AMENDMENT #1

TO

THE PLAN DOCUMENT TO KENYON COLLEGE STUDENT HEALTH BENEFIT PLAN

Effective August 15, 2021 the Plan Document is hereby amended to reflect the following:

- ***Termination of Coverage*** *Section includes the following language:*

  - *For International Students, the date they cease to meet Visa requirements; or*
  - *For International Students, the date they depart the Country of Assignment for their Home Country*

- ***Refund of Premium Section*** *to be added:*

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

  1. If a student ceases to be eligible for the insurance and coverage is terminated prior to the next premium due date, a pro rata refund of Premium will be made for such person. However, if this person has incurred any filed claims whatsoever during the plan year prior to the request, then no premium refund will be granted.

  2. For any student who withdraws from school during the first 31consecutive days of period for which he or she is enrolled for a reason other than withdrawal due to Sickness or Injury. Such a student will not be covered under this Plan Document and a full refund of the Premium will be mad when written request is made within 45 days of withdrawal from school.

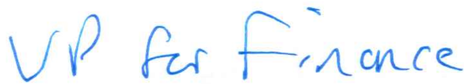
  However, if this person has incurred any filed claims whatsoever during the plan year prior to the request, then no premium refund will be granted.

3. For an Insured Student entering the Armed Forces of any country. Such a student will not be covered under this Plan Document as of the date of his/her entry into the service. A pro rata refund of Premium will be made upon written request received by Us within 45 days of withdrawal from school. However, if this person has incurred any filed claims whatsoever during the plan year prior to the request, then no premium refund will be granted.

4. For a Covered International Student departing school to return to his or her Home Country. We will refund a pro rata refund of Premium when written request is received by Us within 45 days of such departure. However, if this person has incurred any filed claims whatsoever during the plan year prior to the request, then no premium refund will be granted.

Agreed to by:

Kenyon College



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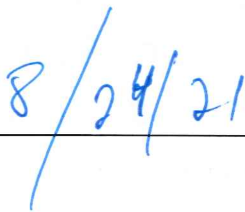

Date

IMPORTANT INFORMATION: This document reflects the known requirements for compliance under The Affordable Care Act as passed on March 23, 2010.

KENYON COLLEGE

STUDENT HEALTH BENEFITS PLAN (SHBP)
PLAN DOCUMENT

Effective: August 15, 2021

For the most current information regarding the SHBP, refer to the SHBP website at:

INTRODUCTION

Kenyon College has prepared this document to help you understand your medical and prescription drug benefits as a Covered Person in the Student Health Benefits Plan (SHBP). Please read it carefully. The Schedule of Benefits provides an overview of your coverage.

The information contained in this document is a description of Kenyon College Medical Care Plan for Students (the "Plan") and defines how this Plan works. If the Covered Person does not understand anything in this document, the Plan Administrator will be able to clarify any of your questions.

Kenyon College fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, maximums, Copayments, exclusions, limitations, definitions, eligibility, and the like.

GENERAL INFORMATION

Plan Name:

Kenyon College Student Health Benefits Plan (referred to hereafter as "SHBP" or "Plan").

Type of Plan:

Non-ERISA governed student health benefits plan providing medical and prescription drug benefits on a self-funded basis.

Effective Date:
August 15, 2021

Plan Sponsor:

Kenyon College

Group Number
ST1854SH

Plan Administrator:

Kenyon College
106 College Park Drive
Gambier, OH 43022

Claims Administrator:
Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369
877-657-5035

Type of Plan
Medical Care Plan

Funding
Plan Benefits provided by Kenyon College

The level of any Student Contribution is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Student Contributions. The Plan Sponsor pays Plan benefits and administration expenses directly from general assets. Contributions received from eligible Participants are used to cover Plan costs and are expended immediately.

Type of Plan Administration
Self-Administered

Termination and/or Modification of SHBP

The Plan Sponsor may terminate the SHBP at the end of any Plan Year or change the provisions of the SHBP at any time by a written Plan Document amendment signed by a duly-authorized officer of the Plan Sponsor. The consent of any Covered Person is not required to terminate or change the SHBP.

Non-Discriminatory Clauses

NOTE: The SHBP is not an employer-sponsored health plan. Accordingly, the rules and regulations of the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1996 (COBRA), and other federal laws that apply exclusively to employer-sponsored health plans are not applicable to the SHBP. To the extent that the SHBP voluntarily adopts certain practices as described under ERISA, such adoption shall not be deemed to subject the SHBP to ERISA regulation.

The federal laws and regulations that are applicable to the SHBP include, but are not limited to, the following.

- Patient Protection and Affordable Care Act (refer to CMS-9981-F).
- Title IX of the Education Amendments of 1972. The SHBP provides pregnancy benefits on the same basis as any other temporary disability.
- Section 504 of the Rehabilitation Act of 1973.
- Age Discrimination Act of 1975.
- Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Regulations of the United States Information Agency applicable to visa recipients.

The SHBP fully complies with the benefit requirements mandated in regulations for fully insured student health insurance plans issued by the U.S. Department of Health and Human Services (refer to Federal Register 77 FR 16453) and covered medical services specified under the Essential Health Benefits Benchmark plan adopted by the State of Ohio.

Full disclosure of Kenyon College's Affirmative Action and Equity Policy may be found online at www.kenyon.edu

General Notice about Nondiscrimination and Accessibility

The SHBP complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The SHBP does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

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SECTION 1 - DEFINITIONS

These are defined terms used throughout this document, .

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

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

Adverse Benefit Determination – means:

(1) the requested benefit is denied, reduced, or terminated, or payment is not made, in whole or in part, for the benefit because a determination was made by the Claims Administrator that, based upon the information provided, the request for benefit under the Plan does not meet the requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, or is determined to be experimental or investigational;

(2) the denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by the Claims Administrator of your ineligibility to participate in the Plan;

(3) any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment in whole or in part for a benefit; or

(4) a rescission of coverage determination.

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

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

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

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

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

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

Claims Administrator means the Claims Administrator responsible for the processing of claims, reviewing benefits for purposes of prior authorization, providing certain financial services, providing reports and making initial benefit determinations subject to the Plan and direction of the Plan Administrator. It does not fund or insure claim payments or bear any financial risk with regard to Plan expenses.

Claimant – means Covered Person to whom the claim relates or, as applicable, to the Covered Person's authorized representative.

Coinsurance means the percentage of Covered Medical Expenses that the Plan will pay. The Coinsurance percentage is stated in the Schedule of Benefits. The Coinsurance is separate and not part of the Deductible and Copayment.

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

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

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

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

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

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

Covered Medical Expense means those Medically Necessary charges for any Treatment, service, or supplies that are: incurred while this Plan is in force, except with respect to any expenses payable under the Extension of Benefits Provision.

Covered Person means a Covered Student who is eligible and covered under this SHBP plan document.

Covered Student means a student of the College who is eligible and covered under this SHBP plan document.

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

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

Deductible means the dollar amount of Covered Medical Expenses the Covered Person must pay before benefits are payable under this Plan. The amount of the Deductible, if any, will be shown in the Schedule of Benefits.

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

Durable Medical Equipment means a device which:
1. Is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of Sickness or Injury and is able to withstand repeated use;
2. Is used exclusively by You;
3. Is routinely used in a Hospital but can be used effectively in a non-medical facility;
4. Can be expected to make a meaningful contribution to treating Your Sickness or Injury; and
5. Is prescribed by a Physician and the device is Medically Necessary for rehabilitation.

Durable Medical Equipment does not include:
1. Comfort and convenience items;
2. Equipment that can be used by Immediate Family Members other than You;
3. Health exercise equipment; and
4. Equipment that may increase the value of Your residence.

Effective Date means the date coverage becomes effective.

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

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

Emergency Medical Condition means an accidental traumatic bodily injury or other medical condition that manifests itself by acute symptoms of such severity (including severe pain) that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:
1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Result in serious impairment to the individual's bodily functions; or
3. Result in serious dysfunction of a bodily organ or part of the individual.

Emergency Services means, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to Stabilize the patient.

Essential Health Benefits mean benefits that are defined in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes the following categories of Covered Services:
1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and Substance Use Disorder services, including behavioral health Treatment;
6. Prescription drugs;
7. Rehabilitative and Habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

Experimental/Investigative means the service or supply has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication. For further explanation, see definition of Medically Necessary/Medical Necessity provision.

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

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

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

Home Health Care Agency means an agency that:
1. Is constituted, licensed and operated under the provision of Title XVIII of the Federal Social Security Act, or qualified to be so operated if application was made, and certified by the jurisdiction in which the Home Health Care plan is established; and
2. Is engaged primarily in providing skilled nursing facility services and other therapeutic services in Your Home under the supervision of a Physician or a Nurse; and
3. Maintains clinical records on all patients.

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

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

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

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

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

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

Medically Necessary or **Medical Necessity** means health care services that a Physician, exercising prudent clinical judgment, would provide for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for an illness, injury or disease; and
3. not primarily for the convenience of a Covered Person, Physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or Treatment of a Covered Person's illness, injury or disease.

The fact that any particular Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Mental Health Disorder means a condition or disorder that substantially limits the life activities of a Covered Person with the disorder. Mental Health Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization.

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

1. Is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
2. Provides medical services which are within the scope of the Nurse's license or certificate who does not ordinarily reside in Your home or is not related to the Covered Person by blood or marriage.

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

Out-of-Pocket Maximum means the most the Covered Person will pay during Plan Year before coverage begins to pay 100% of the allowed amount. Refer to the Out-of-Pocket Maximum in the Description of Benefits section for details on how the Out-of-Pocket Maximum applies. This limit will never include Premium, balance-billed charges or health care this Plan does not cover.

Physical Therapy means any form of the following:
1. Physical or mechanical therapy;
2. Diathermy;
3. Ultra-sonic therapy;
4. Heat Treatment in any form; or
5. Manipulation or massage.

Physician means a health care professional practicing within the scope of his or her license and is duly licensed by the appropriate state regulatory agency to perform a particular service which is covered under this Plan, and who is not:
1. the Covered Person.
2. An Immediate Family Member; or
3. A person employed or retained by the Covered Person.

Plan means the Kenyon College Student Health Benefit Plan (also referred to herein as SHBP).

Plan Administrator means Kenyon College is the sole fiduciary of the SHBP and exercises all discretionary authority and control over the administration of the SHBP and the management and disposition of plan assets. The Plan Administrator shall have the sole discretionary authority to determine eligibility for plan benefits or to construe the terms of the SHBP. The Plan Administrator has the right to amend, modify, or terminate the SHBP in any manner, at any time, regardless of the health status of any plan participant or beneficiary.

- The Plan Administrator has retained Wellfleet as our Third-Party Claims Administrator (TPA) to perform claims processing and other specified services in relation to the SHBP. Wellfleet is not a fiduciary of the SHBP and will not exercise any of the discretionary authority and responsibility granted to the Plan Administrator, as described above.

Plan Document means this document governing the operation of the Kenyon Student Group Health Plan for the 2021-2022 Plan Year.

Plan Sponsor means Kenyon College

Plan Year The twelve (12) month period beginning August 15 and ending August 14, 2022.

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

Qualifying Life Event means an event that qualifies a Student to apply for coverage for him/herself due to a Qualifying Life Event under the plan.

Rehabilitative means the process of restoring the Covered Person's ability to live and work after a disabling condition by:
1. Helping achieve the maximum possible physical and psychological fitness;
2. Helping regain the ability to care for oneself;
3. Offering assistance with relearning skills needed in everyday activities, with occupational training and guidance with psychological readjustment.

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

School or College means the college or university attended by the Covered Student.

Skilled Nursing Facility means a facility, licensed, and operated as set forth in applicable state law, which:
1. Mainly provides inpatient care and Treatment for persons who are recovering from an illness or injury;
2. Provides care supervised by a Physician;
3. Provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. Is not a place primarily for the care of the aged, Custodial or Domiciliary Care, or Treatment of alcohol or drug dependency; and
5. Is not a rest, educational, or custodial facility or similar place.

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

Stabilize means, the provision of medical treatment to the Covered Person in an Emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or occur during any of the following:
- the Covered Person's discharge from an emergency department or other care setting where Emergency Care is provided; or
- transfer from an emergency department or other care setting to another facility; or
- transfer from an Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Substance Use Disorder means any condition or disorder that substantially limits the life activities of an Covered Person with the disorder. Substance Use Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization.

