there is no COB among those separate policies.
 - a. Plan includes: group and nongroup insurance policies, health insuring corporation ("HIC") policies, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care policies, such as skilled nursing care; medical benefits under group or individual automobile policies; and Medicare or any other federal governmental plan, as permitted by law.
 - b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each Certificate for coverage under a. or b. is a separate Plan. If a Plan has 2 parts and COB rules apply only to 1 of the 2, each of the parts is treated as a separate Plan.

2. This plan means, in a COB provision, the part of the Certificate providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the Certificate providing health care benefits is separate from this plan. A Certificate may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
3. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than 1 Plan.

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan. Benefits paid by the secondary group insurance plan may be reduced to avoid paying benefits between the two plans that are greater than the cost of the health care service.

The following are examples of expenses that are not counted as part of a secondary plan:

- a. The difference between the cost of a semi-private hospital room and a private hospital room unless 1 of the Plans provides coverage for private hospital room expenses.
- b. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of Usual and Customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology,
- c. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees.
- d. If a person is covered by 1 Plan that calculates its benefits or services on the basis of Usual and Customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the no greater than the cost of the health care service. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's Policy permits, the negotiated fee or payment no greater than the cost of the health care service.
- e. The amount of any benefit reduction by the Primary plan because You failed to comply with the Plan provisions is not a covered expense. Examples of these types of plan provisions may include second surgical opinions, Pre-Certification of admissions, and preferred provider arrangements.

4. Closed panel plan is a Plan that provides health care benefits to Insured Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
5. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

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

- A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
- B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the Policyholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network Provider benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, Policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two (2) Plans is reversed so that the Plan covering the person as an employee, member, Policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
 2. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
 - a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
 - ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), We will follow the rules of that plan.
 - b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - i. If a court decree states that one (1) of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

- iii. If a court decree states that the parents have joint custody without specifying that 1 parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
- iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The Plan covering the custodial parent;
 - The Plan covering the spouse of the custodial parent;
 - The Plan covering the non-custodial parent; and then
 - The Plan covering the spouse of the non-custodial parent.
- c. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
- d. a. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.
 b. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.
- 3. Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- 4. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- 5. Longer or shorter length of coverage. The Plan that covered the person as an employee, member, Policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
- 6. If the preceding rules do not determine the order of benefits, the cost of the health care service shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

- A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the cost of the health care service. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to the cost of the health care service under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total cost of the health care service for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

- B. If an Insured Person is enrolled in 2 or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by 1 Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

SECTION VII - GENERAL PROVISIONS

Entire Contract Changes

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

We may change coverage under the Policy by notice, if We act as required by applicable federal and state laws for uniform modification of coverage. If We amend the Policy by notice, We will give the Policyholder and Insured Persons 60 days' advance notice.

Time Limit on Certain Defenses

No claim for loss incurred or disability, as defined in the Certificate, commencing after 3 years from the date of issue of this Certificate shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Certificate.

Statements

All statements contained in any application for insurance shall be deemed representations and not warranties. No statement made by the applicant for insurance shall avoid the insurance or reduce benefits thereunder unless contained in the written application signed by the applicant.

Notice of Claim

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

Claim Forms

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

Proof of Loss

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

Time of Payment

Indemnities payable under this Certificate will be paid immediately upon receipt of due proof of such Loss but no later than 30 days.

Payment of Claims

Benefits will be paid to You. Loss of life benefits, if any, will be payable in accordance with the beneficiary designation in effect at the time of payment. If no such designation or provision is then effective, the benefits will be payable to Your estate. Any other accrued indemnities unpaid at the time of Your death may, at Our option, be paid either to such beneficiary or to such estate.

If benefits are payable to Your estate or to a beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity, up to an amount not exceeding \$1,000.00, to any one relative by blood or connection by marriage to You who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment.

We may pay all or a portion of any indemnities provided for health care services to the provider, unless You direct otherwise, in writing, by the time proofs of Loss are filed. We cannot require that the services be rendered by a particular provider.

Assignment

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

Physical Examination and Autopsy

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

Legal Actions

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

Conformity with State Statutes

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

Grace Period

A Policy Grace Period of 31 days will be granted for payment of required Premiums due after the first Premium, unless:

1. We do not intend to renew the Policy beyond the period for which Premium has been accepted; and
2. Written notice of Our intention not to renew is delivered to the Policyholder at least 31 days before the Premium is due.

The Policy will be in force during the Policy Grace Period. If the required Premiums are not paid during the Policy Grace Period, insurance will end on the last day of the Grace Period. The Policyholder is liable to Us for any unpaid Premium for the time the Policy was in force.

Premium Rate Changes

We will not change the Premium rate more than once in a 12-month period. Such notice will either be delivered or mailed to the last known address on file with Us. A copy of such notice may also be sent to the Policyholder's agent, if any, at his or her last address on file with Us. The rate change will become effective on the date stated in the notice or the next Premium due date following the 60th day after We mail or deliver the notice, whichever is later. We will not increase Premium rates more frequently than annually, unless one of the events described below occurs.

We may change the Premium rate during a Policy Term if any one of the following occurs:

1. the terms of the Policy change;
2. a change in any federal or state law or regulation is enacted, adopted or amended to the extent it affects Our benefit obligations under the Policy;
3. the number of Insured Persons or persons eligible for coverage increases or decreases by more than 10% since the later of the Policy Effective Date and the date of the last renewal of the Policy;
4. coverage is reinstated following failure to pay Premium during the Grace Period;
5. an acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by 10% or more the number of eligible persons Insured Persons;
6. the Policyholder fails to provide sufficient information, as required by Us, to confirm adequacy of Premiums and rates currently being paid.

Any increase or decrease in rate will take effect on the date of the applicable change specified above, subject to required notification. A pro rata adjustment will apply from the date of the change to the end of any period for which Premium has been paid.

