

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

STUDENT HEALTH INSURANCE OUTLINE OF COVERAGE

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

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

(3) The benefits, as selected by the Policyholder under this policy, are summarized below:

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.

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
Preadmission Testing	100% of the Maximum Allowance for Covered Medical Expenses
Physician's Visits while Confined	100% of the Maximum Allowance for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Certification Required	100% of the Maximum Allowance for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	100% of the Maximum Allowance for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	100% of the Maximum Allowance for Covered Medical Expenses
MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER BENEFITS In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, and any Pre-Certification requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness. Day or visit limits do not apply to Mental Health Disorder and Substance Use Disorder Benefits.	
Inpatient Mental Health Disorder and Substance Use Disorder Benefits Pre-Certification Required	100% of the Maximum Allowance for Covered Medical Expenses
Outpatient Mental Health Disorder and Substance Use Disorder Benefits Physician's Office Visits including, but not limited to, Physician visits; individual and group therapy; medication management	\$10 Copayment per visit then the plan pays 100% of the Maximum Allowance for Covered Medical Expenses

All Other Outpatient Services (All Other Outpatient Services does not include Emergency Services in an emergency department, Urgent Care Centers, and Emergency Ambulance Service and Prescription Drugs. Refer to the Emergency Services, Ambulance and Non-Emergency Services, and Prescription Drugs sections of this Outline of Coverage for information.) Pre-Certification may be required for certain All Other Outpatient Services. To see if Pre-Certification is required, refer to the Pre-Certification Requirement listing and specific benefit listed in this Schedule of Benefits	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	100% of the Maximum Allowance for Covered Medical Expenses
Pre-Certification Required	
Other Professional Services	
Gender Affirming Services Benefit	Same as any other Mental Health Disorder
Pre-Certification Required for gender affirming surgery	
Home Health Care Expenses	100% of the Maximum Allowance for Covered Medical Expenses
Pre-Certification required	
Hospice Care Coverage	100% of the Maximum Allowance for Covered Medical Expenses
Office Visits	
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.	
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.	
VISION BENEFITS	
Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19)	100% of Usual and Customary Charge for Covered Medical Expenses
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.	

PRESCRIPTION DRUG EXPENSE BENEFIT

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.

(4) 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.

Dental

- 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).

Vision

- 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.

Prescription Drugs

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

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