BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2021/2022

DESIGNED EXCLUSIVELY FOR THE STUDENTS

RICE UNIVERSITY

Houston, TX
("the Policyholder")

Policy Number: WI2122TXSHIP11
Group Number: ST0895SH
Effective: 8/01/2021 – 7/31/2022

UNDERWRITTEN BY:

Wellfleet Insurance Company | Fort Wayne, IN
("the Company")

ADMINISTERED BY:

Wellfleet Group, LLC

WELLFLEET STUDENT

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Welcome Students…

We are pleased to provide you with this summary of the 2021 – 2022 Student Health Insurance Plan ("Plan"), which is fully compliant with the Affordable Care Act. "Benefits at a Glance" includes effective dates and costs of coverage, as well as other helpful information. For additional details about the Plan, please consult the Plan Certificate and other materials at www.wellfleetstudent.com. For questions about medical benefits or claims, please call Wellfleet Student at (877) 657-5030, TTY 711.

Where to Find Help

For Questions About:	Please Contact:
Servicing Agent	**Paul Fisher** **Pinnacle Student Insurance** **2021 Highway 46** **Suite 101** **New Braunfels, TX 78132** **(877) 626-0360** **Paul@psihealthplans.com**
Insurance Benefits **Claims Processing** **ID Cards** **Preferred Provider Listings** **Waivers**	**Wellfleet Group, LLC** **PO Box 15369** **Springfield, Massachusetts 01115-5369** **(877) 657-5030, TTY 711** **www.wellfleetstudent.com**
Preferred PPO Provider Listings	**Wellfleet Student** **www.wellfleetstudent.com** or **PHCS-Multiplan PPO** **www.multiplan.com**
Prescription Drug Provider	**For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit www.wellfleetstudent.com** **Your plan includes Wellfleet Rx – offering over 40 generics at a $0 copay. Please ask your health care provider to review our formulary to see if these medications are right for you. Click here http://wellfleetrx.com/students/formularies/ for more information.**

Am I Eligible?

International students and scholars who are engaged in full-time international education or educational activities, temporarily living outside their home country or country of regular domicile as a non-resident alien in the United States and possess a current passport or student visa. Eligible dependents may also enroll in this plan.

How to Enroll?

To enroll yourself, and/or your dependent(s), go to www.wellfleetstudent.com. Choose your school from "Find My School" and click on Enroll.

Effective Dates & Costs

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

Coverage Period	Coverage Start Date	Coverage End Date
Annual	8/1/2021	7/31/2022
Fall	8/1/2021	12/31/2021
Spring	1/1/2022	7/31/2022

Plan Costs for International Students and their Dependents

	Annual	Fall	Spring
Student*	$1,727	$724	$1,003
Spouse*	$1,727	$724	$1,003
Each Child*	$1,727	$724	$1,003
3 or more Children*	$5,181	$2,172	$3,009

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

Visiting Scholar Monthly Costs	
Scholar*	$144 per month
Spouse*	$144 per month
Each Child*	$144 per month
3 or More Children*	$432 per month

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

Preferred Provider Organization (PPO) Network

…providing access to quality health care at discounted costs!

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

Rice University Schedule of Benefits

This is only a brief description of coverage available under Certificate form TX SHIP CERT (2019) REV-1. The Certificate will contain full details of coverage, coinsurance, limitations, exclusions, and termination provisions. If there are any conflicts between this document and the Certificate, the Certificate governs in all cases.

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

SCHEDULE OF BENEFITS

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

Out-of-Network Provider: Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through an Out-of-Network Provider. Benefits are paid at 70% of the Usual and Customary Rate. Immunizations required under Federal and State Law are paid at no charge to the Insured.

Medical Deductible:

In-Network Provider	Individual:	$100
Out-of-Network Provider	Individual:	$100

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

Out-of-Pocket Maximum:

In-Network Provider	Individual:	$2,500
	Family:	$5,000
Out-of-Network Provider	Individual:	$3,500
	Family:	No Maximum

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

Coinsurance Amounts:

In-Network Provider:	90% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below.
Out-of-Network Provider:	70% of the Usual and Customary Rate (U&C) for Covered Medical Expenses unless otherwise stated below.

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

Dental and Vision Benefit Payments
For dental and vision benefits, You may choose any dental or vision provider.