SECTION VIII - ADDITIONAL PROVISIONS

1. We do not assume any responsibility for the validity of assignment.
2. Our acknowledgment of the receipt of notice given under this Certificate, or the furnishing of forms for filing proofs of Loss or acceptance of such proof, or the investigation of any claim hereunder will not operate as a waiver of any of Our rights in defense of any claim arising under this Certificate.
3. This Certificate is not in lieu of and does not affect any requirement of coverage by Workers' Compensation Insurance.
4. All new persons in the groups or classes eligible to and applying for this insurance will be added in the respective groups or classes in which they are eligible.

5. The insurance of any Insured Person will not be prejudiced by the failure on the part of the Policyholder to transmit reports, pay Premium or comply with any of the provisions of this Certificate when such failure is due to inadvertent error or clerical mistake.
6. All books and records of the Policyholder containing information pertinent to this insurance will be open to examination by Us during the Certificate term and within one year after the termination of this Certificate.
7. Benefits are payable under this Certificate only for those expenses incurred while You are covered. No benefits are payable for expenses incurred after the date Your insurance terminates, except as may be provided under an Extension of Benefits.

SECTION IX – APPEALS PROCEDURE

If You have a claim that is denied by Us, You have the right to appeal it. Your Authorized Representative may act on Your behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination.

For purposes of this Section, the following definitions apply:

Adverse Benefit Determination: Means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Appeal or Internal Appeal: Review by a plan or issuer of an Adverse Benefit Determination.

Authorized Representative: An individual who by law or by the consent of a person may act on behalf of the person.

Complaint: An inquiry to Wellfleet Insurance Company about covered services, an Insured Person's rights or other issues or the communication of dissatisfaction about the quality of service or benefit or other issue which is not an Adverse Benefit Determination.

Clinical peer: A Physician or other licensed health care practitioner who holds a nonrestricted license in a state of the United States, is board certified in the same or similar specialty as typically manages the medical condition, procedure or treatment under review and whose compensation does not depend, directly or indirectly, upon the quantity, type, or cost of the medical condition, procedure or treatment that the Physician or other licensed health care practitioner approves or denies on Our behalf.

Grievance: A request submitted by an enrollee or an Authorized Representative.

Expedited (Urgent Care) Appeal: An appeal that must be reviewed under an expedited process because the application of non-expedited appeal time frames could seriously jeopardize an Insured Person's life or health or their ability to regain maximum function. In determining whether an appeal involves urgent care, Wellfleet Insurance Company must apply the judgment of a prudent layperson that possesses an average knowledge of health and medicine. An Expedited Appeal is also an appeal involving (a) care that the treating Physician deems urgent in nature; (b) the treating Physician determines that a delay in the care would subject the Insured Person to severe pain that could not adequately be managed without the care or Treatment that is being requested; or (c) the Insured Person is a cancer patient and the delay would subject the Insured Person to pain. Such appeal may be made by phone, fax or other available similarly quick method. An Expedited Appeal is not available for services already incurred.

Independent External Review: If the Insured Person receives a final adverse decision of an appeal, the Insured Person or the Insured Person's authorized representative who may include the treating Provider may appeal the adverse decision to the Bureau of Insurance for an Independent External Review.

Independent Review Organization: An entity that conducts independent external reviews of adverse determinations and final adverse determinations.

Post-service Appeal: An appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.

Reconsideration: A review of a not Medically Necessary adverse decision, by either an independent Physician advisor, or a peer of the treating Provider who is licensed in the Provider's same or similar specialty. The Insured Person, a Provider, or an Insured Person's authorized representative may request reconsideration. Reconsiderations are a voluntary and optional step in Wellfleet Insurance Company's appeal process. An Insured Person is not required to go through the Reconsideration process before filing an appeal.

Complaint Resolution

1. Administrative Complaints

Complaints due to the denial of services or payment of a claim must be reported no later than twelve (12) months from the date of service. Most complaints can be resolved by calling, or writing to, Our customer service department. The phone number and address are on the Insured Person's ID card.

If an informal review does not resolve the reported complaint, the Insured Person will be notified of their right to appeal.

2. Quality of Care or Service Complaint

Quality of care complaints will be forwarded to the unit responsible for such investigations immediately upon receipt by customer service. We will send the Insured Person a written acknowledgment within three (3), five (5), ten (10), fifteen (15) working days of receipt of the complaint. All quality of care complaints will be investigated and corrective action taken where problems and/or deficiencies are verified.

3. If We cannot provide the Insured Person with a satisfactory solution to their complaint, the Insured Person may file a standard or urgent (if applicable) appeal for internal review by contacting Us at the address or phone number on the back of the Insured Person's ID card or write to or call the Department of Insurance.

4. If We deny a claim as "not Medically Necessary" and cannot provide the Insured Person with a satisfactory solution to their complaint, the Insured Person may request an Independent External Review by calling State of Maine Bureau of Insurance for assistance at any time at 1-800-300-5000 or TTY 1-888-577-6690, visiting the website at www.maine.gov/insurance, or writing to Consumer Health Care Division, Maine Bureau of Insurance, 34 State House Station, Augusta, Maine 04333-0034

Internal Appeal Review Process

FIRST LEVEL APPEAL PROCESS:

Standard Appeals

The Insured Person, an authorized person, or a Provider, with the Insured Person's consent, may submit a written appeal to Us if coverage is denied, reduced or terminated. Appeals must be received within one hundred eighty (180) days of the date the Insured Person receives written notification of the denial. If it was not reasonably possible to submit this written appeal within in the time required, We may not reduce or deny the claim for this reason if the proof is filed as soon as reasonable possible.

Appeals should be sent to:

Wellfleet Insurance Company
Attention: Appeals Unit
Wellfleet Group, LLC
P.O. Box 15369
Springfield, MA 01115-5369

The receipt of the grievance or appeal will be acknowledged in writing within three (3) days. The appeals staff will review all of the information. A decision will be made within thirty (30) calendar days of receipt for a Pre-Service Claim Appeal and within thirty (30) calendar days of receipt for a Post-Service Claim Appeal. This time period may be extended for up to an additional sixty (60) calendar days if additional information is needed. The Insured Person will be notified in writing of the Appeals Department's decision.