Surgeon means a Physician who actually performs surgical procedures.

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

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

Urgent Care means an illness or injury that requires prompt medical attention but is not an Emergency Medical Condition and services are provided at an Urgent Care Center, as shown in the Schedule of Benefits

Urgent Care Center means a Hospital or other licensed facility which provides diagnosis, Treatment, and care of persons who need acute care under the supervision of Physicians.

Usual and Customary Charge is the amount of a provider's charge that is eligible for coverage and are responsible for all amounts above what is eligible for coverage.

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

Service or Supply	**Usual and Customary Charge**
Professional services and other services or supplies not mentioned below	The Reasonable amount rate
Services of hospitals and other facilities	The Reasonable amount rate

Special terms used

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

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

Reimbursement policies

The Plan reserves the right to apply the reimbursement policies to all Out-of-Network services including involuntary services. The reimbursement policies may affect the Usual and Customary

Charge. These policies consider:

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

The Plan's reimbursement policies are based on review of:

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

No payment will be made under this Plan for any expenses incurred which, in the Plan's judgment, are in excess of Usual and Customary Charges.

SECTION 2 ELIGIBILITY

A. Eligible Students

Eligible Students for the SHBP are defined as:

- All full time students enrolled are eligible for coverage as determined by the Plan Administrator.

The requirements for students to have health insurance are established by Kenyon College under policies published separately from the SHBP Document.

Eligible Students must enroll each Plan Year by the enrollment deadlines established by the Plan Administrator. Eligible Students who have other health insurance will be able to waive coverage under the SHBP if their insurance meets or exceeds the waiver criteria established and published by the Plan Administrator. All waivers must be received by the Plan Administrator by the due dates established and published by the Plan Administrator each Plan Year. Otherwise, Eligible Students will be automatically enrolled in and charged for the SHBP.

Each Eligible Student who meets the eligibility requirements of the SHBP and who submits an enrollment application that has been approved by the Plan Administrator (or who is automatically enrolled per the terms of the SHBP) shall become an Covered Student.

Dependent Eligibility
Dependents are not eligible under this Plan.

B. Qualified Late Enrollees

Students may be approved to enroll in the SHBP after the Plan Year's enrollment deadline under the provision established in this Section. Eligible Students may include those who enroll at Kenyon College in the spring semester, or those who involuntarily lose eligibility under a group health insurance plan either due to a loss of employment or to attainment of a maximum age to be covered under their parent's plan. Such Students will be Qualified Late Enrollees for the SHBP if they request enrollment from the Plan Administrator within thirty (30) days of the Involuntary Loss of their group health insurance plan, or within the enrollment deadlines for spring semester students as established by the Plan Administrator. The cost of the SHBP is pro-rated for Qualified Late Enrollees on a monthly basis. The Effective Date will be the first of the month in which the student involuntarily loses his or her health insurance.

Qualified Late Enrollees also includes any eligible student who is discovered to be without health insurance and who has not yet attained age 19.

C. Unqualified Late Enrollees

Any Eligible Student who is subject to the Kenyon's insurance requirement and is found to be uninsured during the Plan Year (and is not a Qualified Late Enrollee) will be required to enroll in the SHBP and charged for the full year cost regardless of the Effective Date of coverage under the SHBP.

SECTION 3 STUDENT EFFECTIVE AND TERMINATION DATES

Effective Dates: Participation in the Plan by the Student under the SHBP Plan will become effective on the later of:

1. The Plan Effective Date.
2. The beginning date of the term of coverage for which any required student contribution has been paid.
3. The receipt by the Plan of a completed enrollment form and any other information requested by the Plan and payment of any required student contributions;
4. The day after the date of postmark if the enrollment form is mailed; or
5. For Freshmen and other new students who are required to be on campus prior to the Effective Date, coverage is extended, but no earlier than August 1.

Special Enrollment - Qualifying Life Event

The Plan shall permit a Student who is eligible for coverage under the terms of the Plan but not enrolled to enroll for coverage under the Plan pursuant to this section if each of the following conditions is met

1. Involuntary termination of the other health plan;
2. Death of the Spouse;
3. Legal separation, divorce or annulment;

The Student can also enroll 60 days from exhaustion of COBRA or continuation coverage.

Notice and contribution payment must be made within 60 days of the loss of coverage. The Effective Date of coverage will depend on when proof of loss of coverage under another health plan and appropriate contribution payment is received. Coverage shall take effect on the latest of the following dates: (1) this Plan Effective Date; (2) the day after the date for which coverage is lost providing any required Student Contribution has been paid ; (3) the date term of coverage begins; or (4) the date the Student become a member of an eligible class of persons.

In addition, the Student can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. eligibility for Medicaid or a state child health plan ends.
2. eligibility for Medicaid or a state child health plan ends.

Notice and contribution payment must be received within 60 days of the loss of one of these events. The Effective Date of coverage will depend on the date the completed enrollment form and any other information requested by the Plan and payment of any required Student Contributions is made.

Termination Dates: Coverage will terminate on the earliest of:

1. The date the SHBP terminates; or
2. The end of the period of coverage for which the student contribution has been paid; or
3. The date the Student ceases to be eligible for the coverage; or
4. The date the Student enters military service.

Extension of Benefits: Coverage under this Plan ceases on the Termination Date. However, coverage will be extended as follows:

1. If a Covered Student is Hospital Confined for Covered Injury or Covered Sickness on the date insurance coverage terminates. The Plan will continue to pay benefits for up to 90 days from the Termination Date while such Confinement continues.

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SECTION 4 - SCHEDULE OF BENEFITS

Preventive Services:
The Deductible and Coinsurance are not applicable to Preventive Services. Benefits are paid at 100% of the Actual Charge.

Medical Deductible Individual: $250

Out-of-Pocket Maximum: Individual: $6,825

The Out of Pocket Maximum will never exceed the amount shown above for an Covered Person. Benefits will be paid at 100% after the Out of Pocket Maximum has been satisfied.

Coinsurance Amounts: 80% of Covered Medical Expenses

THE COVERED MEDICAL EXPENSE 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.**

BENEFITS FOR COVERED INJURY/SICKNESS	PLAN COST SHARE AND LIMITATIONS PLAN WILL PAY
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.	80% of the Actual Charge after Deductible for Covered Medical Expenses
Preadmission Testing	80% of the Actual Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined: Limited to 1 visit per day of Confinement per provider	80% of the Actual Charge after Deductible for Covered Medical Expenses
Inpatient Surgery: Surgeon Services Anesthetist Assistant Surgeon	 80% of the Actual Charge after Deductible for Covered Medical Expenses 80% of the Actual Charge after Deductible for Covered Medical Expenses 80% of the Actual Charge after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	80% of the Actual Charge after Deductible for Covered Medical Expenses

Physical Therapy while Confined (inpatient) Maximum Visits per Plan Year	60	60
Skilled Nursing Facility Benefit	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Skilled Nursing Facility Benefit Maximum days per Plan Year	90	90
Inpatient Rehabilitation Facility Expense Benefit including Physical Medicine and Day Rehabilitation Therapy services	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Inpatient Rehabilitation Facility Expense Benefit Maximum days per Plan Year	60	60
INPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
Mental Health Disorder and Substance Use Disorder Benefit Including residential treatment facilities In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Outpatient Benefits		
Outpatient Surgery: Surgeon Services Anesthetist Assistant Surgeon	 80% of the Actual Charge after Deductible for Covered Medical Expenses 80% of the Actual Charge after Deductible for Covered Medical Expenses 80% of the Actual Charge after Deductible for Covered Medical Expenses	
Outpatient Surgery Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Physician's Office Visits	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Specialist/Consultant Physician Services	80% of the Actual Charge after Deductible for Covered Medical Expenses	

Telemedicine or Telehealth Services	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Cardiac Rehabilitation	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Cardiac Rehabilitation Maximum Visits per Plan Year	36	36
Pulmonary Rehabilitation	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Pulmonary Rehabilitation Maximum Visits per Plan Year	20	20
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy and Inhalation Therapy	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Maximum Visits for each therapy per Plan Year for Physical Therapy, Occupational Therapy and Speech Therapy	20	20
Habilitative Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Habilitative Services are covered to the extent that they are Medically Necessary – including services for children (up to age 21) with a medical diagnosis of Autism Spectrum Disorder. Clinical Therapeutic intervention, including but not limited to Applied Behavior Analysis, These are separate limits and are not combined with therapy limits for other conditions.	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Habilitative Services Maximum Visits for each therapy per Plan Year for Physical Therapy, Occupational Therapy and Speech Therapy These limits do not apply to the above limits for the condition of Autism.	20	20
Emergency Services (includes Ambulance and Urgent Care for Emergency Medical Conditions).	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Urgent Care Centers for non-life-threatening	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Diagnostic Imaging Services	80% of the Actual Charge after Deductible for Covered Medical Expenses	

CT Scan, MRI and/or PET Scans	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Laboratory Procedures (Outpatient)	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Chemotherapy and Radiation Therapy Including orally administered cancer drugs	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Home Infusion Therapy	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Home Health Care Expenses	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Home Health Care Expenses Maximum visits per Plan Year	100	100
Hospice Care Coverage	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Outpatient Private Duty Nursing	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Outpatient Private Duty Nursing Maximum visit per Plan Year	90	90
OUTPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
Mental Health Disorder and Substance Use Disorder Benefit except for office visits In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating pharmacy		
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 Actual Charge after Deductible for Covered Medical Expenses	
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$20 Copayment then the plan pays 100% 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 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 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 Actual Charge after Deductible for Covered Medical Expenses
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$60 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses
More than a 60 day supply filled at a Retail pharmacy	$90 Copayment then the plan pays 100% 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 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 Actual Charge after Deductible for Covered Medical Expenses
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$100 Copayment then the plan pays 100% 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 Actual Charge after Deductible for Covered Medical Expenses
Zero Cost Generics	
In addition to ACA Preventive Care medications, certain Generic Drugs are covered at no cost to you. These zero cost generics can be identified in the Formulary posted on Our website www.wellfleetstudent.com	100% of Actual Charge for Covered Medical Expenses Deductible waived
Specialty Prescription Drugs	
Specialty Prescription Drugs For each fill up to a 30day supply	$100 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses
More than a 30 day supply but less than a 61 day supply	$200 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses
More than a 60 day supply	$300 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses

Tobacco Cessation	
Tobacco cessation prescription and over-the-counter drugs will be covered for two 90-day treatment regimens only. Any additional prescription drug treatment regimens will be subject to the cost sharing below. For details on the current list of tobacco cessation prescription drugs and OTC drugs covered with no cost sharing during the two 90-day treatment regimens allowed, visit www.wellfleetstudent.com or call 877-657-5030	100%
Tobacco cessation prescription drugs beyond the coverage above. Additional regiments of over-the-counter drugs are excluded.	80% of Actual Charge after Deductible for Covered Medical Expenses Deductible Waived
Orally administered anti-cancer prescription drugs (including specialty drugs)	
Benefit	Greater of: • Chemotherapy Benefit; or • Home Infusion Therapy Benefit
Diabetic Supplies (for Prescription supplies purchased at a pharmacy)	80% of Actual Charge after Deductible for Covered Medical Expenses Deductible Waived

Other Benefits	
Allergy Testing	80% of the Actual Charge after Deductible for Covered Medical Expenses
Allergy Injections/Treatment	80% of the Actual Charge after Deductible for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	80% of the Actual Charge after Deductible for Covered Medical Expenses
Non-Emergency Ambulance Service ground and/or air, water transportation	80% of the Actual Charge after Deductible for Covered Medical Expenses
Covered Cancer Clinical Trials	80% of the Actual Charge after Deductible for Covered Medical Expenses
Durable Medical Equipment	80% of the Actual Charge after Deductible for Covered Medical Expenses
Diabetic services and supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	80% of the Actual Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	80% of the Actual Charge after Deductible for Covered Medical Expenses
Maternity Benefit	80% of the Actual Charge after Deductible for Covered Medical Expenses
Enteral Formulas and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	80% of the Actual Charge after Deductible for Covered Medical Expenses
Prosthetic and Orthotic Devices	80% of the Actual Charge after Deductible for Covered Medical Expenses
Reconstructive Surgery	80% of the Actual Charge after Deductible for Covered Medical Expenses
Pediatric Dental Care Benefit (to the end of the month in which the Covered turns age 19)	
Type A services: Diagnostic and Preventive care	100% of Actual Charge
Type B services: Basic Restorative Care	50% of Actual Charge
Type C services: Major Restorative care	50% of Actual Charge
Orthodontic services	50% of Actual Charge
Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	

