

# WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

## STUDENT HEALTH CERTIFICATE OF COVERAGE

**POLICYHOLDER:** Landmark College  
(Policyholder, You, or Your)  
**POLICY NUMBER:** WI2223VTSHIP86  
**POLICY EFFECTIVE DATE:** August 15, 2022  
**POLICY TERMINATION DATE:** August 14, 2023  
**STATE OF ISSUE:** Vermont

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

### INSURING AGREEMENTS

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

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

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

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

Term of the Certificate

This Certificate terminates at 11:59 p.m. local time at the Policyholder’s address.

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

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

This Certificate does not provide Coverage for:

- 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.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.

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

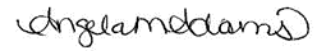
**Non-Participating  
One Year Term Insurance**

### NONDISCRIMINATORY

Health care services and any other benefits to which a Insured Person is entitled are provided on a nondiscriminatory basis, including benefits mandated by state and federal law.



**President**  
Andrew M. DiGiorgio



**Secretary**  
Angela Adams

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

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

## **RIGHTS AND RESPONSIBILITIES**

Your responsibilities as a Covered Person include:

- Carrying Your Identification Card with You and presenting it prior to receiving health care services;
- Paying all Deductible, Coinsurance and Copayment amounts, if any, when due;
- Reading the Certificate, knowing Your Coverage, and following the procedures outlined in the Certificate to receive Maximum Benefits;
- Informing Us of any other health insurance You may have;
- Preventing the dishonest or false use of Your Identification Card by people not eligible for Coverage, and immediately reporting any such use to Us;
- Informing Us of any change in Your address or a Lifestyle Change which may alter Benefits for You or Your Dependents.

Your rights as a Covered Person include:

- Simple information and explanations from Your health plan to help You understand what is covered and what is not covered;
- A current list of Preferred Providers, assistance in locating a provider in your area as well as how to change providers
- Emergency care at any Hospital for a Condition You believe threatens Your life or seriously affects Your health;
- Information about steps You can take if You think Your health insurance plan has denied You Coverage of a treatment You believe is covered.

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## SCHEDULE OF BENEFITS

### Preventive Services:

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

Out-of-Network Provider: Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through an Out-of-Network Provider. Benefits are paid at 70% of the Usual and Customary Charge.

### Medical Deductible\*

In-Network Provider:	Individual:	\$250
Out-of-Network Provider	Individual:	\$250

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

### Out-of-Pocket Maximum:

In-Network Provider	Individual	\$5,550
Out-of-Network Provider	Individual	\$6,850

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

### Prescription Drug Out-of-Pocket Maximum\*:

In-Network Provider	Individual	\$1,350
Out-of-Network Provider	Individual	\$0

\*The Prescription Drug Out-of-Pocket Maximum counts toward the overall Out-of-Pocket Maximum.

### Coinsurance Amounts:

In-Network Provider: 80% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below

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

### Medical Benefit Payments for In-Network Providers and Out-of-Network Providers

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

When You receive Emergency Services, or certain non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, You are protected from Surprise Billing. In these situations, Your cost sharing responsibility will be calculated as if the total amount that would be charged for the services by an In-Network Provider or facility were equal to the Qualifying Payment Amount. Refer to the Preferred Provider Organization provision in the How The Plan Works And Description Of Benefits section for additional information.

### Dental and Vision Benefit Payments

For dental and vision benefits, You may choose any dental or vision provider.

For dental, different benefits may be payable based on the type of service, as shown in the Schedule of Benefits. If You incurred Covered Medical Expenses from an Out-of-Network Provider but were informed by Us prior to receipt of the Treatment that the provider was an In-Network Provider, either through the Provider Directory, or in Our response to Your request for such information (via telephone, electronic communication, web-based or internet-based means), You may be eligible for cost sharing that would be no greater than if the service had been provided by an In-Network Provider. For additional information, contact Us at the number on Your ID card.

**Preferred Provider Organization:**

To locate an In-Network Provider in Your area, consult Your Provider Directory or call toll free 877-657-5030 or visit Our website at [www.wellfleetstudent.com](http://www.wellfleetstudent.com) .