For dental, different benefits may be payable based on the type of service, as shown in the Schedule of Benefits.

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

THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:

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

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Inpatient Benefits		
Hospital Care Includes hospital room & board expenses and miscellaneous services and supplies. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Authorization Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Preadmission Testing	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Physician's Visits while Confined	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Inpatient Surgery: Pre-Authorization Required		
Surgeon Services	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Anesthetist	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Assistant Surgeon	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Registered Nurse Services for private duty nursing while Confined Up to $500 maximum per Policy Year	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Authorization required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses

Inpatient Rehabilitation Facility Expense Benefit Pre-Authorization Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
INPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
Mental Health Disorder and Substance Use Disorder Benefit Pre-Authorization Required In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-Authorization requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Outpatient Benefits		
Outpatient Surgery: Pre-Authorization Required		
Surgeon Services	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Anesthetist	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Assistant Surgeon	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Outpatient Surgery Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Physician's Office Visits	$20 Copayment per visit then the plan pays 90% of the Negotiated after Deductible Charge for Covered Medical Expenses	$20 Copayment per visit then the plan pays 70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Specialist/Consultant Physician Services	$20 Copayment per visit then the plan pays 90% of the Negotiated Charge after Deductible for Covered Medical Expenses	$20 Copayment per visit then the plan pays 70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Telemedicine or Telehealth Services	Payable the same as any other Physician or Specialist Office Visit	

Cardiac Rehabilitation	$20 Copayment per visit then the plan pays 90% of the Negotiated Charge after Deductible for Covered Medical Expenses	$20 Copayment per visit then the plan pays 70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Cardiac Rehabilitation Maximum Visits per Policy Year	35	35
Pulmonary Rehabilitation	$20 Copayment per visit then the plan pays 90% of the Negotiated Charge after Deductible for Covered Medical Expenses	$20 Copayment per visit then the plan pays 70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation Maximum Visits per Policy Year	35	35
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Authorization Required	$20 Copayment per visit then the plan pays 90% of the Negotiated Charge after Deductible for Covered Medical Expenses	$20 Copayment per visit then the plan pays 70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Maximum Visits for each therapy per Policy Year	35	35
Habilitative Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Authorization Required	$20 Copayment per visit then the plan pays 90% of the Negotiated Charge after Deductible for Covered Medical Expenses	$20 Copayment per visit then the plan pays 70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Habilitative Services Maximum Visits for each therapy per Policy Year	35	35
Emergency Care Services in an emergency department (includes Urgent Care for Emergency Medical Conditions).	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Rate.
Urgent Care Centers for non-life-threatening conditions	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Diagnostic Imaging Services Pre-Authorization Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Authorization Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Authorization Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses

Infusion Therapy Pre-Authorization Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Home Health Care Expenses Pre-Authorization Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Hospice Care Coverage	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
OUTPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
Mental Health Disorder and Substance Use Disorder Benefit Pre-Authorization Required except for office visits		
Physician's Office Visits	$20 Copayment per visit then the plan pays 90% of the Negotiated Charge after Deductible for Covered Medical Expenses	$20 Copayment per visit then the plan pays 70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
All Other Outpatient Services except Emergency Services and Prescription Drugs. In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-Authorization requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses

Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy. You will not be required to pay more for a prescription drug than the lesser of the applicable copayment, the allowable claim amount or the amount You would pay if purchasing without health benefits or discounts.		
TIER 1 (Including Enteral Formulas) For each fill up to a 30-day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$10 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$10 Copayment then the plan pays 70% of Actual charge after Deductible for Covered Medical Expenses
More than a 30-day supply but less than a 61day supply filled at a Retail pharmacy	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$20 Copayment then the plan pays 70% of Actual charge after Deductible for Covered Medical Expenses
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 Deductible Waived	$30 Copayment then the plan pays 70% of Actual charge after Deductible for Covered Medical Expenses
TIER 2 (Including Enteral Formulas) For each fill up to a 30-day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$25 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$25 Copayment then the plan pays 70% of Actual charge after Deductible for Covered Medical Expenses