PREVENTIVE AND DIAGNOSTIC SERVICES (TYPE A)	
Diagnostic and Treatment Services:	
Periodic oral evaluation- Limited to 1 every 6 months	
Limited oral evaluation- problem focused- Limited to 1 every 6 months	
Comprehensive oral evaluation- Limited to 1 every 6 months	
Comprehensive periodontal evaluation- Limited to 1 every 6 months	
Intraoral-complete series (including bitewings) 1 every 60 (sixty) months film	
Intraoral- periapical first	
Intraoral- periapical - each additional film	
Intraoral- occlusal film	
Bitewing- single film 1 set every 6 months	
Bitewings -two films 1 set every 6 months	
Bitewings - four films 1 set every 6 months	
Vertical bitewings-7 to 8 films 1 set every 6 months	
Panoramic film-1 film every 60 (sixty) months	
Cephalometric x-ray	
Oral/ Facial Photographic Images	
Diagnostic Models	
Preventative Services:	
Prophylaxis-Child- Limited to 1 every 6 months	
Topical application of fluoride (excluding prophylaxis)--Limited to 2 every 12 months	
Topical application of fluoride (excluding prophylaxis)- 2 every 12 months	
Topical fluoride varnish- 2 in 12 months	
Sealant- per tooth- unrestored permanent molars - 1 sealant per tooth every 36 months	
Preventative resin restorations in a moderate to high caries risk patient- permanent tooth- 1 sealant per tooth every 36 months	
Space maintainer-fixed -unilateral	
Space maintainer-fixed- bilateral	
Space maintainer-removable-unilateral	
Space maintainer-removable-bilateral	
Re-cementation of space maintainer	
Additional Procedures covered as Preventive and Diagnostic:	
Palliative treatment of dental pain- minor procedure	
BASIC RESTORATIVE SERVICES (TYPE B)	
Minor Restorative Services:	
Amalgam- one surface, primary or permanent	
Amalgam- two surfaces, primary or permanent	
Amalgam- three surfaces, primary or permanent	
Amalgam- four or more surfaces, primary or permanent	
Resin-based composite - one surface, anterior	
Resin-based composite -two surfaces, anterior	
Resin-based composite -three surfaces, anterior	
Resin-based composite- four or more surfaces or involving incisal angle (anterior)	
Re-cement inlay	
Re-cement crown	
Prefabricated stainless-steel crown· primary tooth - Limited to I per tooth in 60 months	
Prefabricated stainless-steel crown - permanent tooth - Limited to I per tooth in 60 months	
Protective Restoration	
Pin retention per tooth, in addition to restoration	
Endodontic Services:	
Therapeutic pulpotomy (excluding final restoration)- *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.*	
Partial pulpotomy for apexogenesis- permanent tooth with incomplete root development *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a pan of the root canal procedure and benefits are not payable separately.*	
Pulpal therapy (resorbable filling)- anterior, primary tooth (excluding final restoration)	

Pulpal therapy (resorbable filling)- posterior, primary tooth (excluding final restoration). Incomplete endodontic treatment when treatment is discontinued.	
Periodontal Services:	
Periodontal scaling and root planing-four or more teeth per quadrant- Limited to 1 every 24 months	
Periodontal scaling and root planing-one to three teeth, per quadrant- Limited to 1 every 24 months	
Periodontal maintenance- 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy.	
Prosthodontic Services:	
Adjust complete denture-maxillary	
Adjust complete denture-mandibular	
Adjust partial denture-maxillary	
Adjust partial denture-mandibular	
Repair broken complete denture base	
Replace missing or broken teeth complete denture (each tooth)	
Repair resin denture base	
Repair cast framework	
Repair or replace broken clasp	
Replace broken teeth- per tooth	
Add tooth to existing partial denture	
Add clasp to existing partial denture	
Rebase complete maxillary denture- Limited to 1 in a 36-month period 6 months after the initial installation	
Rebase maxillary partial denture- Limited to 1 in a 36-month period 6 months after the initial installation	
Rebase mandibular partial denture- Limited to 1 in a 36-month period 6 months after the initial installation	
Reline complete maxillary denture -Limited to 1 in a 36-month Period 6 months after the initial installation	
Reline complete mandibular denture -Limited to l in a 36-month period 6 months after the initial installation	
Reline maxillary partial denture- Limited to 1 in a 36-month period 6 months after the initial installation	
Reline mandibular partial denture- Limited to 1 in a 36-month period 6 months after the initial installation	
Reline complete maxillary denture (laboratory) -Limited to 1 in a 36-month period 6 months after the initial	
Reline complete mandibular denture (laboratory)- Limited to 1 in a 36-month period 6 months after the initial	
Reline maxillary partial denture (laboratory)·Limited to 1 in a 36-month period 6 months after the initial installation	
Reline mandibular partial denture (laboratory) Rebase/Reline- Limited to 1 in a 36-month period 6 months after the initial installation	
Tissue conditioning (maxillary)	
Tissue conditioning (mandibular)	
Re-cement fixed partial denture	
Fixed partial denture repair, by report	
Oral Surgery:	
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
Removal of impacted tooth - soft tissue	
Removal of impacted tooth- partially bony	
Removal of impacted tooth - completely bony	
Removal of impacted tooth - completely bony with unusual surgical complications	
Surgical removal of residual tooth roots (cutting procedure)	
Coronectomy- intentional partial tooth removal	
Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
Surgical access of an unerupted tooth	
Alveoloplasty in conjunction with extractions - per quadrant	
Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant	
Alveoloplasty not in conjunction with extractions- per quadrant	
Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant	
Removal of exostosis	
Incision and drainage of abscess intraoral soft tissue	
Suture of recent small wounds up to *5* cm	
Excision of pericoronal gingiva	

MAJOR SERVICES (TYPE C)	
Major Restorative Services:	
Detailed and extensive oral evaluation- problem focused, by report	
Inlay- metallic- one surface- An alternate benefit will be provided	
Inlay- metallic- two surfaces -An alternate benefit will be provided	
Inlay- metallic-three surfaces -An alternate benefit will be provided	
On lay- metallic- two surfaces- Limited to 1 per tooth every 60 months	
On lay - metallic- three surfaces- Limited to 1 per tooth every 60 months	
On lay - metallic- four or more surfaces- Limited to 1 per tooth every 60 months	
Crown- porcelain/ceramic substrate- Limited to 1 per tooth every 60 months	
Crown- porcelain fused to high noble metal- Limited to 1 per tooth every 60 months	
Crown- porcelain fused to predominately base metal-Limited to 1 per tooth every 60 months	
Crown- porcelain fused to noble metal-Limited to 1 per tooth every 60 months	
Crown - 3/4 cast high noble metal- Limited to 1 per tooth every 60 months	
Crown - 3/4 cast predominately base metal- Limited to 1 per tooth every 60 months	
Crown - 3/4 porcelain/ceramic- Limited to 1 per tooth every 60 months	
Crown - full cast high noble metal- Limited to 1 per tooth every 60 months	
Crown- full cast predominately base metal-Limited to 1 per tooth every 60 months	
Crown - full cast noble metal- Limited to I per tooth every 60 months	
Crown-titanium- Limited to 1 per tooth every 60 months	
Core buildup, including any pins- Limited to 1 per tooth every 60 months	
Prefabricated post and core, in addition to crown- Limited to 1 per tooth every 60 months	
Crown repair, by report	
Endodontic Services:	
Anterior root canal (excluding final restoration)	
Bicuspid root canal (excluding final restoration)	
Molar root canal (excluding final restoration)	
Retreatment of previous root canal therapy-anterior	
Retreatment of previous root canal therapy-bicuspid	
Retreatment of previous root canal therapy-molar	
Apexification/recalcification- initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
Apexification/recalcification- interim medication replacement (apical closure/calcific repair of perforations, root	
Apexification/recalcification- final visit (includes completed root canal therapy, apical closure/calcific repair of perfor	ations.
Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp)	
Apicoectomy/periradicular surgery- anterior	
Apicoectomy/periradicular surgery- bicuspid (first root)	
Apicoectomy/periradicular surgery -molar (first root)	
Apicoectomy/periradicular surgery (each additional root)	
Root amputation- per root	
Hemisection (including any root removal)- not including root canal therapy	
Periodontal Services:	
Gingivectomy or gingivoplasty- four or more teeth-Limited to 1 every 36 months	
Gingivectomy or gingivoplasty-one to three teeth	
Gingival flap procedure, four or more teeth-Limited to 1 every 36 months	
Clinical crown lengthening-hard tissue	
Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant-	Limit
Pedicle soft tissue graft procedure	
Free soft tissue graft procedure (including donor site surgery)	
Subepithelial connective tissue graft procedures (including donor site surgery)	
Full mouth debridement to enable comprehensive evaluation and diagnosis	
Prosthodontic Services:	
Complete denture - maxillary-Limited to 1 every 60 months	
Complete denture- mandibular-Limited to 1 every 60 months	
Immediate denture- maxillary-Limited to 1 every 60 months	
Immediate denture- mandibular-Limited to 1 every 60 months	
Maxillary partial denture- resin base (including any conventional clasps, rests and teeth)- Limited to 1 every 60	
Mandibular partial denture- resin base (including any conventional clasps, rests and teeth)-Limited to 1 every 60	

	Maxillary partial denture- cast metal framework with resin denture base (including any conventional clasps, rests	
	Mandibular partial denture- cast metal framework with resin denture base (including any conventional clasps, rests	
	Removable unilateral partial denture-one-piece cast metal (including clasps and teeth)-Limited to 1 every 60 months	
	Endosteal Implant- 1 every 60 months	
	Surgical Placement of lnterim Implant Body- 1 every 60 months	
	Eposteal Implant- 1 every 60 months	
	Transosteal Implant. Including Hardware- 1 every 60 months	
	Implant supported complete denture	
	Implant supported partial denture	
	Connecting Bar-implant or abutment supported- 1 every 60 months	
	Prefabricated Abutment- 1 every 60 months	
	Abutment supported porcelain ceramic crown - 1 every 60 months	
	Abutment supported porcelain fused to high noble metal- 1 every 60 months	
	Abutment supported porcelain fused to predominately base metal crown- 1 every 60 months	
	Abutment supported porcelain fused to noble metal crown 1 every 60 months	
	Abutment supported cast high noble metal crown - 1 every 60 months	
	Abutment supported cast predominately base metal crown – 1 every 60 months	
	Abutment supported Cast noble metal crown 1 every 60 months	
	Implant supported porcelain/ceramic crown- 1 every 60 months	
	Implant supported porcelain fused to high metal crown - 1 every 60 months	
	Implant supported metal crown- 1 every 60 months	
	Abutment supported retainer for porcelain/ceramic fixed partial denture- 1 every 60 months	
	Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months	
	Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months	
	Abutment supported retainer for porcelain fused to noble metal fixed partial denture- 1 every 60 months	
	Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months	
	Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months	
	Abutment supported retainer for cast noble metal fixed partial denture- 1 every 60 months	
	Implant supported retainer for ceramic fixed Partial denture- 1 every 60 months	
	Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months	
	Implant supported retainer for cast metal fixed partial denture - 1 every 60 months	
	Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months	
	Implant/abutment supported fixed partial denture for partially edentulous arch- 1 every 60 months	
	Implant Maintenance Procedures -1 every 60 months	
	Repair Implant Prosthesis -1 every 60 months	
	Replacement of Semi-Precision or Precision Attachment- 1 every 60 months	
	Repair Implant Abutment -1 every 60 months	
	Implant Removal-1 every 60 months	
	Implant Index -1 every 60 months	
	Pontic-cast high noble metal- Limited to 1 every 60 months	
	Pontic-cast predominately base metal -Limited to 1 every 60 months	
	Pontic-cast noble metal- Limited to 1 every 60 months	
	Pontic-titanium-Limited to 1 every 60 months	
	Pontic -porcelain fused to high noble metal-Limited to 1 every 60 months	
	Pontic-porcelain fused to predominately base metal-Limited to 1 every 60 months	
	Pontic-porcelain fused to noble metal Limited to 1 every 60 months	
	Pontic-porcelain/ceramic-Limited to 1 every 60 months	
	Inlay/on lay- porcelain/ceramic-Limited to 1 every 60 months	
	Inlay-metallic-two surfaces-Limited to 1 every 60 months	
	Inlay- metallic-three or more surfaces- Limited to 1 every 60 months	
	On lay- metallic- three surfaces- 1 every 60 months	
	On lay- metallic- four or more surfaces -1 every 60 months	
	Retainer -cast metal for resin bonded fixed prosthesis -1 every 60 months	
	Retainer- porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months	
	Crown- porcelain/ceramic- 1 every 60 months	
	Crown -porcelain fused to high noble metal - 1 every 60 months	
	Crown- porcelain fused to predominately base metal- 1 every 60 months	