If You incurred Covered Medical Expenses from an Out-of-Network Provider but were informed by Us prior to receipt of the Treatment that the provider was an In-Network Provider, either through the Provider Directory, or in Our response to Your request for such information (via telephone, electronic communication, web-based or internet-based means), You may be eligible for cost sharing that would be no greater than if the service had been provided by an In-Network Provider. For additional information, contact Us at the number on Your ID card.

**THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:**

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

<b>BENEFITS FOR COVERED INJURY/SICKNESS</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>INPATIENT SERVICES</b>		
Hospital Care Includes Hospital room & board expenses and miscellaneous services and supplies. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care.  Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary 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 Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Skilled Nursing Facility Benefit  Pre-Certification required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit  Pre-Certification required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Registered Nurse Services for private duty nursing while Confined	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
<b>MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER BENEFITS</b>		
In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-certification requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.		
<b>Inpatient Mental Health Disorder and Substance Use Disorder Benefit</b> Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
<b>Outpatient Mental Health Disorder and Substance Use Disorder Benefit</b>  Physician's Office Visits including, but not limited to, Physician visits; individual and group therapy; medication management  All Other Outpatient Services including, but not limited to, Intensive Outpatient Programs (IOP); partial hospitalization; Electronic Convulsive Therapy (ECT); Repetitive Transcranial Magnetic Stimulation (rTMS); Psychiatric and Neuro Psychiatric testing	\$20 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses  Deductible waived  80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses      70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
<b>PROFESSIONAL AND OUTPATIENT SERVICES</b>		
<b><i>Surgical Expenses</i></b>		
<b>Inpatient and Outpatient Surgery includes:</b> Pre-Certification Required Surgeon Services Anesthetist Assistant Surgeon	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Outpatient Surgical Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Abortion Expense	\$20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	\$20 Copayment per visit then the plan pays 70% of the Negotiated Charge after Deductible for Covered Medical Expenses
Bariatric Surgery Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Organ Transplant Surgery travel and lodging expenses a maximum of \$2,000 per Policy Year or \$250 per day, whichever is less while at the transplant facility.  Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Reconstructive Surgery  Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
<b>Other Professional Services</b>		
Gender Affirmation Services Benefit  Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Pre-Certification required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hospice Care Coverage	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maximum Social Services visits per lifetime	6 visits	6 visits
Maximum Bereavement visits per lifetime	2 visits	2 visits
<b>Office Visits</b>		
Physician's Office Visits including Specialists/Consultants	\$20 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses  Deductible waived	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telemedicine or Telehealth Services	\$20 Copayment per visit then the plan pays 100% of the Negotiated for Covered Medical Expenses  Deductible waived	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Allergy Testing and Treatment including injections	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Negotiated Charge after Deductible for Covered Medical Expenses



Chiropractic Care Benefit Pre-Certification Required	\$20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	\$20 Copayment per visit then the plan pays 70% of the Negotiated Charge after Deductible for Covered Medical Expenses
Tuberculosis screening, Titers, QuantiFERON B tests including shots (other than covered under preventive services)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Negotiated Charge after Deductible for Covered Medical Expenses
<b>Emergency Services, Ambulance And Non-Emergency Services</b>		
Emergency Services in an emergency department for Emergency Medical Conditions.	\$200 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Urgent Care Centers for non-life-threatening conditions	\$20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	\$20 Copayment per visit then the plan pays 70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Non-Emergency Ambulance Service ground and/or air, water transportation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Negotiated Charge after Deductible for Covered Medical Expenses
<b>Diagnostic Laboratory, Testing and Imaging Services</b>		
Diagnostic Imaging Services Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Negotiated Charge after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Negotiated Charge after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Negotiated Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Negotiated Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required only when administered in the home as part of home health care	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Negotiated Charge after Deductible for Covered Medical Expenses
<b>Rehabilitation and Habilitation Therapies</b>		
Cardiac Rehabilitation	\$20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	\$20 Copayment per visit then the plan pays 70% of the Negotiated Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	\$20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	\$20 Copayment per visit then the plan pays 70% of the Negotiated Charge after Deductible for Covered Medical Expenses

Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy  Pre-Certification Required	\$20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	\$20 Copayment per visit then the plan pays 70% of the Negotiated Charge after Deductible for Covered Medical Expenses
Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy  Pre-Certification Required	\$20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	\$20 Copayment per visit then the plan pays 70% of the Negotiated Charge after Deductible for Covered Medical Expenses
<b>OTHER SERVICES AND SUPPLIES</b>		
Covered Cancer Clinical Trials	Same as any other Covered Sickness	
Diabetic services and supplies (including equipment and training)  Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Negotiated Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Negotiated Charge after Deductible for Covered Medical Expenses
Durable Medical Equipment Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Negotiated 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 Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Negotiated Charge after Deductible for Covered Medical Expenses
Maternity Benefit including Midwife and Home Birth Coverage	Same as any other Covered Sickness or Provider	
Prosthetic and Orthotic Devices  Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Negotiated Charge after Deductible for Covered Medical Expenses
Outpatient Private Duty Nursing  Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Negotiated Charge after Deductible for Covered Medical Expenses
Sports Accident Expense Benefit - incurred as the result of the play or practice of Intercollegiate or club sports	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Negotiated Charge after Deductible for Covered Medical Expenses

Non-emergency Care While Traveling Outside of the United States	70% of Actual Charge after Deductible for Covered Medical Expenses Subject to \$10,000 maximum per Policy Year
Medical Evacuation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived  Subject to \$50,000 maximum per Policy Year
Repatriation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived  Subject to \$25,000 maximum per Policy Year
<b>Pediatric and Adult Dental and Vision Care</b>	
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 21)	See the Pediatric Dental Care Benefit description in the Certificate for further information.
Preventive Dental Care Limited to 2 dental exams every 12 months	100% of Usual and Customary Charge for Covered Medical Expenses
The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care:	
Emergency Dental	50% of Usual and Customary Charge
Routine Dental Care	50% of Usual and Customary Charge
Endodontic Services	50% of Usual and Customary Charge
Prosthodontic Services	50% of Usual and Customary Charge
Periodontic Services	50% of Usual and Customary Charge
Medically Necessary Orthodontic Care	50% of Usual and Customary Charge
Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	
Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 21)  Limited to 1 visit(s) per Policy Year	100% of Usual and Customary Charge after Deductible for Covered Medical Expenses

<p>and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year</p> <p>Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.</p>		
<p>Adult Vision Care (age 21 and older) Routine Eye Exam once every 12- months Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions</p>	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses	
<b>Miscellaneous Dental Services</b>		
<p>Accidental Injury Dental Treatment</p>	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Negotiated Charge after Deductible for Covered Medical Expenses
<p>Sickness Dental Expense Benefit</p>	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Negotiated Charge after Deductible for Covered Medical Expenses
<p>Treatment for Temporomandibular Joint (TMJ) Disorders</p>	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Negotiated Charge after Deductible for Covered Medical Expenses
<b>PRESCRIPTION DRUGS</b>		
<p><b>Prescription Drugs Retail Pharmacy</b> No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy</p> <p>You will be notified of any changes in prescription drug coverage and can access the preferred drug list at <a href="http://www.wellfleetstudent.com">www.wellfleetstudent.com</a></p> <p>Your benefit is limited to a 30 day supply. Coverage for more than a 30 day supply only applies if the smallest package size exceeds a 30 day supply. See “Retail Pharmacy Supply Limits” section for more information.</p>		
<p><b>TIER 1</b> (Including Enteral Formulas For each fill up to a 30 day supply filled at a Retail pharmacy</p> <p>See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.</p>	<p>\$25 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	70% 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	\$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses  Deductible Waived	70% of Actual Charge after Deductible for Covered Medical Expenses
More than a 60 day supply filled at a Retail pharmacy	\$75 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses  Deductible Waived	70% of Actual Charge after Deductible for Covered Medical Expenses
TIER 2 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy  See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	\$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses  Deductible Waived	70% of Actual Charge after Deductible for Covered Medical Expenses
More than a 30 day supply but less than a 60 day supply filled at a Retail pharmacy	\$100 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses  Deductible Waived	70% of Actual Charge after Deductible for Covered Medical Expenses
More than a 60 day supply filled at a Retail pharmacy	\$150 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses  Deductible Waived	70% of Actual Charge after Deductible for Covered Medical Expenses
TIER 3 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail Pharmacy  See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	\$75 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses  Deductible Waived	70% 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	\$150 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses  Deductible Waived	70% of Actual Charge after Deductible for Covered Medical Expenses