A Post-Service Claims Appeal is an appeal of a decision to deny or reduce Benefits for claim that has already been incurred.

Urgent Appeals

The Insured Person, an authorized person or a Provider, with the Insured Person's consent, may request an Urgent Appeal. This request may be verbal or written. A decision will be made by phone within forty-eight (48) hours after receipt of all necessary information for an Urgent Appeal. A written notice of the decision will also be provided to the Insured Person within one (1) working day.

An Urgent Appeal is an appeal for which the medical condition, in the absence of immediate medical attention, may result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, severe pain that cannot be managed adequately, or places in serious jeopardy the health of an individual, and with respect to a pregnant woman, includes her unborn child.

For urgent health situations, the Insured Person may ask for an external review request at the same time as their internal appeal request. This decision will be made within one (1) working day after receipt of all necessary information and We will notify the Insured Person. The service will continue without liability to the Insured Person until the Insured Person has been notified.

The types of denials that can go to external review are:

1. Any denial that involves medical judgment (such as Medically Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit) where the Insured Person or their Provider may disagree with the health insurance plan.
2. Any denial that involves a determination that a Treatment is Experimental or Investigational.

SECOND LEVEL APPEAL PROCESS:

A second level grievance review is available to Insured Persons dissatisfied with the first level grievance review. An Insured Person or an Insured Person's Provider acting on the Insured Person's behalf may submit a second level grievance. Within three (3) days of receipt of a request for a second level review, the Insured Person will be provided with the following information:

1. Name, address and phone number of the grievance review coordinator;
2. Statement of the Insured Person's rights, including the right to:
 - a. Request and receive from Us all information relevant to the case;
 - b. Present his case to the review panel;
 - c. Submit supporting material prior to and at the review meeting;
 - d. Ask questions of any member of the panel;

- e. Be assisted or represented by a person of the Insured Person's choosing, including an Immediate Family Member, authorized representative or attorney; and
- f. Obtain his medical file and information relevant to the appeal free of charge upon request.

The second level grievance review meeting will be held within forty-five (45) days of receipt of the second level review request, and the Insured Person will receive at least fifteen (15) days notice of the meeting date. The Insured Person may attend the second level review if desired. If an attorney will be present to present Our case, the Insured Person will be notified at least fifteen (15) days in advance of the meeting date, and advised that the Insured Person has the right to obtain legal representation. Our written decision to the Insured Person and Provider (if applicable) shall be issued within five (5) business days after the review meeting, or thirty (30) calendar days if the Insured Person does not request to attend the review, and will contain:

- 1. The professional qualifications and licensure of the members of the clinical peer review panel;
- 2. A statement of the review panel's understanding of the nature of the grievance and all pertinent facts;
- 3. The review panel's recommendation to Us and the basis behind that recommendation;
- 4. A description of or reference to the evidence or documents considered by the review panel in making the recommendation;
- 5. In the review of a clinical matter, a written statement of the clinical basis, including the clinical review criteria, that was used by the review panel to make the recommendation; and
- 6. Notice of the availability of the Commissioner's office for assistance, including the phone number and address of the Commissioner's office.

You have the right to waive a second level appeal and request an external review after the first level appeal process.

EMERGENCY SERVICES

- 1. We shall cover medical emergencies necessary to screen and stabilize an Insured Person and will not require prior authorization of such services.
- 2. If We authorize Emergency Services, We will not subsequently retract Our authorization after the Emergency Services have been provided or reduce payment for an item or service furnished in reliance on approval, unless the approval was based on fraudulent or materially incorrect information.

External Review Process

Under certain circumstances, the Insured Person has a right to an external appeal of a denial of coverage. Specifically, if We denied coverage on the basis that the service does not meet the plan's requirements for Medical Necessity (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or is an Experimental or Investigational Treatment (including clinical trials and Treatments for rare diseases), the Insured Person or their representative may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals. The Insured Person has a right to an external appeal if We failed to make a decision on an internal grievance within the time period required or otherwise failed to adhere to all the requirements applicable to the appeal pursuant to state and federal law.

The Insured Person, an authorized person or a Provider, with the Insured Person's consent, may request the external review within twelve (12) months after the receipt of the notice of adverse determination or final internal adverse benefit determination. You may request an external review from the State of Maine Bureau of Insurance by calling 1-800-300-5000 or TTY 1-888-577-6690, visiting the website at www.maine.gov/insurance, or writing to Consumer Health Care Division, Maine Bureau of Insurance, 34 State House Station, Augusta, Maine 04333-0034. The Maine Bureau of Insurance will provide the Insured Person with all necessary paperwork.

There is no charge to the Insured Person for the external review.

An external review decision must be made in accordance with the following requirements.

1. The Independent Review Organization (IRO) must give consideration to the appropriateness of the requested covered service based on the following:
 - a. All relevant clinical information relating to the Insured Person's physical and mental condition, including any competing clinical information;
 - b. Any concerns expressed by the Insured Person concerning their health status; and
 - c. All relevant clinical standards and guidelines, including, but not limited to, those standards and guidelines relied upon by Us.
2. An external review decision must be issued in writing and must be based on the evidence presented by Us and the Insured Person or their authorized representative. An Insured Person may submit and obtain evidence relating to the adverse health care Treatment decision under review, attend the external review, ask questions of any representative of Wellfleet Insurance Company present at the review and use outside assistance during the review process at the Insured Person's own expense.
3. Except for Expedited External review, the external review decision must be made by the IRO within thirty (30) days of receipt of a completed request for external review from the bureau.
4. Expedited External review decisions must be made as expeditiously as an Insured Person's medical condition requires but in no event more than forty-eight (48) hours after receipt of a completed request.
5. The Company shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by an Insured Person who is deaf or hard of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an Insured Person who is visually impaired.
6. An external review decision is binding on Us. An Insured Person or their authorized representative may not file a request for a subsequent external review involving the same adverse health care Treatment decision for which the Insured Person has already received an external review decision. However, an external review decision made under this provision is not considered final agency action.