Crown- porcelain fused to noble metal - 1 every 60 months	
Crown -3/4 cast high noble metal - 1 every 60 months	
Crown- 314 cast predominately base metal • 1 every 60 months	
Crown 3/4 cast noble metal 1 every 60 months	
Crown - 3/4 porcelain/ceramic- 1 every 60 months	
Crown • full cast high noble metal- 1 every 60 months	
Crown -full cast predominately base metal- 1 every 60 months	
Crown full cast noble metal 1 every 60 months	
Core build up for retainer including any pins 1 every 60 months	
Occlusal guard, by report- 1 in 12 months	
GENERAL SERVICES (TYPE C)	
Anesthesia Services:	
Deep sedation/general anesthesia- first 30 minutes	
Deep sedation/general anesthesia- each additional 15 minutes	
Intravenous Sedation:	
Intravenous conscious sedation/analgesia- first 30 minutes	
Intravenous conscious sedation/analgesia each additional 15 minutes	
Consultations:	
Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	
Medications:	
Therapeutic drug injection, by report	
Post-Surgical Services:	
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	
Limited orthodontic treatment of the primary dentition	
Limited orthodontic treatment of the transitional dentition	
Limited orthodontic treatment of the adolescent dentition	
Interceptive orthodontic treatment of the primary dentition	
Interceptive orthodontic treatment of the transitional dentition	
Comprehensive orthodontic treatment of the transitional dentition	
Comprehensive orthodontic treatment of the adolescent dentition	
Removable appliance therapy	
Periodic orthodontic treatment visits (as part of contract)	
Orthodontic retention (removal of appliances, construction and placement of retainer(s)	

Pediatric Vision Care Benefit (including low vision services) (to the end of the month in which the Covered Person turns age 19) Limited to 1 visit(s) per Plan Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Plan Year Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	80% of Actual Charge for Covered Medical Expenses per Plan Year
Accidental Injury Dental Treatment Limited to $3,000 per Injury	80% of the Actual Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit	80% of the Actual Charge after Deductible for Covered Medical Expenses

Chiropractic Care Benefit Maximum visits per Plan Year	12	12
Organ Transplant Surgery Donor's search for bone marrow/stem cell transplants limited to $30,000 per Transplant Maximum benefit payable for travel and lodging expenses for any one transplant $10,000	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Treatment for Temporomandibular (TMJ) or Craniomandibular Joint (CMJ) Disorder and Craniomandibular Jaw Disorder	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Abortion Expense	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Adult Vision Care for Covered Persons beyond the end of the month they turn 19 Routine Eye Exam once every 12months Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Medical Evacuation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $50,000 maximum per Plan Year	
Repatriation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $25,000 maximum per Plan Year	
Non-emergency Care While Traveling Outside of the United States	80% of Actual Charge after Deductible for Covered Medical Expenses for Medically Necessary treatment when You are traveling outside of the United States. Subject to $10,000 maximum per Plan Year	
Sickness Dental Expense beyond the end of the month the Covered Person turns 19.	80% of Actual Charge after Deductible for Covered Medical Expenses	
Tuberculosis screening, Titers, Quantiferon B tests including shots (other than covered under preventive services)	80% of Actual Charge after Deductible for Covered Medical Expenses	
Sports Accident Expense - incurred as the result of the play or practice of Intercollegiate or club sports	80% of Actual Charge after Deductible for Covered Medical Expenses	

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 anyone (1) Accident. This benefit is payable in addition to any other benefits payable under this Plan.

SECTION 5 - HOW THE PLAN WORKS AND DESCRIPTION OF BENEFITS

Schedule of Benefits
The following are shown in the Schedule of Benefits:

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

How the Deductible Works

Deductible
The Deductible amount (if any) is shown in the Schedule of Benefits. This dollar amount is what the Covered Person has to incur in Covered Medical Expenses before benefits are payable under this Plan. The Deductible applies to all Covered Medical Expenses, unless specifically noted. Any expenses that are not Covered Medical Expenses are not applied toward the Deductible.

The Deductible is an amount the individual must incur for Covered Medical Expenses before the plan pays. After the amount of Covered Medical Expenses reaches the Plan Year Deductible, this Plan will pay for Covered Medical Expenses as shown on the Schedule of Benefits for the rest of the Plan Year.

Coinsurance is the percentage of Covered Medical Expenses that the Plan pays. The Coinsurance percentage is stated in the Schedule of Benefits. The Coinsurance is separate and not part of the Deductible and Copayment.

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

How Your Out-of-Pocket Maximum Works
The Out-of-Pocket Maximums are shown in the Schedule of Benefits. The Out-of-Pocket Maximum provides is the amount of Covered Medical Expenses the Covered Person must incur before Covered Medical Expense will be paid at 100% for the reminder of the Plan Year subject to any benefit maximums or limits that may apply. Any applicable Coinsurance amounts, Deductibles and Copayments will apply toward the Out-of-Pocket Maximum.

Services that are not Covered Medical Expenses, balance billed charges, and premiums do not count toward meeting the Out-of-Pocket Maximum.

The Out-of-Pocket Maximum is the maximum amount of Covered Medical Expenses the Covered Person must incur for Copayments, Coinsurance and Plan Year Deductibles during the Plan Year.

Once the amount of the Copayments, Coinsurance and Plan Year Deductibles for Covered Medical Expenses during the Plan Year meet the Out-of-Pocket Maximum, this Plan will pay:100% of the actual charges for Covered Medical Expenses that apply towards the limits for the rest of the Plan Year for that covered individual.

Essential Health Benefits

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

SECTION 6 - PREVENTIVE SERVICES

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

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). Such as, but not limited to, cytologic screening for the presence of cervical cancer and mammography screening to detect the presence of breast cancer in adult women. These can be found at the following websites: www.uspreventiveservicestaskforce.org/recommendations; and http://www.healthcare.gov/coverage/preventive-care-benefits/.
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the Covered Person involved.
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
4. With respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration, including the following:
    a. Women's contraceptives for each of the methods identified by the FDA, sterilization procedures, and counseling. This includes Generic and single-source Brand Name Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Name Drugs will be covered under the Prescription Drug benefit.
    b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per Plan Year.
    c. Gestational diabetes screening.
5. Outpatient/office contraceptive services are covered, provided that the services are related to the use of FDA approved contraceptives. Examples of covered contraceptive services are: office visits, consultations, examinations and services related to the use of federal legend oral contraception or IUD insertion, diaphragm fitting, contraceptive injections. Please note that prescription and nonprescription contraceptive drugs and devices (such as oral contraceptives, IUDs, diaphragms, and contraceptive injections) are covered under the Prescription Drug Benefit. See Prescription Drugs for information on those services and devices.

    Contraception Exception Process

    If a Covered Person's attending Physician recommends a particular service or FDA-approved item based on a determination of Medical Necessity with respect to that Covered Person, the Plan must cover that service or item without cost sharing. The Plan must defer to the determination of the attending Physician. Medical Necessity may include considerations such as severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service, as determined by the attending Physician.

Important Notes:

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

To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, refer to the information found at the https://www.healthcare.gov/ website.

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

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

SECTION 7 - COVERED MEDICAL EXPENSES

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

Inpatient Benefits

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

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

3. **Physician's Visits while Confined** not to exceed 1 visit per day of confinement per provider. Physician's visits will be paid for either inpatient or outpatient visits when incurred on the same day, but not both. Surgeon's fees are not payable under this benefit.

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

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

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

   2. **Through Different Incisions.** If Covered multiple surgical procedures are performed during the same operative session but through different incisions, the Plan will pay:
      - For the procedure with the highest allowed amount; and
      - 50% of the amount this Plan would otherwise pay for the other procedures.

5. **Physical Therapy while Confined** when prescribed by the attending Physician.

6. **Skilled Nursing Facility Benefit** for services received in a licensed Skilled Nursing Facility. Services must be Medically Necessary.

7. **Inpatient Rehabilitation Facility Expense Benefit**, or the services, supplies and Treatments rendered to You in an **Inpatient Rehabilitation** Facility. You must enter an **Inpatient Rehabilitation** Facility:
   a. Within 7 days after Your discharge from a Hospital Confinement;
   b. Such Confinement must be of at least 3 consecutive days that began while coverage was in force under this Plan; and
   c. Was for the same or related Sickness or Accident.

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

8. **Mental Health Disorder Benefit** for inpatient services including but not limited a residential treatment facility for the Treatment of Mental Health Disorders as specified on the Schedule of Benefits.

9. **Substance Use Disorder Benefit** for inpatient services including but not limited a residential treatment facility for the Treatment of Substance Use Disorders on the same basis as any other Covered Sickness as specified on the Schedule of Benefits.

Outpatient Benefits

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

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

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

2. **Through Different Incisions.** If Covered multiple surgical procedures are performed during the same operative session but through different incisions, this Plan will pay:
   - For the procedure with the highest allowed amount; and
   - 50% of the amount SHBP would otherwise pay for the other procedures.

1. **Outpatient Surgical Facility and Miscellaneous** expense benefit. Benefits will be paid for services and supplies, including:
   a. Operating room;
   b. Therapeutic services;
   c. Oxygen, oxygen tent; and
   d. Blood and blood plasma.

3. **Physician's Office Visits**. This Plan will not pay for more than 1 visit per day to the same Physician. Physician's Visits include second surgical opinions. Benefits will be paid for either outpatient or inpatient visits on the same day, but not both. Surgeon fees are NOT payable under this benefit.

4. **Specialist/Consultant Physician's Services.** When requested and approved by the attending Physician.

5. **Telemedicine or Telehealth Services** for health care delivery, diagnosis, consultation, Treatment, transfer of medical data, and education using interactive audio, video, or data communications involving a real time (synchronous) or near real time (asynchronous) 2-way transfer of medical data and information.

6. **Cardiac Rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.

7. **Inhalation Therapy** for the treatment of a Covered Injury or Illness, by the administration of medicine, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; non-pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

8. **Pulmonary Rehabilitation.** to restore an individual's functional status after an illness or injury. Covered services include, but are not limited to, outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in a Physician's office, including, but not limited to, breathing exercise, exercise not elsewhere classified and other counseling. Pulmonary rehabilitation in an acute inpatient rehabilitation setting is not a covered service.

9. **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part.

10. **Speech Therapy** for the correction of a speech impairment.

    Occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).

11. **Rehabilitative Therapy** when prescribed by the attending Physician, limited to 1 visit per day.

12. **Habilitative Services** when prescribed by the attending Physician.
    Habilitative Services for children (0 to 21) with a medical diagnosis of Autism Spectrum disorder at a minimum shall include:
    1. Out-Patient Physical Rehabilitation Services including
        a. Speech and Language therapy and/or Occupational therapy, performed by licensed therapists;
        b. Clinical Therapeutic Intervention defined as therapies supported by empirical evidence, which include but are not limited to Applied Behavioral Analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of Ohio to perform the services in accordance with a treatment plan.
    2. Mental/Behavioral Health Outpatient Services performed by a licensed Psychologist, Psychiatrist, or Physician to provide consultation, assessment development and oversight of the treatment plan.

    See the Schedule of Benefits for any applicable benefit limitations.

13. **Emergency Services** only in connection with care for an Emergency Medical Condition as defined. Payment of this benefit will not be denied based on the final diagnosis following stabilization. If the Covered Person is experiencing an Emergency, call 9-1-1 or go to the nearest hospital.

14. **Urgent Care Center** for services provided at an Urgent Care Center, as shown in the Schedule of Benefits.

15. **Diagnostic Imaging Services** for diagnostic X-ray services as shown in the Schedule of Benefits when prescribed by a Physician.

16. **CT Scan, MRI and/or PET Scans** for diagnostic services when prescribed by a Physician.

17. **Laboratory Procedures (Outpatient)** for laboratory procedures as shown in the Schedule of Benefits when prescribed by a Physician.