More than a 30-day supply but less than a 61day supply filled at a Retail pharmacy	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$50 Copayment then the plan pays 70% of Actual charge after Deductible for Covered Medical Expenses
More than a 60-day supply filled at a Retail pharmacy	$75 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$75 Copayment then the plan pays 70% of Actual charge after Deductible for Covered Medical Expenses
TIER 3 (Including Enteral Formulas) For each fill up to a 30-day supply filled at a Retail Pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$50 Copayment then the plan pays 70% of Actual charge after Deductible for Covered Medical Expenses
More than a 30-day supply but less than a 61day supply filled at a Retail pharmacy	$100 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$100 Copayment then the plan pays 70% of Actual charge after Deductible for Covered Medical Expenses
More than a 60-day supply filled at a Retail pharmacy	$150 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$150 Copayment then the plan pays 70% of Actual charge after Deductible for Covered Medical Expenses
Zero Cost Generics		
Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	100% of Actual charge for Covered Medical Expenses Deductible Waived

Specialty Prescription Drugs		
Specialty Prescription Drugs For each fill up to a 30-day supply Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$50 Copayment then the plan pays 70% of Actual charge after Deductible for Covered Medical Expenses
More than a 30-day supply but less than a 61day supply filled at a Retail pharmacy	$100 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$100 Copayment then the plan pays 70% of Usual and Customary Charge Actual charge after Deductible for Covered Medical Expenses
More than a 60-day supply filled at a Retail pharmacy	$150 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$150 Copayment then the plan pays 70% of Usual and Customary Charge Actual charge after Deductible for Covered Medical Expenses
Orally administered anti-cancer prescription drugs (including specialty drugs)		
Benefit	Greater of: • Chemotherapy Benefit; or • Infusion Therapy Benefit	
Diabetic Supplies (for Prescription supplies purchased at a pharmacy)		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill	
Other Benefits		
Allergy Testing	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Allergy Injections/Treatment	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Rate.
Non-Emergency Ambulance Service ground and/or air, water transportation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Covered Clinical Trials	Same as any other Covered Sickness	
Durable Medical Equipment Pre-Authorization Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses

Diabetic services and supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Dialysis Treatment	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Hearing Aids and Cochlear Implants Limited to 1 hearing aid per ear per 3-year period; and one cochlear implant in each ear with internal replacement as medically or audiologically necessary	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
Enteral Formulas and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Prosthetic and Orthotic Devices Pre-Authorization Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Reconstructive Surgery Pre-Authorization Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)		
Type A services: Diagnostic and Preventive care	100% of Usual and Customary Rate	
Type B services: Basic Restorative Care	50% of Usual and Customary Rate	
Type C services: Major Restorative care	50% of Usual and Customary Rate	
Orthodontic services	50% of Usual and Customary Rate	
Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.		

PREVENTIVE AND DIAGNOSTIC SERVICES (TYPE A)
Diagnostic and Treatment Services:
D0120 Periodic oral evaluation- Limited to 1 every 6 months
D0140 Limited oral evaluation- problem focused- Limited to 1 every 6 months
D0150 Comprehensive oral evaluation- Limited to 1 every 6 months
D0180 Comprehensive periodontal evaluation- Limited to 1 every 6 months