NOTICE TO INSURED STUDENTS OF DEPENDENT CHILDREN

We will notify the Insured Student of a Dependent child of the following events unless the Dependent child has the right to withhold consent and does not affirmatively consent to Us notifying the Insured Student. Notice will be sent to the address on file provided by the Insured Student.

1. Payment or denial of claim
2. Change in terms and conditions of the Certificate
3. Notice of Lapse.

ADDITIONAL BENEFITS

SECTION X DENTAL BENEFITS

DEFINITIONS

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

Usual and Customary Charge is the amount of a Provider's charge that is eligible for coverage. The Insured Person is responsible for all amounts above what is eligible for coverage.

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

Service or Supply	Usual and Customary Charge
Dental expenses	The Reasonable amount rate

Special terms used

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

Service or Supply	Reasonable Amount Rate
Professional services, supplies and facilities	The lesser of: 1. The billed charge for the services; or 2. An amount determined using current publicly-available data which is usual and customary when compared with the charges made for a) similar services and supplies and b) to persons having similar medical conditions in the geographic area where service is rendered; or 3. An amount based on information provided by a third-party vendor, which may reflect 1 or more of the following factors: 1) the complexity or severity of Treatment; 2) level of skill and experience required for the Treatment; or 3) comparable providers' fees and costs to deliver care.

Our reimbursement policies

We reserve the right to apply Our reimbursement policies to all services including involuntary services. Our reimbursement policies may affect the Usual and Customary Charge. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an Assistant Surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique

- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the provider

In some instances, We may negotiate a lower rate with Providers.

Our reimbursement policies are based on Our review of:

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

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services. No payment will be made under this Certificate for any expenses incurred which, in Our judgment, are in excess of Usual and Customary Charges.

SCHEDULE OF BENEFITS

DENTAL BENEFITS	
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/Bicuspid excluding Wisdom Teeth)
Caries preventive medicament application – per tooth - 1 every 36 months
Space maintainer – fixed – unilateral - Limited to children under age 19
Space Maintainer- Fixed-bilateral, Maxillary-Limited to children under age 19
Space Maintainer- Fixed-bilateral, mandibular-Limited to children under age 19
Space maintainer - removable – unilateral - Limited to children under age 19
Space Maintainer removable-bilateral, maxillary-Limited to children under age 19
Space Maintainer Removable bilateral, mandibular-Limited to children under age 19
Re-cement or re-bond bilateral space maintainer-maxillary
Re-cement or re-bond bilateral space maintainer-mandibular
Re-cement or re-bond unilateral space maintainer-per quadrant
Distal space maintainer fixed

Additional Procedures Covered as Basic Services

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

Type B – Intermediate Services

Minor Restorative Services

Amalgam - one surface, primary or permanent

Amalgam - two surfaces, primary or permanent

Amalgam - three surfaces, primary or permanent

Amalgam - four or more surfaces, primary or permanent

Resin-based composite - one surface, anterior

Resin-based composite - two surfaces, anterior

Resin-based composite - three surfaces, anterior

Resin-based composite - four or more surfaces or involving incisal angle (anterior)

Resin Crown-1 every 60 months

Porcelain Inlay-1 every 60 months

2 Surface Porcelain Inlay-1 every 60 months

3 or More Surf. Porcelain Onlay-1 every 60 months

Re-cement inlay or re-bond inlay, onlay veneer or partial coverage restoration

Re-cement or re-bond indirectly fabricated or prefabricated post and core

Re-cement or re-bond crown

Reattachment of Tooth Fragment

Prefabricated porcelain crown - primary - Limited to 1 every 60 months

Prefabricated stainless steel crown - primary tooth – Under age 15 - Limited to 1 per tooth in 60 months

Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth in 60 months

Protective Restoration

Pin retention - per tooth, in addition to restoration

Endodontic Services

Therapeutic pulpotomy (excluding final restoration) - *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.*

Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development - *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.*

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

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

Pulpal regeneration – initial visit - Limited to 1 per lifetime

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

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

Periodontal Services

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

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

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

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

Periodontal maintenance – 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy

Prosthodontic Services

Adjust complete denture – maxillary

Adjust complete denture – mandibular

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

Oral Surgery

Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
 Removal of impacted tooth - soft tissue
 Removal of impacted tooth – partially bony
 Removal of impacted tooth - completely bony
 Removal of impacted tooth - completely bony with unusual surgical complications
 Surgical removal of residual tooth roots (cutting procedure)
 Coronectomy - intentional partial tooth removal
 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
 Surgical access of an unerupted tooth
 Alveoloplasty in conjunction with extractions - per quadrant
 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
 Alveoloplasty not in conjunction with extractions - per quadrant

Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
Removal of exostosis
Incision and drainage of abscess - intraoral soft tissue
Suture of recent small wounds up to 5 cm
Collect-Apply Autologous Product-1 every 36 months
Bone replacement graft for ridge preservation-per site
Buccal/Labial Frenectomy
Lingual Frenectomy
Excision of pericoronal gingiva

Type C – Major Services

Major Restorative Services

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

Endodontic Services

Anterior root canal (excluding final restoration)
Bicuspid root canal (excluding final restoration)
Molar root canal (excluding final restoration)
Retreatment of previous root canal therapy-anterior
Retreatment of previous root canal therapy-bicuspid
Retreatment of previous root canal therapy-molar
Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)

Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)

Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)

Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration

Apicoectomy/periradicular surgery - anterior

Apicoectomy/periradicular surgery - bicuspid (first root)

Apicoectomy/periradicular surgery - molar (first root)

Apicoectomy/periradicular surgery (each additional root)

Root amputation - per root

Surgical repair of root resorption - anterior

Surgical repair of root resorption – premolar

Surgical repair of root resorption – molar

Surg Exp of Root-Anterior

Surg Exp of Root-Premolar

Surg Exp of Root-Molar

Hemisection (including any root removal) - not including root canal therapy

Intentional removal of coronal tooth structure for preservation of the root and surrounding bone