18. **Chemotherapy and Radiation Therapy** Chemotherapy, oral chemotherapy drugs, for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents. Radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning**.**

19. **Home Infusion Therapy** Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services that are delivered and administered through an IV in the Covered Person's home. Home IV therapy includes, but is not limited to:
    a. Injections (intra-muscular, subcutaneous, continuous subcutaneous)
    b. Total Parenteral Nutrition (TPN)
    c. Enteral nutrition therapy,
    d. Antibiotic therapy
    e. Pain management
    f. Chemotherapy

20. **Home Health Care Expenses** includes home health care services provided by a home health agency in the home, but only when all of the following criteria are met:
    a. The Covered Person is homebound for medical reasons.
    b. The Covered Peron is physically unable to obtain the services on an outpatient basis.

    Home health care eligible health services include, but are not limited to:
    a. Medical/social and diagnostic services
    b. Nutritional guidance
    c. Medical and surgical supplies
    d. Durable medical equipment
    e. Private duty nursing (provided by an R.N. or L.P.N. for non-hospitalized acute illness or injury if your condition requires skilled nursing care)
    f. Prescription drugs (if provided and billed by a home health care agency)
    g. Intermittent skilled nursing services (by an R.N. or L.P.N.)
    h. Home health aide services when the Covered Person is receiving skilled nursing or therapy services. The services are provided by trained personnel that are employed by the home health care agency. Other organizations may provide services when SHBP approves it. Their duties must be assigned and be supervised by a professional nurse employed by the home health care agency.
    i. Therapy services (except manipulation therapy, which is not covered when provided in the home). Please see your schedule of benefits for any applicable limits when therapy is provided in the home.

21. **Hospice Care Coverage** may be provided in the home or at a hospice care facility where medical, social and psychological services are given to help treat patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible, a Covered Person must have a life expectancy of six months or less, as confirmed by their provider. These benefits will continue if they live longer than six months.

    When approved by your Physician, covered services include:
    a. Inpatient confinement at a Hospice
    b. Medical supplies, equipment and appliances (benefits are not covered for equipment when the Covered Person is in a Facility that should provide such equipment.
    c. Prescription Drugs given by the Hospice.

d. Counseling services
e. Skilled nursing care (by an R.N. or L.P.N.) and home health aid
f. Diagnostic services
g. Physical, speech and inhalation therapies, if part of the treatment plan.

22. **Outpatient Private Duty Nursing** services for non-hospitalized care performed by a R.N. or L.P.N for a Covered Injury or Covered Sickness if the condition requires skilled nursing care and visiting nursing care is not adequate. Services must be:
    - rendered in the home;
    - prescribed by the attending Physician as being medically necessary; and
    - performed by a certified Home Health Agency.

23. **Mental Health Disorder Benefit** for outpatient services including but not limited to the following: Intensive Outpatient Programs; Partial Hospitalization, Electronic Convulsive Therapy, Repetitive Transcranial Magnetic Stimulation (rTMS); and Psychiatric and Neuro Psychiatric testing.

24. **Substance Use Disorder Benefit** for outpatient services including but not limited to the following: Intensive Outpatient Programs; Partial Hospitalization, Electronic Convulsive Therapy, Repetitive Transcranial Magnetic Stimulation (rTMS); and Psychiatric and Neuro Psychiatric testing.

25. **Prescription Drugs** are medications filled in an outpatient pharmacy for which a Physician's written prescription is required up to the amount shown in the Schedule of Benefits. This benefit is limited to medication necessary for the Treatment of the Covered Injury or Covered Sickness for which a claim is made. Some outpatient prescription drugs are subject to pre-certification. These prescription requirements help Your prescriber and pharmacists check that Your outpatient prescription drug is clinically appropriate using evidence-based criteria.

    a. **Off-Label Drug Treatments** - When prescription drugs are provided as a benefit, it will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
        1. The drug is approved by the FDA;
        2. The drug is prescribed for the Treatment of a life-threatening condition, including cancer, HIV or AIDS;
        3. The drug has been recognized for Treatment of that condition by 1 of the following: a) The American Medical Association Drug Evaluations; b) The American Hospital Formulary Service Drug Information; c) The United States Pharmacopoeia Dispensing Information, volume 1, "Drug Information for Health Care Professionals"; or d) 2 articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal.
        When this portion of the prescription benefit is used, it will be the responsibility of the prescriber to submit to the Plan documentation supporting compliance with the requirements of this benefit.

    As it pertains to this benefit, life threatening means either or both of the following:
        a. Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted; or
        b. Disease or conditions with a potentially fatal outcome and where the end point of clinical intervention is survival.

b. **Dispense as Written (DAW)** – If a prescriber prescribes a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available and specifies: "Dispense as Written" (DAW), the Covered Person will pay the cost sharing for the Brand-Name Prescription Drug. If a prescriber does not specify DAW and the Member requests a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available, the Member will be responsible for the cost difference between the Brand-Name Prescription Drug and the Generic Prescription Drug equivalent, and the cost sharing that applies to Brand-Name Prescription Drugs.

c. **Investigational Drugs and Medical Devices** – The Prescription Drug benefit includes a drug or device that is Investigational if the intended use of the drug or device is included in the labeling authorized by the FDA or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature.

d. **Specialty Prescription Drugs** are limited to no more than a 30-day supply. However, if the Specialty Prescription Drug dispensed is the smallest package size available and exceeds a 30-day supply, the Covered Person is responsible for the cost sharing defined for the day supply in your schedule of benefits.
Specialty Drugs – are Prescription Drugs which:
   1. Are only approved to treat limited patient populations, indications, or conditions; or
   2. Are normally injected, infused, or require close monitoring by a Physician or clinically trained individual; or
   3. Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

e. **Self-Administered Prescription Drugs** – Certain self-administered Prescription Drugs are only covered under the Prescription Drug benefit and are excluded from the medical benefit. Self-administered Prescription Drugs will not be covered when dispensed through a Physician's office or outpatient hospital, except in emergency situations. While members may self-administer these medications, they can still obtain these medications at the pharmacy and have them administered at an office visit. Coverage exceptions may be granted if self-administered Prescription Drugs are required as part of a hospitalization or emergency room visit. The list of self-administered Prescription Drugs only covered under the Prescription Drug benefit and excluded from the medical benefit can be found here: www.wellfleetstudent.com.

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

g. **Step Therapy** – When medications for the Treatment of any medical condition are restricted for use by a step therapy or fail-first protocol, the prescribing practitioner shall have access to a clear and convenient process to request an override of the restriction from Us. An override of that restriction will be granted by the Plan upon completion of the review if all necessary information to perform the override review has been provided, under the following documented circumstances:
   1. The prescribing practitioner can demonstrate, based on sound clinical evidence, that the preferred Treatment required under step therapy or fail-first protocol has been ineffective in the Treatment of Your disease or medical condition; or

2. Based on sound clinical evidence or medical and scientific evidence:
    a. The prescribing practitioner can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the Covered Person and known characteristics of the drug regimen; or
    b. The prescribing practitioner can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to You.

h. **Quantity Limits** – Some Outpatient Prescription Drugs are subject to quantity limits. The quantity limits help the prescriber and pharmacist check that the Outpatient Prescription Drug is used correctly and safely. The Plan relies on medical guidelines, FDA-approved recommendations and other criteria developed by the Plan to set these quantity limits.

i. **Tier Status** – The tier status of a Prescription Drug may change periodically. These changes may occur without prior notice to the Covered Person. However, if the Covered Person has a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic Drug) the Plan will notify the Covered Person. When such changes occur, the out-of-pocket expense may change. The Covered Person may access the most up to date tier status on the Plan's website at www.wellfleetstudent.com or by calling the number on the Covered Person's ID card.

j. **Compounded Prescription Drugs** will be Covered only when they contain at least 1 ingredient that is a Covered legend Prescription Drug, do not contain bulk chemicals, and are obtained from a pharmacy that is approved for compounding. Compounded Prescription Drugs may require the Provider to obtain Preauthorization. Compounded Prescription Drugs will be covered at $125 per Prescription Drug Order

k. **Formulary Exception Process** – If a Prescription Drug is not on the Formulary, the Covered Person or an Authorized Representative or prescribing Physician may request a Formulary exception for clinically appropriate Prescription Drug in writing, electronically or telephonically. If coverage is denied under the Plan's standard or expedited Formulary exception process, the Covered Person is entitled to an external appeal as outlined in the External Appeal section of this document. Refer to the Formulary posted on www.wellfleetstudent.com or the number on the Covered Person's ID card to find out more about this process.

   Standard Review of a Formulary Exception – The Plan will make a decision and notify the Covered Person or their Authorized Representative and the prescribing Health Care Professional no later than 72 hours after receipt of the Member's request. If the Plan approves the request, they will cover the Prescription Drug while the Covered Person is taking the Prescription Drug, including any refills.

   Expedited Review of a Formulary Exception – If the Covered Person is suffering from a health condition that may seriously jeopardize the Covered Person's health, life or ability to regain maximum function or if the Covered Person is undergoing a current course of Treatment using a Non-Formulary Prescription Drug, the Covered Person may request an expedited review of a Formulary exception. The request should include a statement from the prescribing Physician that harm could reasonably come to the Covered Person if the requested drug is not provided within the timeframes for the standard Formulary exception process. The Plan will make a decision and notify the Covered Person or their Authorized Representative and the prescribing Physician no later than 24 hours after receipt

of the Covered Person's request. If the Plan approves the request, they will cover the Prescription Drug.

l. **Tobacco cessation prescription and over-the-counter drugs** – Refer to the Schedule of Benefits.

m. **Zero Cost Generics** – In addition to ACA Preventive Care medications, certain Generic Drugs are covered at no cost to the Covered Person. These zero cost generics can be identified in the Formulary posted on Our website www.wellfleetstudent.com.

n. **Preventive contraceptives -** For females who are able to reproduce, the Outpatient Prescription Drug plan covers certain Prescription drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a Physician and the prescription is submitted to the pharmacist for processing. The outpatient prescription drug plan also covers related services and supplies needed to administer covered devices. At least 1 form of contraception in each of the methods identified by the FDA is included. The Covered Person can access the list of contraceptive prescription drugs by referring to the Formulary posted on this website www.wellfleetstudent.com or calling the toll-free number on your ID card.

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

o. **Orally administered anti-cancer drugs, including chemotherapy drugs -** Coverage for oral anti-cancer prescription drugs under the pharmacy benefit will not be less favorable than for chemotherapy under the medical benefit.

p. **Diabetic supplies**
   The following diabetic supplies may be obtained under the Prescription Drug benefit upon prescription by a Physician:
   - Insulin
   - Insulin syringes and needles
   - Blood glucose test strips
   - Lancets
   - Alcohol swabs
   - Blood glucose meters

   You can access the list of diabetic supplies by referring to the Formulary posted on this website www.wellfleetstudent.com or by calling the toll-free number on your ID card. See the Diabetic services and supplies (including equipment and training) section for coverage of blood glucose meters and external insulin pumps.

q. **Preventive Care drugs and Supplements-** Covered Medical expenses include preventive care drugs and supplements (including over the counter drug and supplements as required by the Affordable Care Act (ACA) guidelines when prescribed by a Physician and the prescription is submitted to the pharmacist for processing.

Other Benefits

1. **Allergy Testing** this includes tests that the Covered Person needs such as PRIST, RAST, and scratch tests.

2. **Allergy Injections/Treatment** includes the administration of allergy therapy, injections, allergy serum, and supplies used for allergy therapy.

3. **Emergency Ambulance Service** include transport by professional ambulance services (including ground, water, fixed wing and rotary wing air transportation):
    a. From the scene of an accident or medical emergency to the closest hospital to provide emergency services.
    b. From one hospital to another hospital.
    c. From hospital or skilled nursing facility to a Covered Person's home or to another facility, if an ambulance is the only safe way to transport a Covered Person.
    d. From an Covered Person's home to a hospital if an ambulance is the only safe way to transport a Covered Person.

4. **Non-Emergency Ambulance Service** for Medically Necessary transportation by a licensed Ambulance, whether by ground or air Ambulance (as appropriate), when the Medically Necessary transportation is:
    - To a Hospital that provides a higher level of care that was not available at the original Hospital;
    - To a more cost-effective acute care Hospital/facility; or
    - From an acute care Hospital/facility to a sub-acute setting.

    Transportation from a facility to your home is not covered.