D0210 Intraoral-complete series (including bitewings) 1 every 60 (sixty) months film
D0220 Intraoral- periapical first
D0230 Intraoral- periapical - each additional film
D0240 Intraoral- occlusal film
D0270 Bitewing- single film 1 set every 6 months
D0272 Bitewings -two films 1 set every 6 months
D0274 Bitewings - four films 1 set every 6 months
D0277 Vertical bitewings-7 to 8 films 1 set every 6 months
D0330 Panoramic film-1 film every 60 (sixty) months
D0340 Cephalometric x-ray
D0350 Oral/ Facial Photographic Images
D0391 Interpretation of Diagnostic Image
D0470 Diagnostic Models
Preventative Services:
D1120 Prophylaxis-Child- Limited to 1 every 6 months
D1206 Topical fluoride varnish- 2 in 12 months
D1208 Topical application of fluoride (excluding prophylaxis)- 2 every 12 months
D1351 Sealant- per tooth- unrestored permanent molars - 1 sealant per tooth every 36 months
D1352 Preventative resin restorations in a moderate to high caries risk patient- permanent tooth- 1 sealant per tooth every 36 months
D1510 Space maintainer-fixed -unilateral
D1515 Space maintainer-fixed- bilateral
D1520 Space maintainer-removable-unilateral
D1525 Space maintainer-removable-bilateral
D1550 Re-cementation of space maintainer
Additional Procedures covered as Preventive and Diagnostic:
D9110 Palliative treatment of dental pain- minor procedure
BASIC RESTORATIVE SERVICES (TYPE B)
Minor Restorative Services:
D2140 Amalgam- one surface, primary or permanent
D2150 Amalgam- two surfaces, primary or permanent
D2160 Amalgam- three surfaces, primary or permanent
D2161 Amalgam- four or more surfaces, primary or permanent
D2330 Resin-based composite - one surface, anterior
D2331 Resin-based composite -two surfaces, anterior
D2332 Resin-based composite -three surfaces, anterior
D2335 Resin-based composite- four or more surfaces or involving incisal angle (anterior)
D2910 Re-cement inlay
D2920 Re-cement crown
D2930 Prefabricated stainless steel crown· primary tooth - Limited to I per tooth in 60 months
D2931 Prefabricated stainless steel crown - permanent tooth - Limited to I per tooth in 60 months
D2940 Protective Restoration
D2951 Pin retention per tooth, in addition to restoration
Endodontic Services:
D3220 Therapeutic pulpotomy (excluding final restoration)- *If a root canal is within 45 days of the pulpotomy, the Pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.*
D3222 Partial pulpotomy for apexogenesis- permanent tooth with incomplete root development *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal Procedure and benefits are not payable separately.*
D3230 Pulpal therapy (resorbable filling)- anterior, primary tooth (excluding final restoration)
D3240 Pulpal therapy (resorbable filling)- posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when treatment is discontinued.
Periodontal Services:
D4341 Periodontal scaling and root planing-four or more teeth per quadrant- Limited to 1 every 24 months
D4342 Periodontal scaling and root planing-one to three teeth, per quadrant- Limited to 1 every 24 months

D4910 Periodontal maintenance- 4 in 12 months combined with adult prophylaxis after the completion of active periodontal
Prosthodontic Services:
D5410 Adjust complete denture-maxillary
D5411 Adjust complete denture-mandibular
D5421 Adjust partial denture-maxillary
D5422 Adjust partial denture-mandibular
D5510 Repair broken complete denture base
D5520 Replace missing or broken teeth complete denture (each tooth)
D5610 Repair resin denture base
D5620 Repair cast framework
D5630 Repair or replace broken clasp
D5640 Replace broken teeth- per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture
D5710 Rebase complete maxillary denture- Limited to 1 in a 36-month period 6 months after the initial installation
D5720 Rebase maxillary partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
D5721 Rebase mandibular partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
D5730 Reline complete maxillary denture -Limited to 1 in a 36-month Period 6 months after the initial installation
D5731 Reline complete mandibular denture -Limited to l in a 36-month period 6 months after the initial installation
D5740 Reline maxillary partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
D5741 Reline mandibular partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
D5750 Reline complete maxillary denture (laboratory) -Limited to 1 in a 36-month period 6 months after the initial
D5751 Reline complete mandibular denture (laboratory)- Limited to 1 in a 36-month period 6 months after the initial
D5760 Reline maxillary partial denture (laboratory)·Limited to 1 in a 36-month period 6 months after the initial installation
D5761 Reline mandibular partial denture (laboratory) Rebase/Reline- Limited to 1 in a 36-month period 6 months after the initial installation
D5850 Tissue conditioning (maxillary)
D5851 Tissue conditioning (mandibular)
D6930 Re-cement fixed partial denture
D6980 Fixed partial denture repair, by report
Oral Surgery:
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of Tooth
D7220 Removal of impacted tooth - soft tissue
D7230 Removal of impacted tooth- partially bony
D7240 Removal of impacted tooth - completely bony
D7241 Removal of impacted tooth - completely bony with unusual surgical complications
D7250 Surgical removal of residual tooth roots (cutting procedure)
D7251 Coronectomy- intentional partial tooth removal
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Surgical access of an unerupted tooth
D7310 Alveoloplasty in conjunction with extractions - per quadrant
D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions- per quadrant
D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7471 Removal of exostosis
D7510 Incision and drainage of abscess intraoral soft tissue
D7910 Suture of recent small wounds up to *5* cm
D7971 Excision of pericoronal gingiva
MAJOR SERVICES (TYPE C)
Major Restorative Services:
D0160 Detailed and extensive oral evaluation- problem focused, by report
D2510 Inlay- metallic- one surface- An alternate benefit will be provided
D2520 Inlay- metallic- two surfaces -An alternate benefit will be provided
D2530 Inlay- metallic-three surfaces -An alternate benefit will be provided