More than a 60 day supply filled at a Retail pharmacy	\$225 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses  Deductible Waived	70% of Actual Charge after Deductible for Covered Medical Expenses
<b>Specialty Prescription Drugs</b>		
For each fill up to a 30 day supply.	\$75 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses  Deductible Waived	70% of Actual Charge after Deductible for Covered Medical Expenses
More than a 30 day supply but less than a 61 day supply	\$150 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses  Deductible Waived	70% of Actual Charge after Deductible for Covered Medical Expenses
More than a 60 day supply	\$225 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses  Deductible Waived	70% of Actual Charge after Deductible for Covered Medical Expenses
<b>Zero Cost Medications</b>		
	100% of the Negotiated Charge for Covered Medical Expenses  Deductible Waived	100% of Actual charge for Covered Medical Expenses  Deductible Waived
<b>Orally administered anti-cancer prescription drugs (including specialty drugs)</b>		
Benefit	Greater of: Chemotherapy Benefit; or Infusion Therapy Benefit	
<b>Diabetic Supplies (for Prescription supplies purchased at a pharmacy)</b>		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill except, that the Insured Person's out-of-pocket costs for covered prescription insulin drugs will not exceed \$100 per 30-day supply regardless of the amount or type of insulin that is needed to fill the Insured Person's prescription. Deductible waived for insulin.	
<b>Mandated Benefits</b>		
Athletic Trainer	Same as any other Physician	
Autism Spectrum Disorders for Children	Same as any other Covered Sickness	
Colorectal Cancer Screening for Insured Persons (50) years of age or older, or at high risk for colorectal cancer.	Same as any other Preventive Service	
Craniofacial Disorders	Same as any other Covered Sickness	
Dental Coverage for Anesthesia and Hospitalization Benefit	Same as any other Covered Sickness	
Mammography Screening	Same as any other Preventive Service	
Naturopathic Physician	Same as any other Physician	
Prostate Screening	Same as any other Preventive Service	
Sexual Assault Benefit	Same as any other Covered Sickness, except no Copayment, Coinsurance or Deductible will apply.	

## Accidental Death and Dismemberment

Principal Sum	\$10,000
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Loss must occur within 365 days of the date of a covered Accident.

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

### SECTION I - ELIGIBILITY

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

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

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

All International Students are required to have a J-1 F-1 M-1 Visa to be eligible for this insurance plan.

We maintain the right to investigate eligibility status and attendance records to verify that the Certificate eligibility requirements have been and continue to be met. If We discover that the Certificate eligibility requirements have not been met, Our only obligation is refund of premium less any claims paid. Eligibility requirements must be met each time premium is paid to continue Coverage.

If You performed an act that constitutes fraud; or You have made an intentional misrepresentation of material fact during Your enrollment under this insurance plan in order to obtain coverage for a service, coverage will be terminated immediately upon written notice of termination delivered by Us to You.

#### Who is Eligible

Class	Description of Class(es)
1	All Undergraduate and Graduate students of the Policyholder.

**Class 1:** All students, as determined by the Policyholder, are eligible for coverage under the Policy. Eligible students are required to have health insurance coverage and will be automatically enrolled in the Student Health Insurance Plan at registration and the premium will be added to the student's tuition fees unless proof of comparable coverage is provided by completing the waiver.

#### Who is not Eligible

Dependents are not eligible for coverage under this plan.

### SECTION II – EFFECTIVE AND TERMINATION DATES

**Effective Dates:** Your Insurance under this Certificate will become effective on the later of:

1. The Policy Effective Date;
2. The beginning date of the term of coverage for which premium has been paid;

3. The day after Enrollment (if applicable) and premium payment is received by Us, Our authorized agent or the School;
4. The day after the date of postmark if the Enrollment form is mailed; or
5. For International Students, the departure date to his or her Home Country to travel to the Country of Assignment. The scheduled arrival in the Country of Assignment must be not more than 48 hours later than the departure from the Home Country.

### **Special Enrollment – Qualifying Life Event**

You can also enroll for coverage within 60 days of the loss of coverage in a health plan if coverage was terminated because You are no longer eligible for coverage under the other health plan due to:

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

You can also enroll 60 days from exhaustion of Your COBRA or continuation coverage.