5. **Covered Cancer Clinical Trials** includes coverage for routine costs associated with participation in a clinical trial for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709. Coverage does not include the studied device, equipment or drug, data collection services and any service not associated with direct clinical care to the Covered Person.

    In addition, services include routine costs if the Covered Person is participating in any stage of a Cancer Clinical Trial. Benefits are available for routine patient care rendered as part of a cancer clinical trial if the services would be eligible health services under this Plan and the clinical trial meets the requirements.

    Cancer Clinical Trial means a cancer clinical trial that meets all of the following criteria:
    1. The purpose of the trial is to test whether the intervention may improve the participant's health or the treatment is given with the intention of improving the participant's health, and is not designed to test toxicity or disease pathophysiology
    2. The trial does one of the following:
        a. Tests how to administer and the responses to health care services, items, or drugs for cancer treatment
        b. Compares the effectiveness of a health care service, item, or drug for cancer treatment
        c. Studies new uses of health care services, items, or drugs for cancer treatment
    3. The trial is approved by one of the following:
        a. The National Institutes of Health
        b. The Food and Drug Administration
        c. The Department of Defense
        d. The Department of Veterans Affairs

e. The Centers for Disease Control and Prevention
f. The Agency for Health Care Research and Quality
g. The Centers for Medicare & Medicaid Services
h. Cooperative group or center of any of the entities described above
i. The Department of Energy

6. **Durable Medical Equipment** for the rental or purchase of Durable Medical Equipment, including, but not limited to, cochlear implants, Hospital beds, wheelchairs, walkers, braces that stabilize an injured body part and braces to treat curvature of the spine. Benefits will also include breast prosthesis, whether internal or external, following a mastectomy. The Plan will pay the lesser of either the rental or purchase charges, but not both. Such equipment must be prescribed by a Physician and a copy of the written prescription must accompany the claim. Durable Medical Equipment must:
   a. Be primarily and customarily used to serve a medical, Rehabilitative purpose;
   b. Be able to withstand repeated use; and
   c. Generally, not be useful to a person in the absence of Injury or Sickness.

   Covered DME items include, but are not limited to:
   a. Hemodialysis equipment
   b. Crutches and replacement of pads and tips
   c. Pressure machines
   d. Infusion pump for IV fluids and medicines
   e. Tracheotomy tube
   f. Cardiac, neonatal and sleep apnea monitors
   g. Augmentive communication devices, when approved based on the condition

   Medical and surgical supplies include certain supplies and equipment for the management of diseases. This does not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

7. **Diabetic services and supplies (including equipment and training)** Benefits will be paid the same as any other Sickness for the cost associated with equipment, supplies, and self-management training and education for the treatment of all types of diabetes mellitus when prescribed by a Physician.

   Benefits includes services and supplies:
   - Insulin preparations
   - Foot care to minimize the risk of infection
   - Injection aids for the blind
   - Diabetic test agents
   - Prescribed oral medications whose primary purpose is to control blood sugar
   - Injectable glucagons
   - Glucagon emergency kits

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

   Training
   - Self-management training

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

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

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

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

8. **Dialysis Treatment** of an acute or chronic kidney ailment, provided in an Outpatient facility of a Hospital, a free- standing renal Dialysis facility or in the home. Covered services for home Treatment will include equipment, training and medical supplies. Private Duty Nursing is not covered.

9. **Maternity Benefit** includes prenatal and postpartum care and obstetrical services. Coverage also includes the services and supplies needed for circumcision by a provider. After a child is born, eligible health services include:
   a. A minimum of 48 hours of inpatient care in a hospital after a vaginal delivery.
   b. A minimum of 96 hours of inpatient care in a hospital after a cesarean delivery.
   c. A shorter stay, if the attending physician, with the consent of the mother, discharges the mother or newborn earlier based upon the evaluation of:
      i. The antepartum, intrapartum, and postpartum course of the mother and infant
      ii. The gestational stage, birth weight, and clinical condition of the infant
      iii. The demonstrated ability of the mother to care for the infant after discharge
      iv. The availability of post-discharge follow-up to verify the condition of the infant after discharge
   d. The mother could be discharged earlier. If so, the plan will pay for post-delivery home visits for follow-up care for the mother and newborn when ordered and supervised by the attending physician or an advanced practice registered nurse, except that if a certified nurse-midwife is attending the mother in collaboration with a physician, the decision may be made by the certified nurse-midwife. If the mother is discharged earlier than the minimum lengths of stay, the Plan will pay for all follow-up care received within 72 hours after discharge. If the mother receives at least the minimum number of hours of inpatient care, the Plan will pay for eligible health services as recommended by the attending physician. The follow-up care includes:
      i. Parent education
      ii. Assistance and training in breast or bottle feeding
      iii. Physical assessment of the newborn, mother and home support system
      iv. The collection of an adequate sample for the hereditary and metabolic newborn screening

Clinical tests and other services that are in line with the follow-up care recommended in the protocols and guidelines developed by national organizations representing the providers.

Coverage also includes benefits for therapeutic abortions when performed to save the life or health of the mother, or as a result of incest or rape.

Non-covered Service for Maternity Benefit include but are not limited to services that are duplicated when provided by both a certified Nurse-midwife and a Physician.

10. **Enteral Formulas and Nutritional Supplements** Covered Medical expenses prescribed by a Physician used to treat malabsorption of food caused by:

- Crohn's Disease
- Ulcerative colitis
- Gastroesophageal reflux
- Gastrointestinal motility;
- Chronic intestinal pseudoobstruction
- Phenylketonuria
- Eosinophilic gastrointestinal disorders
- Inherited diseases of amino acids and organic acids
- Multiple severe food allergies
- Branded-chain ketonuria,
- Galactosemia
- Homocystinuria

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

11. **Prosthetic and Orthotic Devices** to replace all or part of a body organ or replace all or part of the function of a permanently inoperative, absent, or malfunctioning body part when Medically Necessary and prescribed by a Physician.

12. **Reconstructive Surgery** covers all stages of reconstruction of the breast on which the mastectomy has been performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and Treatment of physical complications for all stages of mastectomy, including lymphedemas.

13. **Pediatric Dental Care Benefit** Please refer to the Schedule of Benefits section of this Plan for cost-sharing requirements. The Plan covers preventive and diagnostic, basic restorative, major and general, and Medically Necessary orthodontia services. Coverage is limited to covered persons through the end of the month in which the person turns 19.

14. **Pediatric Vision Care Benefit** include a routine vision exam provided by an ophthalmologist or optometrist. The exam will include refraction and glaucoma testing. Coverage is limited to covered persons through the end of the month in which they turn 19. Please refer to the Schedule of Benefits section of this Plan for cost-sharing requirements.

    Vision care services and supplies include:

    a. Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
    b. Eyeglass frames, prescription lenses or prescription contact lenses

        i. Prescription lenses include glass or plastic lenses, all lens power (single, bifocal, trifocal, lenticular), fashion and gradient tinting, ultraviolet protective coating, oversized and glass-grey #3 prescription sunglass lenses
        ii. Polycarbonate lenses are covered in full for children, monocular patients and those with prescriptions > +/- 6.00 diopters
    c. Non-conventional prescription contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses
    d. Aphakic prescription lenses prescribed after cataract surgery has been performed
    e. Low vision services: a significant loss of vision, but not total blindness
        i. Providers specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the Covered Person's remaining usable vision
        ii. After precertification eligible health services include one comprehensive low vision evaluation every 5 years; 4 follow-up visits in any 5-year period. Also included are prescription optical devices, such as high-power spectacles, magnifiers and telescopes
    f. Services and materials include:
        i. Vision exam
        ii. Single vision lenses
        iii. Bifocal, trifocal, and lenticular lenses
        iv. Medically necessary and elective contact lenses
        v. Frames
        vi. Scratch resistant coatings
    g. Optional lenses and treatments include:
        i. Ultraviolet protective coating
        ii. Polycarbonate lenses (if not a child, monocular patients or prescription ≥+/-6.00 diopters)
        iii. Blended segment lenses
        iv. Intermediate vision lenses
        v. Standard and premium progressives
        vi. Photochromic glass lenses
        vii. Plastic photosensitive lenses
        viii. Polarized lenses
        ix. Standard, premium, and ultra anti-reflective coating
        x. Hi-index lenses

15. **Accidental Injury Dental Treatment** as the result of Injury to sound natural teeth. Routine dental care and Treatment are not payable under this benefit. Damage to teeth due to chewing or biting is not deemed an accidental Injury and is not covered.

16. **Chiropractic Care Benefit** for Treatment of a Covered Injury or Covered Sickness and performed by a Physician.

17. **Organ Transplant Surgery**
    Recipient Surgery for Medically Necessary, non-experimental and non-investigational solid organ, bone marrow, stem-cell or tissue transplants. SHBP will provide benefits for the Hospital and medical expenses of when the Covered Person is the recipient of an organ transplant. These benefits include, but are not limited to, necessary acquisition procedures, harvest and storage, and including medically necessary preparatory myeloablative therapy, and initial evaluation/testing to determine eligibility as a transplant candidate. Also included is obtaining an organ from a live donor, including complications from the surgery for up to six

weeks from the date the organ is obtained.

There are instances where a provider requests approval for HLA testing, donor searches and or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing.

Donor's Surgery for Medically Necessary transplant services required by the Covered Person who serves as an organ donor only if the recipient is also a Covered Person.

Travel Expenses when the facility performing the Medically Necessary transplant is located more than 200 miles from Your residence, coverage will be provided for lodging, meals and transportation expenses (coach class only) while at the transplant facility. Benefits are limited as shown in the Schedule of Benefits.

Benefits will also be provided for the expenses of a donor including transportation (coach class only), lodging, and meal expenses.

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

a. Child care;
b. Mileage within the medical transplant facility city;
c. Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us;
d. Frequent Flyer miles;
e. Coupons, Vouchers, or Travel tickets;
f. Prepayments or deposits;
g. Services for a condition that is not directly related or a direct result of the transplant;
h. Telephone calls;
i. Laundry;
j. Postage;
k. Entertainment;
l. Interim visits to a medical care facility while waiting for the actual transplant procedure;
m. Travel expenses for donor companion/caregiver;
n. Return visits for the donor for a Treatment of condition found during the evaluation.

17. **Treatment for Temporomandibular (TMJ) or Craniomandibular Joint (CMJ) Disorder and Craniomandibular Jaw Disorder** for Treatment provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

18. **Behavioral Health Services** includes coverage for Biologically Based Mental Illness services. Biologically Based Mental Illness means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Behavioral Health Services will be paid on the same basis as any other Covered Sickness.

19. **Abortion Expense** for the expense of an elective non-therapeutic, abortion.

20. **Adult Vision Care** for Covered Persons beyond the end of the month they turn 19. We will provide benefits for one routine eye examination every 12 months.

21. **Sickness Dental Expense Benefit** for Covered Persons beyond the end of the month they turn 19, by reason of Sickness, You require Treatment for impacted wisdom teeth or dental abscesses, the Plan will pay the Covered Percentage of the Covered Charges incurred for the Treatment.

22. **Tuberculosis (TB) screening,** Titers, Quantiferon B tests including shots (other than covered under Preventive Services) when required by the school for high risk Covered Persons.

23. **Sports Accident Expense Benefit** as the result of covered sports accident while at play or practice of intercollegiate or club sports as shown in the Schedule of Benefits.

24. **Non-emergency Care While Traveling Outside of the United States** for Medically Necessary treatment when traveling outside of the United States.

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

    If:
    a. A Covered Person is unable to continue their academic program as the result of a Covered Injury or Covered Sickness;
    b. That occurs while they are covered under this Plan,

    The Plan will pay the necessary Usual and Customary Charges for evacuation to another medical facility or their Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

    Payment of this benefit is subject to the following conditions:
    a. the Covered Person must have been in a Hospital due to a Covered Injury or Covered Sickness for a Confinement of five or more consecutive days immediately prior to medical evacuation;
    b. Prior to the medical evacuation occurring, the attending Physician must have recommended and the Plan must have approved the medical evacuation;
    c. The Plan must approve the Usual and Customary Expenses incurred prior to the medical evacuation occurring, if applicable;
    d. No benefits are payable for Usual and Customary Expenses after the date insurance terminates. However, if on the date of termination, they are in the Hospital, this benefit continues in force until the earlier of the date the Confinement ends or 31 days after the date of termination;
    e. Evacuation to their Home Country terminates any further insurance; and
    f. Transportation must be by the most direct and economical route.