D2542 Onlay- metallic- two surfaces- Limited to 1 per tooth every 60 months
D2543 Onlay - metallic- three surfaces- Limited to 1 per tooth every 60 months
D2544 Onlay - metallic- four or more surfaces- Limited to 1 per tooth every 60 months
D2740 Crown- porcelain/ceramic substrate- Limited to 1 per tooth every 60 months
D2750 Crown- porcelain fused to high noble metal- Limited to 1 per tooth every 60 months
D2751 Crown- porcelain fused to predominately base metal-Limited to 1 per tooth every 60 months
D2752 Crown- porcelain fused to noble metal-Limited to 1 per tooth every 60 months
D2780 Crown - 3/4 cast high noble metal- Limited to 1 per tooth every 60 months
D2781 Crown - 3/4 cast predominately base metal- Limited to 1 per tooth every 60 months
D2783 Crown - 3/4 porcelain/ceramic- Limited to 1 per tooth every 60 months
D2790 Crown - full cast high noble metal- Limited to 1 per tooth every 60 months
D2791 Crown- full cast predominately base metal-Limited to 1 per tooth every 60 months
D2792 Crown - full cast noble metal- Limited to I per tooth every 60 months
D2794 Crown-titanium- Limited to 1 per tooth every 60 months
D2950 Core buildup, including any pins- Limited to 1 per tooth every 60 months
D2954 Prefabricated post and core, in addition to crown- Limited to 1 per tooth every 60 months
D2980 Crown repair, by report
Endodontic Services:
D3310 Anterior root canal (excluding final restoration)
D3320 Bicuspid root canal (excluding final restoration)
D3330 Molar root canal (excluding final restoration)
D3346 Retreatment of previous root canal therapy-anterior
D3347 Retreatment of previous root canal therapy-bicuspid
D3348 Retreatment of previous root canal therapy-molar
D3351 Apexification/recalcification- initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352 Apexification/recalcification- interim medication replacement (apical closure/calcific repair of perforations, root
D3353 Apexification/recalcification- final visit (includes completed root canal therapy, apical closure/calcific repair of perforations. root resorption. etc.)
D3354 Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration
D3410 Apicoectomy/periradicular surgery- anterior
D3421 Apicoectomy/periradicular surgery- bicuspid (first root)
D3425 Apicoectomy/periradicular surgery -molar (first root)
D3426 Apicoectomy/periradicular surgery (each additional root)
D3450 Root amputation- per root
D3920 Hemisection (including any root removal)- not including root canal therapy
Periodontal Services:
D4210 Gingivectomy or gingivoplasty- four or more teeth-Limited to 1 every 36 months
D4211 Gingivectomy or gingivoplasty-one to three teeth
D4240 Gingival flap procedure, four or more teeth-Limited to 1 every 36 months
D4249 Clinical crown lengthening-hard tissue
D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant- Limited to 1 every 36 months
D4261 Osseous surgery (including flap entry and closure), oneto three contiguous teeth or bounded teeth spaces per quadrant- Limited to 1 every 36 months
D4270 Pedicle soft tissue graft procedure
D4273 Subepithelial connective tissue graft procedures (including donor site surgery)
D4277 Free soft tissue graft procedure (including donor site surgery)
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis
Prosthodontic Services:
D5110 Complete denture - maxillary-Limited to 1 every 60 months
D5120 Complete denture- mandibular-Limited to 1 every 60 months
D5130 Immediate denture- maxillary-Limited to 1 every 60 months
D5140 Immediate denture- mandibular-Limited to 1 every 60 months
D5211 Maxillary partial denture- resin base (including any conventional clasps, rests and teeth)- Limited to 1 every 60
D5212 Mandibular partial denture- resin base (including any conventional clasps, rests and teeth)-Limited to 1 every 60
D5213 Maxillary partial denture- cast metal framework with resin denture base (including any conventional clasps, rests