Periodontal Services

Gingivectomy or gingivoplasty – four or more teeth - Limited to 1 every 36 months

Gingivectomy or gingivoplasty – one to three teeth - Limited to 1 every 36 months

Gingivectomy or gingivoplasty - with restorative procedures, per tooth - Limited to 1 every 36 months

Gingival flap procedure, four or more teeth – Limited to 1 every 36 months

Gingival flap procedure, including root planning - one to three contiguous teeth or tooth bounded spaces per quadrant – Limited to 1 every 36 months

Clinical crown lengthening-hard tissue

Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months

Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months

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

Pedicle soft tissue graft procedure

Autogenous connective tissue graft procedures (including donor site surgery)

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

Free soft tissue graft 1st tooth

Free soft tissue graft-additional teeth

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

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

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

Prosthodontic Services

Complete denture - maxillary – Limited to 1 every 60 months

Complete denture - mandibular – Limited to 1 every 60 months

Immediate denture - maxillary – Limited to 1 every 60 months

Immediate denture - mandibular – Limited to 1 every 60 months

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Add metal substructure to acrylic full denture (per arch)-Limit 1 every 60 months.

Endosteal Implant - 1 every 60 months

Surgical Placement of Interim Implant Body - 1 every 60 months

Epsteal 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 preimplant defect - Limited to 1 every 60 months
 Debridement and osseous preimplant defect - Limited to 1 every 60 months
 Bone graft preimplant defect
 Bone graft implant replacement
 Implant/abutment supported removable denture for edentulous arch-maxillary- 1 every 60 months
 Implant/abutment supported removable denture for edentulous arch-mandibular- 1 every 60 months
 Implant/abutment supported removable denture for partially edentulous arch-maxillary- 1 every 60 months
 Implant/abutment supported removable denture for partially edentulous arch-mandibular- 1 every 60 months
 Implant/abutment supported fixed denture for edentulous arch-maxillary- 1 every 60 months
 Implant/abutment supported fixed denture for edentulous arch-mandibular- 1 every 60 months
 Implant/abutment supported fixed denture for partially edentulous arch-maxillary- 1 every 60 months
 Implant/abutment supported fixed denture for partially edentulous arch-mandibular- 1 every 60 months
 Implant supported retainer – porcelain fused to titanium and titanium alloys - 1 every 60 months
 Implant supported retainer for metal FPD – predominantly base alloys - 1 every 60 months
 Implant supported retainer for metal FPD – noble alloys - 1 every 60 months
 Implant supported retainer for metal FPD – titanium and titanium alloys - 1 every 60 months
 Implant Index - 1 every 60 months
 Semi-precision abutment – placement - 1 every 60 months
 Semi-precision attachment – placement - 1 every 60 months
 Abutment supported retainer – porcelain fused to titanium and titanium alloys - 1 every 60 months
 Pontic - cast high noble metal – Limited to 1 every 60 months
 Pontic - cast predominately base metal – Limited to 1 every 60 months
 Pontic - cast noble metal– Limited to 1 every 60 months
 Pontic – titanium – Limited to 1 every 60 months
 Pontic - porcelain fused to high noble metal – Limited to 1 every 60 months
 Pontic - porcelain fused to predominately base metal – Limited to 1 every 60 months
 Pontic - porcelain fused to noble metal – Limited to 1 every 60 months
 Pontic – porcelain fused to titanium and titanium alloys - 1 every 60 months
 Pontic - porcelain/ceramic – Limited to 1 every 60 months
 Inlay/onlay – porcelain/ceramic – Limited to 1 every 60 months
 Inlay – metallic – two surfaces – Limited to 1 every 60 months
 Inlay – metallic – three or more surfaces - Limited to 1 every 60 months
 Onlay – metallic – three surfaces - 1 every 60 months
 Onlay – metallic – four or more surfaces -1 every 60 months
 Retainer - cast metal for resin bonded fixed prosthesis -1 every 60 months
 Retainer - porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months

Resin retainer-for resin bonded fixed prosthesis - 1 every 60 months
 Crown - porcelain/ceramic - 1 every 60 months
 Crown - porcelain fused to high noble metal - 1 every 60 months
 Crown - porcelain fused to predominately base metal - 1 every 60 months
 Crown - porcelain fused to noble metal - 1 every 60 months
 Retainer crown – porcelain fused to titanium and titanium alloys - 1 every 60 months
 Crown - 3/4 cast high noble metal - 1 every 60 months
 Crown - 3/4 cast predominately base metal - 1 every 60 months
 Crown - 3/4 cast noble metal - 1 every 60 months
 Crown - 3/4 porcelain/ceramic - 1 every 60 months
 Retainer crown 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

Dental Benefits

1. **Pediatric Dental Care Benefit** for dental care services for Insured Persons (to the end of the month in which the Insured Person turns age 19). Please refer to the Schedule of Benefits section of this Certificate for cost sharing requirements.

EXCLUSIONS

- Any expenses in excess of the Usual and Customary Charge;
- Adult Dental Care;
- Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit;
- Services and treatment resulting from Your failure to comply with professionally prescribed treatment;
- Any charges for failure to keep a scheduled appointment;
- Any service charges for personalization or characterization of prosthetic dental appliances;
- Office infection control charges;
- Duplicate, provisional and temporary devices, appliances, and services;
- Plaque control programs, oral hygiene instruction, and dietary instructions;
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
- Gold foil restorations;
- Charges by the provider for completing dental forms;
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;
- Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Sealants for teeth other than permanent molars;
- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Replacement of dentures that have been lost, stolen or misplaced;
- Medically Necessary orthodontic services provided to a Covered Person who has not met any applicable waiting period requirement;
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliances;
- Fabrication of athletic mouth guard;
- Internal bleaching;
- Nitrous oxide;
- Oral sedation;
- Topical medicament center;
- Bone grafts when done in connection with extractions, apicoectomies or non-covered/non eligible implants;
- Treatment and periodically adjusted;
- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

SECTION XI VISION BENEFITS

DEFINITIONS

Usual and Customary Charge is the amount of a Provider's charge that is eligible for coverage. The Insured Person is responsible for all amounts above what is eligible for coverage.