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

    If a Covered Person die's while covered under this Plan, the Plan will pay a benefit. The benefit will be the necessary Usual and Customary Charges for preparation, including cremation, and transportation of the remains to their place of residence or Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

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

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

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

SECTION 8 - EXCLUSIONS AND LIMITATIONS

The following services or charges shall not be considered Covered Medical Expenses under the Plan:

1. 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 an attending Physician or dentist.
2. Medical services rendered by a provider employed for or contracted with the Plan Sponsor, including team physicians or trainers, except as specifically provided in the Schedule of Benefits.
3. Professional services rendered by an Immediate Family Member or anyone who lives with the Covered Person.
4. 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.
5. 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.

6. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
7. 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.
8. Any expenses in excess of Usual and Customary Charges except as provided in the Plan.
9. 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.
10. 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.
11. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
12. 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 the Covered Person is required to pay.
13. Services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
14. Expenses payable under any prior policy which was in force for the person making the claim.
15. Injury sustained as the result of the Covered Person's operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.
16. Expenses incurred after:
    - The date insurance terminates as to an Covered Person, except as specified in the extension of benefits provision; and
    - The end of the Plan Year
17. Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Plan.
18. Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
19. 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 Plan.
20. Treatment for obesity and Surgery for removal of excess skin or fat.
25. Charges for hair growth or removal unless otherwise specifically covered under the Plan.
26. Expenses for radial keratotomy.
27. Adult Vision unless specifically provided in the Plan.
28. 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.
29. Charges for hearing exams, hearing screening, hearing aids and the fitting or repair or replacement of hearing aids or cochlear implants except as specifically provided in the Plan.
30. 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.
31. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma.
32. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
33. The Covered Person is:

- committing or attempting to commit a felony,
- engaged in an illegal occupation, or
- participating in a riot.

34. Custodial Care service and supplies.
35. Charges for hot or cold packs for personal use.
36. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
37. Services of private duty Nurse except as provided in the Plan.
38. Expenses that are not recommended and approved by a Physician.
39. 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.
40. 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.
41. Sleep Disorders, except for the diagnosis and treatment of obstructive sleep apnea..
42. Treatment of Acne unless Medically Necessary.
43. Experimental or Investigational drugs, devices, treatments or procedures unless otherwise covered under Covered Clinical Trials or covered under clinical trials (routine patient costs).
44. 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 this Plan. 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 Plan;
    - 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 Plan 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 Plan;
    - repackaged products;
    - blood components except factors;
    - immunology products.
45. Non-chemical addictions.

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

SECTION 9 - COORDINATION OF BENEFITS

A. Maximum Benefits under All Plans

If any Covered Person covered under the Plan is also covered under one or more Other Plan(s), and the sum of the benefits payable under all the plans exceeds the Covered Person's eligible charges during any claim determination period, then the benefits payable under all the plans involved will not exceed the eligible charges for such period as determined under the Plan. Benefits payable under another plan are included, whether or not a claim has been made. For these purposes,

(1) claim determination period means a Plan Year; and

(2) eligible charge means any necessary allowed amount item of which at least a portion is covered under the Plan but does not include charges specifically excluded from benefits under the Plan that may also be eligible under any Other Plans covering the Covered Person for whom the claim is made.

B. Other Plans

Other Plan means the following plans providing benefits or services for medical and dental care or treatment and include:

(1) group insurance or any other arrangement for coverage for Covered Persons in a group, whether on an insured or uninsured basis;

(2) Blue Cross, Blue Shield, or any other prepayment coverage, including health maintenance organizations (HMOs), Medicare, or Medicaid; or

(3) no-fault automobile insurance (for purposes of the Plan, in states with compulsory no-fault automobile insurance laws, each Covered Person will be deemed to have full no-fault coverage to the maximum available in that state. The Plan will coordinate benefits with no-fault coverage as defined in the state of residence, whether or not the Covered Person is in compliance with the law, or whether or not the maximum coverage is carried).

C. Determining Order of Payment

If a Covered Person is covered under two or more plans, the order in which benefits will be determined is as follows.

(1) The plan covering the covered person other than as an eligible dependent, for example as an employee, member, subscriber, policyholder or retiree, pays benefits first. The plan covering the covered person as an eligible dependent pays benefits second.

(2) If no plan is determined to have primary benefit payment responsibility under (1) above, then the plan

that covered the Covered Person for the longest period has the primary responsibility.

(3) A plan that has no Coordination of Benefits provision will be deemed to have primary benefit payment responsibility.

(4) The plan covering the parent of the dependent child pays first if the parent's birthday (month and day of birth, not year) falls earlier in the calendar year. The plan covering the parent of an dependent child pays second if the parent's birthday falls later in the calendar year.

(5) In the event that the parents of the dependent child are divorced or separated, the following order of benefit determination applies:

   (a) the plan covering the parent with custody pays benefits first;

   (b) if the parent with custody has not remarried, then the plan covering the parent without custody pays benefits second;

   (c) if the parent with custody has remarried, then the plan covering the step-parent pays benefits second, and the plan covering the parent without custody pays benefits third; and

   (d) if a divorce decree or other order of a court of competent jurisdiction places the financial responsibility for the child's health care expenses on one of the parents, then the plan covering that parent pays benefits first.

D. Facilitation of Coordination

For the purpose of Coordination of Benefits, the Claims Administrator:

(1) may release to, or obtain from, any other insurance company or other organization or individual any claim information, and any Covered Person claiming benefits under the Plan must furnish any information that the Plan Administrator may require;

(2) may recover on behalf of the Plan any benefit overpayment from any other individual, insurance company, or organization; and

(3) has the right to pay to any other organization an amount it will determine to be warranted, if payments that should have been made by the Plan have been made by such organization.

Right to Receive and Release Needed Information

For the purposes of determining the applicability of and implementing the terms of this Section or any provision of similar purpose of any other plan, the Plan, through its authorized administrator, may, without the consent of or notice to any person to the extent permitted by law, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which is deemed to be necessary for such purposes. Any person claiming benefits under the Plan will furnish such information as may be necessary to implement this provision.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, this Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. The Plan will not have to pay that amount again. The term payment

made includes providing benefits in the form of services, in which case payment made means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

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

SECTION 10 - SUBROGATION AND RECOVERY RIGHTS

A. Payment Condition

(1) In the event a Covered Person initiates litigation against, negotiates a settlement with, or otherwise recovers from any third party or Coverage, the Covered Person agrees to promptly notify the Plan of the litigation, settlement or other recovery. The Covered Person agrees to reimburse the Plan for its proportional share of any judgment, settlement or other recovery, and acknowledges that the Plan, except as otherwise ordered or directed by a court of competent jurisdiction, has the priority lien against any judgment, settlement or other recovery against any third party or Coverage.

(2) If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person is only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may see reimbursement. The SHBP may assert its right of subrogation against any and all parties that may be responsible for an SHBP Beneficiary's medical expenses paid by the Plan.

B. Subrogation

(1) As a condition to participating in and receiving benefits under this the Plan, the Covered Person agrees to assign to the Plan to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation, and/or entity, and to any Coverage for which the Covered Person claims an entitlement, regardless of how classified or characterized. In the event the Covered Person is successful in obtaining a judgement or settlement with any third party or Coverage, the Covered Person agrees to reimburse the Plan for its proportional share of the judgment or settlement.

(2) If the Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claims which any Covered Person may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the SHBP plus reasonable costs of collection.

(3) The Plan may, in its own name or in the name of the Covered Person or their personal representative, commence a proceeding or pursue a claim against such other third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

(4) The Covered Person then authorizes the Plan to pursue, sue, compromise, or settle any such claims in their name and agrees to cooperate fully with the Plan in the prosecution of any such claims. The Covered Person, his or her guardian, or the estate of a Covered Person, assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any sources listed above. This

includes the failure of the Covered Person to file a claim or pursue damages against:

(a) the responsible party, their insurer, or any other source on behalf of that party;

(b) any first party insurance through personal injury protection, no-fault coverage, or uninsured or underinsured motorist coverage;

(c) any policy of insurance from any insurance company or guarantor of a third party;

(d) any worker's compensation or other liability insurance company; or

(e) any other source, including but not limited to, crime victim restitution funds, any medical, disability, or other benefit payments, and school insurance coverage.

C. Right of Reimbursement

(1) The Plan shall be entitled to recover its proportional share of the value of the benefits paid.

(2) The Plan will not be responsible for any expenses, attorney fees, costs, or other monies incurred by the attorney for the Covered Person or his/her beneficiaries, commonly known as the common fund doctrine. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of a litigious nature may be deducted from the Plan's recovery without the prior expressed written consent of the Plan.

(3) Furthermore, it is prohibited for the Covered Person to settle a claim against a third party or any available coverage for certain elements of damages, but eliminating damages relating to medical Expenses Incurred.

(4) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

(5) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, disease, or disability.

D. Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person or filing of bankruptcy by the Covered Person, will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

E. Wrongful Death Claims

In the event that the Covered Person dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage under the laws of any state, the Plan's subrogation and reimbursement rights still apply.

F. Obligations

It is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the

Plan, to:

(1) cooperate with the Plan, or any representatives of the Plan, in protecting its rights of subrogation and reimbursement, including completing discovery, attending depositions, and/or attending or cooperating in a trial in order to preserve the Plan's subrogation rights;
(2) provide the Plan with pertinent information regarding the Injury, including accident reports, settlement information, and any other requested additional information;

(3) take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

(4) do nothing to prejudice the Plan's rights of subrogation and reimbursement;

(5) promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received;

(6) not settle, without the prior consent of the Plan, any claim that the Covered Person may have against any legally-responsible party or insurance carrier; and

(7) refrain from releasing any party, person, corporation, entity, insurance company, or insurance policies or funds that may be responsible for or obligated to the Covered Person for the Injury or condition without obtaining the Plan's written approval.

If the Covered Person fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) incurred with the Plan's attempt to recover such money from the Covered Person.

The Plan rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person's cooperation or adherence to these terms.

G. Minor Status

In the event the Covered Person is a minor, as that term is defined by applicable law, the minor's parent(s) or court-appointed guardian shall cooperate in any and all actions requested by the Plan to seek and obtain any requisite court approval in order to bind the minor and his or her estate insofar as the subrogation and reimbursement provisions are concerned.

H. Severability

In the event that any part of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining Sections of this provision and the SHBP. The affected section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal Sections had never been inserted in the Plan.

SECTION 11 - SHBP AMENDMENT AND TERMINATION

A. Amendment

The Plan Administrator has the right to amend this SHBP in any and all respects at any time, and from time to time. For modifications that affect the Summary of Benefits and Coverage (SBC), the Plan

Administrator will provide notification of such change 60 days prior to the Effective Date. Any such amendment will be by a written instrument signed by a duly-authorized Officer of the Plan Sponsor. For all other Plan changes, the Plan Administrator will notify all Covered Persons of any amendment modifying the material terms of the SHBP as soon as is administratively feasible after its adoption.

B. Termination of SHBP

Regardless of any other provision of the SHBP, the Plan Sponsor reserves the right to terminate the SHBP at any time. Such termination will be evidenced by a written resolution of the Plan Sponsor. The Plan Administrator will provide notice of the SHBP's termination as soon at least 60 days prior to termination date.

SECTION 12 - GENERAL PROVISIONS

A. Plan Funding

All benefits paid under the SHBP shall be paid in cash from the designated SHBP fund established and maintained by the Plan Sponsor. No person shall have any right or title to, or interest in, any investment reserves, accounts, or funds that Kenyon College may purchase, establish, or accumulate to aid in providing benefits under the SHBP. No person shall acquire any interest greater than that of an unsecured creditor.

B. In General

Any and all rights provided to any person under the SHBP shall be subject to the terms and conditions of the SHBP. This Plan Document shall not constitute a contract between the Plan Sponsor and any SHBP-Covered Person or other person(s) nor shall it be consideration or an inducement for the initial or continued enrollment of any Student in Kenyon College. Likewise, maintenance of this SHBP shall not be construed to give any SHBP-Covered Person the right to be retained as a Covered Person by the Plan Sponsor or the right to any benefits not specifically provided by the SHBP.

C. Waiver and Estoppel

No term, condition, or provision of the SHBP shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the SHBP, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived, and it shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No Covered Person or eligible beneficiary other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

D. Non-Vested Benefits

Nothing in the SHBP shall be construed as creating any vested rights to benefits in favor of any Covered Person.