D5214 Mandibular partial denture- cast metal framework with resin denture base (including any conventional clasps, rests
D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth)-Limited to 1 every 60
D6010 Endosteal Implant- 1 every 60 months
D6012 Surgical Placement of Interim Implant Body- 1 every 60 months
D6040 Eposteal Implant- 1 every 60 months
D6050 Transosteal Implant. Including Hardware- 1 every 60 months
D6053 Implant supported complete denture
D6054 Implant supported partial denture
D6055 Connecting Bar-implant or abutment supported- 1 every 60 months
D6056 Prefabricated Abutment- 1 every 60 months
D6057 Custom Abutment – 1 every 60 months
D6058 Abutment supported porcelain ceramic crown - 1 every 60 months
D6059 Abutment supported porcelain fused to high noble metal- 1 every 60 months
D6060 Abutment supported porcelain fused to predominately base metal crown- 1 every 60 months
D6061 Abutment supported porcelain fused to noble metal crown 1 every 60 months
D6062 Abutment supported cast high noble metal crown - 1 every 60 months
D6063 Abutment supported cast predominately base metal crown – 1 every 60 months
D6064 Abutment supported Cast noble metal crown 1 every 60 months
D6065 Implant supported porcelain/ceramic crown- 1 every 60 months
D6066 Implant supported porcelain fused to high metal crown - 1 every 60 months
D6067 Implant supported metal crown- 1 every 60 months
D6068 Abutment supported retainer for porcelain/ceramic fixed partial denture- 1 every 60 months
D6069 Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
D6070 Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60
D6071 Abutment supported retainer for porcelain fused to noble metal fixed partial denture- 1 every 60 months
D6072 Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months
D6073 Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months
D6074 Abutment supported retainer for cast noble metal fixed partial denture- 1 every 60 months
D6075 Implant supported retainer for ceramic fixed Partial denture- 1 every 60 months
D6076 Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
D6077 Implant supported retainer for cast metal fixed partial denture - 1 every 60 months
D6078 Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months
D6079 Implant/abutment supported fixed partial denture for partially edentulous arch- 1 every 60 months
D6080 Implant Maintenance Procedures -1 every 60 months
D6090 Repair Implant Prosthesis -1 every 60 months
D6091 Replacement of Semi-Precision or Precision Attachment- 1 every 60 months
D6095 Repair Implant Abutment -1 every 60 months
D6100 Implant Removal-1 every 60 months
D6101 Debridement periimplant defect, covered if implants are covered – Limited to 1 every 60 months
D6102 Debridement and osseous periimplant defect, covered if implants are covered – Limited to 1 every 60 months
D6103 Bone Graft periimplant defect, covered if implants are covered
D6104 Bone Graft implant replacement, covered if implants are covered
D6190 Implant Index -1 every 60 months
D6210 Pontic-cast high noble metal- Limited to 1 every 60 months
D6211 Pontic-cast predominately base metal -Limited to 1 every 60 months
D6212 Pontic-cast noble metal- Limited to 1 every 60 months
D6214 Pontic-titanium-Limited to 1 every 60 months
D6240 Pontic -porcelain fused to high noble metal-Limited to 1 every 60 months
D6241 Pontic-porcelain fused to predominately base metal-Limited to 1 every 60 months
D6242 Pontic-porcelain fused to noble metal Limited to 1 every 60 months
D6245 Pontic-porcelain/ceramic-Limited to 1 every 60 months
D6545 Retainer -cast metal for resin bonded fixed prosthesis -1 every 60 months
D6548 Retainer- porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months
D6740 Crown- porcelain/ceramic- 1 every 60 months
D6750 Crown -porcelain fused to high noble metal - 1 every 60 months
D6751 Crown- porcelain fused to predominately base metal- 1 every 60 months
D6752 Crown- porcelain fused to noble metal - 1 every 60 months