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

Service or Supply	Usual and Customary Charge
Vision expenses	The Reasonable amount rate

Special terms used

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

Service or Supply	Reasonable Amount Rate
Professional services	The lesser of: 1. The billed charge for the services; or 2. An amount determined using current publicly-available data which is usual and customary when compared with the charges made for a) similar services and supplies and b) to persons having similar medical conditions in the geographic area where service is rendered; or 3. An amount based on information provided by a third-party vendor, which may reflect 1 or more of the following factors: 1) the complexity or severity of Treatment; 2) level of skill and experience required for the Treatment; or 3) comparable providers' fees and costs to deliver care

Our reimbursement policies

We reserve the right to apply Our reimbursement policies to all services including involuntary services. Our reimbursement policies may affect the Usual and Customary Charge. These policies consider:

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

In some instances, We may negotiate a lower rate with Providers.

Our reimbursement policies are based on Our review of:

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

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services. No payment will be made under this Certificate for any expenses incurred which, in Our judgment, are in excess of Usual and Customary Charges.

SCHEDULE OF BENEFITS

VISION BENEFITS	
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

Vision Benefits

1. **Pediatric Vision Care Benefit** for Insured Persons (to the end of the month in which the Insured Person turns age 19). We will provide benefits for:
 - a. 1 vision examination per Policy Year; and
 - b. 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year.

EXCLUSIONS

- Expenses for radial keratotomy.
- Any expenses in excess of the Usual and Customary Charge;
- Adult Vision Care.
- Charges for office visit exam for the fitting of prescription contact lenses, duplicate spare eyeglasses, non-prescription lenses or contact lenses that are for cosmetic purposes.

SECTION XII PRESCRIPTION DRUG EXPENSE BENEFIT

DEFINITIONS

Actual Charge means the charge for the Treatment by the provider who furnishes it.

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

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

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

In-Network Providers are providers who have agreed to pre-arranged fee schedules.

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

Out-of-Network Providers are providers who have not agreed to any pre-arranged fee schedules.

Quantity Limits means limits that restrict the amount dispensed per Prescription Drug order or refill and/or the amount dispensed per month's supply and are applied to ensure the Insured Person receives clinically appropriate and Medically Necessary drugs.

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

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

Service or Supply	Usual and Customary Charge
Prescription Drug expenses	The Reasonable amount rate

Special terms used

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

Service or Supply	Reasonable Amount Rate
Professional services	The lesser of: 1. The billed charge for the services; or 2. An amount determined using current publicly-available data which is usual and customary when compared with the charges made for a) similar services and supplies and b) to

	persons having similar medical conditions in the geographic area where service is rendered; or 3. An amount based on information provided by a third-party vendor, which may reflect 1 or more of the following factors: 1) the complexity or severity of Treatment; 2) level of skill and experience required for the Treatment; or 3) comparable providers' fees and costs to deliver care
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Our reimbursement policies

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

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

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

Our reimbursement policies are based on Our review of:

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

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services. No payment will be made under this Certificate for any expenses incurred which, in Our judgment, are in excess of Usual and Customary Charges.

SCHEDULE OF BENEFITS

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

Please note: Amounts You pay out-of-pocket for covered Specialty Prescription Drugs will be applied towards the Deductible (if applicable) and Out-of-Pocket Maximum. Copayment Assistance may be available to You for certain Specialty Prescription Drugs when Your prescription is filled at a participating network pharmacy. Copayment Assistance dollars paid by the drug manufacturer for covered Specialty Prescription Drugs will be applied towards the Deductible (if applicable) or Out-of-Pocket Maximum. Any amounts paid by You for a covered Specialty Prescription Drug after Copayment Assistance will be applied to the deductible (if applicable) and Out-of-Pocket Maximum.

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 with Copayment Assistance Program Copayment Assistance Program - Prior Authorization May Be Required: Amounts You pay out-of-pocket for covered Specialty Prescription Drugs will not exceed the applicable Tier’s cost share per 30 day supply and will be applied towards the Deductible (if applicable) and Out-of-Pocket Maximum. Copayment Assistance may be available to You for certain Specialty Prescription Drugs when Your prescription is filled at a participating network pharmacy. Visit www.wellfleetstudent.com for the applicable Specialty Prescription Drugs. Copayment Assistance dollars paid by the drug manufacturer for covered Specialty Prescription Drugs will be applied towards the Deductible (if applicable) or Out-of-Pocket Maximum. Any amounts paid by You for a covered Specialty Prescription Drug after Copayment Assistance will be applied to the Deductible (if applicable) and Out-of-Pocket Maximum. For details, contact the Copayment Assistance Program at 636-271-5280.		
For each fill up to a 30 day supply.	75% of the Negotiated Charge for Covered Medical Expenses	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 \$35, per 30-day supply regardless of the amount or type of insulin that is needed to fill the Insured Person’s prescription.	

Prescription Drug Benefits

1. **Prescription Drugs** are medications filled in an outpatient pharmacy for which a Physician's written prescription is required. This benefit is limited to medication necessary for the Treatment of the Covered Injury or Covered Sickness for which a claim is made. Some outpatient Prescription Drugs are subject to pre-certification. These prescription requirements help Your prescriber and pharmacists check that Your outpatient Prescription Drug is clinically appropriate using evidence-based criteria. Prior authorization is not required for medication-assisted Treatment for opioid use disorder for the prescription of at least one drug for each therapeutic class of medication used in medication-assisted Treatment. For a pregnant Insured Person, there will be no prior authorization requirements for any drug product prescribed for medication-assisted Treatment.