E. Interests Not Transferable

The interests of the Covered Student under the SHBP are not subject to the claim of their creditors and may not be voluntarily or involuntarily transferred, alienated, or encumbered without the written consent of the Plan Administrator.

F. Severability

If any provision of the SHBP shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the SHBP, but the SHBP shall be construed and enforced as if the invalid

or illegal provision had never been inserted. The Plan Sponsor shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the SHBP.

G. Confidentiality and Release of Information

The SHBP will use reasonable efforts to preserve the confidentiality of your medical information. The SHBP may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying you.

Medical Information may only be released with your written consent or as required by law. It must be signed, dated, and must specify the nature of the information and to which persons and/or organizations it may be disclosed.

You may access your own records.

H. Right of Recovery

Whenever payment has been made in error, the SHBP or its Claims Administrator, will have the right to recover such payment from you or, if applicable, the Provider. You will not receive notice of an adjusted cost share amount as a result of such recovery activity

I. Unauthorized Use of Identification Card

If you permit your identification card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expense incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of coverage.

SECTION 13 - PLAN ADMINISTRATION

A. Allocation of Authority The Plan Administrator will control and manage the operation and administration of the SHBP. The Plan Administrator shall have the sole and exclusive right and discretion:

(1) to interpret the SHBP, the Plan Document, and any other writings affecting the establishment or operation of the SHBP, both as to legal import and as to the application of the provisions of any such documents to the facts of a particular claim for benefits, and to decide all matters arising under the SHBP, including the right to remedy possible ambiguities, inconsistencies, or omissions; and

(2) to make factual findings and decide conclusively all questions regarding any claim for benefits made under the SHBP.

All determinations of the Plan Administrator with respect to any matter relating to the administration of the SHBP will be conclusive and binding on all persons. *You have the right to appeal our determination. Please refer to the Appeals section of this Plan Document.*

B. Powers and Duties of Plan Administrator

The Plan Administrator will have the following powers and duties:

(1) to require any person to furnish such reasonable information as the Plan Administrator may request for the proper administration of the SHBP as a condition to receiving any benefits under the SHBP;

(2) to make and enforce such rules and regulations and prescribe the use of such forms as the Plan Administrator will deem necessary for the efficient administration of the SHBP;

(3) to decide on questions concerning the SHBP, or the eligibility of any person to participate in the SHBP, in accordance with the provisions of the SHBP;

(4) to determine the amount of benefits that will be payable to any person in accordance with the provisions of the SHBP;

(5) to inform Covered Person(s), as appropriate, of the amount of such benefits payable in accordance with the provisions of the SHBP;

(6) to designate other persons to carry out any duty or power that would otherwise be a fiduciary or clerical responsibility of the Plan Administrator under the terms of the SHBP;

(7) to retain such actuaries, accountants, consultants, third-party administration services, legal counsel, or other specialists, as the Plan Administrator may deem appropriate and necessary for the SHBP's effective administration; and

(8) to perform any other functions or actions that would commonly be within the purview of a similarly situated administrator for a student health insurance/benefits plan.

C. Delegation by the Plan Administrator

The Plan Administrator may employ the services of such persons (including an insurance company or third-party administrator) as it may deem necessary or desirable in connection with the administration of claims or other operations of the SHBP.

The Plan Administrator will also have the power and duty to retain the services of one or more health care professionals, for the purpose of reviewing benefit claims that are under Appeal for reasons based on medical judgment, such as Medical Necessity or Experimental treatments.

The Plan Administrator (and any person to whom any duty or power in connection with the operation of the SHBP is delegated) may rely upon all tables, valuations, certificates, reports, and opinions furnished by any duly-appointed actuary, accountant, consultant, third-party administration service, legal counsel, or other specialist, and the Plan Administrator or such delegate will be fully protected in respect to any action taken or permitted in good faith in reliance upon such table, valuations, certificates, etc.

D. Payment of Administrative Expenses

All reasonable costs incurred in the administration of the SHBP including, but not limited to, administrative fees and expenses owed to any third-party administrative service, actuary, consultant, accountant, specialist, or other person or organization that may be employed by the Plan Administrator in connection with the administration thereof, will be paid by the Plan Sponsor unless the Plan Administrator directs the SHBP to pay such expenses and such payment by the SHBP is permitted by law.

SECTION 14 - HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) affords protection to patients from unwarranted disclosure of private medical information by specifying those situations in which, and those persons to whom, personal information may be disclosed.

A. Permitted Disclosures

There are three circumstances under which the SHBP may disclose an individual's protected health information to the Plan Sponsor.

(1) The SHBP may inform the Plan Sponsor whether an individual is enrolled in the SHBP.

(2) The SHBP may disclose summary health information to the Plan Sponsor. The Plan Sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the SHBP. Summary health information is information that summarizes claims history, claims expenses, and/or types of claims without identifying the individual.

(3) The SHBP may disclose an individual's protected health information to the Plan Sponsor for SHBP administrative purposes. This is because the Plan Sponsor performs many of the administrative functions necessary for the management and operation of the SHBP. The Plan Sponsor has certified to the SHBP that the SHBP's terms have been amended to incorporate the terms of this summary. The Plan Sponsor has agreed to abide by the terms of this summary. The SHBP's privacy notice also permits the SHBP to disclose an individual's protected health information to the Plan Sponsor as described in this summary.

B. Restrictions on Plan Administrator and Disclosure

The restrictions that apply to the Plan Sponsor's use and disclosure of an individual's protected health information are as follows:

(1) The Plan Sponsor will only use or disclose an individual's protected health information for SHBP administrative purposes, as required by law, or as permitted under HIPAA regulations. (Refer to SHBP's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.)

(2) If the Plan Sponsor discloses any of an individual's protected health information to any of its agents or subcontractors, the Plan Sponsor will require the agent or subcontractor to keep an individual's protected health information confidential as required by the HIPAA regulations.

(3) The Plan Sponsor will not use or disclose an individual's protected health information for Kenyon's admissions-related or employment-related actions or decisions or in connection with any other benefit or benefit plan of the Plan Sponsor unless permitted under HIPAA.

(4) The Plan Sponsor will promptly report to the SHBP any use or disclosure of an individual's protected health information that is inconsistent with the uses or disclosures allowed in this summary.

(5) The Plan Sponsor will allow an individual or the SHBP to inspect and copy any protected health information about that individual who is in the Plan Sponsor's custody and control. The HIPAA Regulations set forth the rules that an individual and the SHBP must follow in this regard. There are some exceptions to this provision allowed under federal regulations.

(6) The Plan Sponsor will amend, or allow the SHBP to amend, any portion of an individual's protected health information to the extent permitted or required under the HIPAA Regulations.

(7) With respect to some types of disclosures, the Plan Sponsor will keep a disclosure log for a period of not less than six (6) years (but not before April 14, 2004). An individual has a right to see the disclosure log. The Plan Sponsor does not have to maintain the log if disclosures are for certain SHBP-related purposes, such as payment of benefits or health care operations.

(8) The Plan Sponsor will make its internal practices, books, and records relating to its use and disclosure of an individual's protected health information available to the SHBP and to the U.S. Department of Health and Human Services.

(9) The Plan Sponsor will, if feasible, return or destroy all of an individual's protected health information in the Plan Sponsor's custody or control that the Plan Sponsor has received from the SHBP or from any business partner, agent, or subcontractor when the Plan Sponsor no longer needs an individual's protected health information to administer the SHBP. If it is not feasible for the Plan Sponsor to return or destroy an individual's protected health information, the Plan Sponsor will limit the use or disclosure of such protected health information.

C. Authorized Recipients of Protected Health Information

In addition to the Privacy Officer, the following classes of individuals or other workforce members under the control of the Plan Sponsor may be given access to an individual's protected health information on a need-to-know basis, solely for the purposes set forth above:

(1) Vice President for Finance

(2) Director, Cox Health & Counseling Center

(3) Consultants or other third parties retained by the Plan Sponsor to perform duties necessary for the function of the SHBP.

This list includes every class of individuals or other workforce members under the control of the Plan Sponsor who may receive an individual's protected health information. If any of these individuals or workforce members use or disclose an individual's protected health information in violation of the rules that are set out in this summary, the responsible individual(s) or workforce member(s) will be subject to disciplinary action and sanctions. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to the SHBP and will cooperate with the SHBP to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to the individual. Any violations will also be reported to the Centers for Medicare and Medicaid Services.

D. Security Provisions

The Plan Sponsor will receive or generate electronic protected health information. The information may be identified to the individual in some cases. In relation to such electronic protected health information, the Plan Sponsor certifies to the SHBP that it agrees to:

(1) take appropriate and reasonable safeguards (administrative, physical, and technical) to protect the confidentiality, integrity, and availability of the information it creates, receives, maintains, or transmits;

(2) require that any agent or subcontractor of the Plan Sponsor agrees to the same requirements that apply to the Plan Sponsor under this provision;

(3) report to the SHBP any security incident of which the Plan Sponsor becomes aware; and

(4) apply reasonable and appropriate security measures to maintain adequate separation between the SHBP and Plan Sponsor.

SECTION 15 - CLAIMS PROCESSING

Claims Administrator

The Claims Administrator shall be responsible for the processing of claims, reviewing benefits for purposes of prior authorization, providing certain financial services, providing reports and making initial benefit determinations subject to the Plan and direction of the SHBP. It does not fund or ensure claim payments or bear any financial risk with regard to Plan expenses.

Authorization of Claims Processing

The Plan Administrator has delegated the administration of claims processing under the Plan to the Claim Administrator. As directed by the Plan Administrator, the Claim Administrator makes initial claim and initial appeal determinations based on the specific terms of the SHBP Plan Document. The Claims Administrator has authority to interpret the SHBP Document to determine the amount of benefits that will be paid on any particular benefit claim and has discretion and authority to make factual findings regarding a claim and to interpret the terms of the Plan as they apply to the claims

SECTION 16- APPEALS PROCESSING

Appeal of Adverse Benefit Determination

Review Procedures: If the Covered Person believes an adverse benefit determination occurred, including a belief that a denial of a claims was improper, the following process should be adhered to:

1. Within 180 days of receipt of the adverse benefit determination or denial of the claim, the Participant may request, in writing, that the Claims Administrator conduct a review of the determination. The Claims Administrator will review the benefit determination and inform the Participant whether or not an error was made.

2. All requests for review of adverse benefit determination, including denied claims, should

include a copy of the initial denial letter and any other pertinent information. All information should be sent to:

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

Authorized Representative

A Covered Person is permitted to designate an authorized representative to act on their behalf with respect to a benefit claim or appeal of an adverse benefit determination. Designation of an authorized representative must be in writing. The Plan will permit a health care professional with knowledge of the Covered Person's condition (such as a treating Physician) to act as the authorized representative of the Covered Person.

1. This designation of an authorized representative should be sent to the Claims Administrator as noted to the above provided address.
2. Amendment of Claims Procedures The claims and payment procedures may be amended at any time, in whole or in part, in accordance with the amendment procedures set forth in the Plan.

Expedited Reviews

Expedited Review of an appeal may be initiated orally, in writing, or by other reasonable means available to the Covered Person or their Provider. Expedited Review is available only if the medical care for which coverage is being denied has not yet been rendered. We will complete expedited review of an appeal as soon as possible given the medical exigencies but no later than seventy-two hours (72 hours) after the Plan's receipt of the request and will communicate its decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of our determination to the Covered Person, their attending Physician or ordering Provider, and the facility rendering the service.

The Covered Person may request an expedited review for:

- Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent cares determinations:
    1. Could seriously jeopardize the Covered Person's life or health or ability to regain maximum function, or,
    2. In the opinion of a Physician with knowledge of the medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- Except as provided above, a claim involving urgent care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
- Any claim that a Physician with knowledge of your medical condition determines is a claim involving urgent care.

External Reviews

After exhaustion of all appeal rights stated above, a Covered Person may also request a final independent external review of any Adverse Benefit Determination involving a question of Medical Necessity, or other issue requiring medical expertise for resolution.

To assert this right to independent external medical review, the Covered Person must request such review in writing within one hundred twenty (120) days after a decision is made upon the second level benefit determination above.

If an independent external review is requested, the Claims Administrator will forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO will notify the Covered Person of its procedures to submit further information.

The IRO will issue a final decision within forty-five (45) days after receipt of all necessary information.

The decision of the IRO will be final and binding except that the Covered Person shall have an additional right to appeal the matter to a court with jurisdiction.