D6780 Crown -3/4 cast high noble metal - 1 every 60 months
D6781 Crown- 314 cast predominately base metal • 1 every 60 months
D6782 Crown 3/4 cast noble metal 1 every 60 months
D6783 Crown - 3/4 porcelain/ceramic- 1 every 60 months
D6790 Crown • full cast high noble metal- 1 every 60 months
D6791 Crown -full cast predominately base metal- 1 every 60 months
D6792Crown full cast noble metal 1 every 60 months
D9940 Occlusal guard, by report- 1 in 12 months
GENERAL SERVICES (TYPE C)
Anesthesia Services:
D9222 Deep sedation/general anesthesia- first 30 minutes
D9223Deep sedation/general anesthesia- each additional 15 minutes
Intravenous Sedation:
D9239 Intravenous conscious sedation/analgesia- first 30 minutes
D9243 Intravenous conscious sedation/analgesia each additional 15 minutes
Consultations:
D9310 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)
Medications:
D9610 Therapeutic drug injection, by report
Post-Surgical Services:
D9930 Treatment of complications (post-surgical) unusual circumstances, by report
MEDICALLY NECESSARY ORTHODONTIA SERVICES (TYPE D)
Orthodontic Services -covered for persons with severe and handicapping malocclusion
D8010 Limited orthodontic treatment of the primary dentition
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8050 Interceptive orthodontic treatment of the primary dentition
D8060 Interceptive orthodontic treatment of the transitional dentition
D8070Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8670 Periodic orthodontic treatment visits (as part of contract)
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)
D8681 Removable appliance therapy

Pediatric Vision Care Benefit (including low vision services) to the end of the month in which the Insured Person turns age 19 Limited to 1 visit 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.	90% of Usual and Customary Rate after Deductible for Covered Medical Expenses	
Accidental Injury Dental Treatment	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Sickness Dental Expense	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses

Oral Surgery and Treatment	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Pre-Authorization Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Maximum visits per Policy Year Combined with Outpatient Rehabilitation.	35	35
Organ Transplant Surgery travel and lodging expenses a maximum of $2,000 per Policy Year or $250 per day, whichever is less Pre-Authorization Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Shots and Injections unless considered Preventive Services	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Tuberculosis screening, Titers, Quantiferon B tests including shots (other than covered under preventive services)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Sports Accident Expense - incurred as the result of the play or practice of Intercollegiate or club sports	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Non-emergency Care While Traveling Outside of the United States	70% of Actual Charge after Deductible for Covered Medical Expenses	
Medical Evacuation Expense (International Students and their Dependents	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $50,000 maximum per Policy Year	
Repatriation Expense (International Students and their Dependents	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $25,000 maximum per Policy Year	
Mandated Benefits		
Acquired Brain Injury	Same as any other Covered Sickness	
Autism Spectrum Disorder	Same as any other Mental Health Disorder	
Cervical and Ovarian Cancer Screening	Same as any other Covered Sickness, unless considered a Preventive Service	
Colorectal Cancer Screening	Same as any other Covered Sickness, unless considered a Preventive Service	

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

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

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 the Certificate.

Preauthorization

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

Exclusions and Limitations

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

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

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

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

7. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
8. Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services covered by Student Health Fees.
9. Any expenses in excess of Usual and Customary Rate except as provided in the Certificate.
10. Loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
11. Loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority.
12. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
13. 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.
14. Services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
15. Expenses payable under any prior policy which was in force for the person making the claim.
16. 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.
17. 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.
18. Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
19. Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
20. 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.
21. Treatment for obesity. Surgery for removal of excess skin or fat.
22. Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
23. Expenses for radial keratotomy.
24. Adult Vision unless specifically provided in the Certificate.
25. Charges for office visit exam for the fitting of prescription contact lenses, duplicate spare eyeglasses, lenses or frames, non-prescription lenses or contact lenses that are for cosmetic purposes.
26. Charges for hearing exams, hearing screening, and the fitting or repair or replacement of hearing aids

except as specifically provided in the Certificate.

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

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

Value Added Services

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

VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:

www.wellfleetstudent.com

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

Wellfleet Student provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Wellfleet Student at (877) 657-5030. **If you are traveling and need assistance in North America, call the Assistance Center toll-free at: (877) 305-1966 *or* if you are in a foreign country, call collect at: (715) 295-9311**. When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

24 HOUR NURSELINE

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

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

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

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

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

(800) 634-7629

CareConnect

Integrated Behavioral Health from Wellfleet Student

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

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