- a. **Off-Label Drug Treatments** – When Prescription Drugs are provided as a benefit under the Certificate, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
1. The drug is approved by the FDA;
 2. The drug is prescribed for the Treatment of a life-threatening condition, including cancer, HIV or AIDS;
 3. The drug has been recognized for Treatment of that condition by a nationally recognized drug database or two separate articles in major peer reviewed medical journals/clinical practice guidelines (cancer indications will only require evidence from ONE article or clinical practice guideline).

When this portion of the prescription benefit is used, it will be the responsibility of the prescriber to submit to Us documentation supporting compliance with the requirements of this benefit.

As it pertains to this benefit, life threatening means either or both of the following:

- a. Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted;
or
 - b. Disease or conditions with a potentially fatal outcome and where the end point of clinical intervention is survival.
- b. **Dispense as Written (DAW)** – If a prescriber prescribes a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available and specifies: “Dispense as Written” (DAW), You will pay the cost sharing for the Brand-Name Prescription Drug. If a prescriber does not specify DAW and You request a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available, You will be responsible for the cost difference between the Brand-Name Prescription Drug and the Generic Prescription Drug equivalent, and the cost sharing that applies to Brand-Name Prescription Drugs. This DAW penalty does not apply to Your Out-of-Pocket Maximum Deductible.
- c. **Investigational Drugs and Medical Devices** – The Prescription Drug benefit includes a drug or device that is Investigational if the intended use of the drug or device is included in the labeling authorized by the FDA or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature.
- d. **Specialty Prescription Drugs** are limited to no more than a 30 day supply. However, if the Specialty Prescription Drug dispensed is the smallest package size available and exceeds a 30 day supply, You are responsible for the cost sharing defined for the day supply as shown in the Schedule of Benefits.

Specialty Drugs – are Prescription Drugs which:

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

Specialty Prescription Drugs are identified in the Formulary posted on Our website at www.wellfleetrx.com.

- e. **Self-Administered Prescription Drugs** – Certain self-administered Prescription Drugs are only covered under the Prescription Drug benefit and are excluded from the medical benefits. Self-administered Prescription Drugs will not be covered when dispensed through a Physician’s office or outpatient Hospital, except in emergency situations. While Insured Persons may self-administer these medications, they can still obtain these medications

at the pharmacy and have them administered at an office visit. Coverage exceptions may be granted if self-administered Prescription Drugs are required as part of a hospitalization or emergency room visit. The list of self-administered Prescription Drugs only covered under the Prescription Drug benefit and excluded from the medical benefit can be found here: www.wellfleetrx.com.

Retail Pharmacy Supply Limits – We will pay for no more than a 30-36 day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for 1 cost sharing amount for up to a 30-36 day supply. However, if the Prescription Drug dispensed is the smallest package size available and exceeds a 30-36 day supply, You are responsible for the cost sharing defined for the day supply as shown in the Schedule of Benefits.

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

Prescription Drugs to treat metastatic cancer and associated conditions will not require Step Therapy.

- g. **Quantity Limits** – Some Outpatient Prescription Drugs are subject to quantity limits. The quantity limits help the prescriber and pharmacist check that the Outpatient Prescription Drug is used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by Us to set these quantity limits.
- h. **Tier Status** – The tier status of a Prescription Drug may change periodically. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Prescription Drug that becomes available as a Generic Prescription Drug) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website at www.wellfleetrx.com or by calling the number on Your ID card.

NOTICE: For an adverse change to Our Formulary, We will provide at least 60 days' written Notice to You. If a drug is removed from Our Formulary, You may request a Formulary exception. If You have already received prior authorization for the drug, We will continue to honor the authorization until it expires, if You continue to be covered under this Certificate and the drug has not been removed due to safety concerns. If a drug has been removed from Our Formulary (except if removed due to safety concerns), and the Formulary exception request is received prior to the effective date of the change, We will continue to cover the drug until a decision is reached on the Formulary exception request.

- i. **Compounded Prescription Drugs** will be covered only when they contain at least 1 ingredient that is a covered legend Prescription Drug, do not contain bulk chemicals, and are obtained from a pharmacy that is approved for

compounding. Compounded Prescription Drugs may require Your Provider to obtain Preauthorization. Compounded Prescription Drugs will be covered as the tier associated with the highest tier ingredient.

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

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

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

- k. **Tobacco cessation prescription and over-the-counter drugs** – Tobacco cessation Prescription Drugs and OTC drugs will be covered for two 90-day treatment regimens only. Any additional prescription drug and OTC drug treatment regimens will be subject to the cost sharing as shown in the Schedule of Benefits. For details on the current list of tobacco cessation Prescription Drugs and OTC drugs covered with no cost sharing during the two 90-day treatment regimens allowed, refer to the Formulary posted on Our website www.wellfleetrx.com or call the toll-free number on Your ID card.
- l. **Zero Cost Drugs** – In addition to ACA Preventive Care medications, certain Prescription Drugs are covered at no cost to You. These zero cost drugs can be identified in the Formulary posted on Our website at www.wellfleetrx.com.
- m. **Preventive contraceptives** - Your Outpatient Prescription Drug benefits cover certain Prescription drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a Physician and the prescription is submitted to the pharmacist for processing. We will also cover nonprescription oral hormonal contraceptives and nonprescription emergency contraceptives. Your outpatient Prescription Drug benefits also cover related services and supplies needed to administer covered devices. At least 1 form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive prescription drugs and applicable supply limits by referring to the Formulary posted on Our website at www.wellfleetrx.com or calling the toll-free number on Your ID card. You may receive the entire prescribed supply of contraceptive drugs or devices and nonprescription oral hormonal contraceptive with up a 12 month supply dispensed at the same time or over the course of 12 months.

We cover over-the-counter (OTC) and Generic Prescription Drugs and devices for each of the methods identified by the FDA at no cost share. If a Generic Prescription Drug or device is not available for a certain method, You may obtain a certain Brand-Name Prescription Drug for that method at no cost share.

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

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

- p. **Preventive Care drugs and Supplements**- Covered Medical Expenses include preventive care drugs and supplements (including over the counter drug and supplements as required by the Affordable Care Act (ACA) guidelines when prescribed by a Physician and the prescription is submitted to the pharmacist for processing.
- q. **Continuity of Prescription Drugs**: If an enrollee has been undergoing a course of Treatment with a prescription drug by prior authorization of the enrollee's previous carrier, we will honor the prior authorization for that prescription drug and provide coverage in the same manner as the previous carrier until the we have been able to conduct a review of the prior authorization for that prescription drug with the enrollee's prescribing provider. We reserve the right to request a review with the enrollee's provider. We will honor the prior carrier's authorization for a period not to exceed 6 months if the enrollee's provider participates in the review and requests the prior authorization be continued. We are not required to provide benefits for conditions or services not otherwise covered under this Policy as shown in the Schedule of Benefits.
- r. **Early refill of Prescription eye drops**: We may cover a prescription refilled early by a pharmacy for liquid eye drops. This is because You may have difficulty with wastage that You cannot avoid. If You have a valid prescription, We will refill the prescription when 70% of the initial days supply is remaining as long as the following conditions are met.
- The specific number of refills are authorized
 - The number of refills is indicated on the original prescription
 - The prescription has not been refilled more than once during the period authorized.
 - Prescription eye drops are a covered benefit under this certificate.
- s. **Medication synchronization**: We may cover a prescription filled by a pharmacy early one time. This way the pharmacy can synchronize Your chronic medications. If You take multiple medications, We can help make sure You follow the prescribed course of Treatment by dispensing them all at the same time. And at the same pharmacy. We will do this if Your prescriber or pharmacist decides filling or refilling the prescription that way is in Your best interest and You request less than a 30-day supply.
- t. **Abuse-deterrent opioid analgesic drugs**: Abuse-deterrent opioid analgesic drugs products are brand or generic opioid analgesic drug products approved by the FDA with abuse-deterrent labeling claims that indicate the drug product is expected to result in a meaningful reduction in abuse. We shall cover abuse-deterrent opioid analgesic drug products no less favorably than opioid analgesic drug products that are not abuse-deterrent.

- u. **Prescription Drug coverage during a state of emergency:** We will cover a prescription drug filled by a pharmacy in a quantity sufficient for an extended period up to a 180-day supply during a statewide emergency declared by the Governor in accordance with Title 37-B, section 742.
- v. **Coverage of drugs to treat serious mental illness:** Pre-certification will not be denied for a prescription drug that is prescribed to assess or treat a serious mental illness. Prescription drugs to treat a serious mental illness will not require Step Therapy.
- w. **HIV Prevention Drug:** At least one FDA-approved HIV prevention drug for each method of administration will be covered with no member cost share.
- x. **Emergency Supply of Chronic Maintenance Drugs:** A pharmacist may dispense an emergency supply of a chronic Maintenance Drug to an Insured Person without a prescription if the pharmacist is unable to obtain authorization to refill the prescription from a health care provider and the pharmacist has a record of the prescription in the name of the Insured Person, including the amount of the drug dispensed in the most recent prescription or the standard unit of dispensing the drug, and that record does not indicate that no emergency supply is permitted. A pharmacist may dispense an emergency supply of a chronic Maintenance Drug to an Insured Person as long as the following conditions are met:
 - (1) The drug dispensed may not be a controlled substance included in Schedules I and II under the federal Controlled Substances Act;
 - (2) The amount dispensed may not exceed a 30-day supply or, if the standard unit of dispensing exceeds a 30-day supply, may not exceed the smallest standard unit of dispensing, except that, if the drug is included on Schedule III or IV of the federal Controlled Substances Act, the amount dispensed may not exceed a 7-day supply;
 - (3) The pharmacist may not dispense the chronic maintenance drug in an emergency supply to the same patient more than twice in a 12-month period; and
 - (4) The pharmacist must determine, in the pharmacist's professional judgment, that the prescription is essential to sustain the life of the patient or to continue therapy for a chronic condition of the patient and that failure to dispense the drug could reasonably produce undesirable health consequences or cause physical or mental discomfort.

EXCLUSIONS AND LIMITATIONS

- 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.

HIPAA Notice of Privacy Practices

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

PLEASE REVIEW IT CAREFULLY

Effective: August 01, 2019

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

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

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

Our Responsibilities

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

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

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

Overview of this Notice

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

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

YOUR HEALTH INFORMATION

How We Acquire Your Information

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

How We use Your Health Information

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

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

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

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

Additionally:

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

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

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

Authorizations

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

YOUR RIGHTS

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

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

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

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

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

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

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

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

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

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

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

CONTACT

For all inquiries, requests and complaints, please contact:

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

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

This Notice is Subject to Change

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

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

Gramm-Leach-Bliley (“GLB”) Privacy Notice

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

COLLECTING YOUR INFORMATION

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

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

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

SHARING YOUR INFORMATION

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

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

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

HEALTH INFORMATION

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

SAFEGUARDING YOUR INFORMATION

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

ACCESSING YOUR INFORMATION

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

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

CORRECTING YOUR INFORMATION

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

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

CONTACTING US

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

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

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

NOTICE OF NON-DISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

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

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

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

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

1. Interpreters
2. information translated into other languages

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

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

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

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
800-868-1019; 800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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

ADVISORY NOTICE TO POLICYHOLDERS

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

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

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

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

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

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

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

Women's Health & Cancer Rights Act

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

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

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

LANGUAGE ASSISTANCE PROGRAM

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

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

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

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

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

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

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

میںینت: اذانتک تدرتت تبیرطا (**Arabic**)، نإفاتامدخ ددعاسملا تبوغلا تیناجملا تحاتمكل. عاجرلا لاصتلاا ب (877) 657-5030.

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

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

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

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

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

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

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

ی سراف امشد نابز رگا: مجوت (**Farsi**) دشاب می مامشد رایتخا رد نابزیار روط بی نابز دادما تامدخ، تسا. (877) 657-5030 تمسا بیگرید.

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

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

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

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

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

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

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

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

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

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደው(877) 657-5030

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

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