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

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

1. You lose eligibility for Medicaid or a state child health plan.
2. You become eligible for Medicaid or a state child health plan.

We must receive notice and premium payment within 60 days of the loss of 1 of these events. The Effective Date of Your coverage will depend on the date We receive Your completed enrollment information and required premium.

**Termination Dates:** Your insurance will terminate on the earliest of:

1. The date this Certificate terminates; or
2. The end of the period of coverage for which premium has been paid; or
3. The date You cease to be eligible for the insurance; or
4. The date You enter military service; or
5. For International Students, the date they cease to meet Visa requirements; or
6. For International Students, the date they depart the Country of Assignment for their Home Country (except for scheduled School breaks)); or
7. On any premium due date the Policyholder fails to pay the required premium for You except as the result of an inadvertent error and subject to any Grace Period provision.

### **Dependent Child Coverage:**

**Newly Born Children** – A newly born child of Yours will be covered from the moment of birth. Such newborn child will be covered for Covered Injury or Covered Sickness for an initial period of 60 days. This includes the necessary care and Treatment of medically diagnosed congenital defects and birth abnormalities from the moment of birth. Dependent coverage is not available under this plan. When this 60 day provision has been exhausted, all Dependent coverage ends. No further benefits will be paid

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

1. If You are Hospital Confined for Covered Injury or Covered Sickness on the date Your insurance coverage terminates, We will continue to pay benefits for that Covered Injury or Covered Sickness for up to 90 days from the Termination Date while such Confinement continues; or



2. If You are Totally Disabled due to Covered Injury or Covered Sickness for which benefits were paid before the Termination Date, the coverage for that condition will be extended for up to 12 months from the Termination Date or until the date the disability ends, whichever is earlier.

**Reinstatement Of Reservist After Release From Active Duty:** If Your insurance ends due to Your being called or ordered to active duty, such insurance will be reinstated without any waiting period when You return to School and satisfy the eligibility requirements defined by the School or College.

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

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

### SECTION III – DEFINITIONS

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

**Accident** means unexpected, and unintended, event which You have no control.

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

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

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

1. Is equipped and operated to provide medical care and Treatment by a Physician;
2. Does not provide services or accommodations for overnight stays;
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.

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

**Coinsurance** means the percentage of Covered Medical Expenses that We pay. The Coinsurance percentage is stated in the Schedule of Benefits. The Coinsurance is separate and not part of 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 Services, which is a review or assessment of 48 hours or less, of a condition that does not result in admission to a Hospital or health care facility.

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

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

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

**Covered Injury/Injury** means a bodily injury due to an external event which results in bodily infirmity. 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:

1. Not in excess of the Usual and Customary Charge therefore;
2. Not in excess of the charges that would have been made in the absence of this insurance;
3. Not in excess of the Negotiated Charge; and
4. Incurred while Your Certificate is in force, except with respect to any expenses payable under the Extension of Benefits Provision.

**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 You must pay before benefits are payable under this Certificate. 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 Policyholder.

**Emergency Medical Condition** means the sudden and, at the time, unexpected onset of an Illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possess an average knowledge of health and medicine to result in:

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

**Emergency Services** means, with respect to an Emergency Medical Condition: transportation services, including but not limited to Ambulance Services, a medical screening examination that is within the capability of the emergency department, including ancillary services routinely available to the emergency department, and covered inpatient and outpatient services furnished by a Hospital, independent freestanding emergency department, or Physician qualified to furnish those services that are needed to evaluate or Stabilize an Emergency Medical Condition. Coverage also includes Post-Stabilization services after You are Stabilized. Post-Stabilization services include undergoing outpatient Observation Services, or an inpatient or outpatient stay with respect to the visit in which the other Emergency Services are furnished. The Post-Stabilization services will no longer qualify as Emergency Services once You can travel using non-medical or non-emergency transportation and You are in a condition to receive notice of, and to consent to, Out-of-Network Treatment.

**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 Disorder and Substance Use Disorder services, including behavioral health Treatment;
6. Prescription drugs;
7. Rehabilitation and Habilitation services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

**Experimental/Investigative** means the health care items or services that are:

1. Not generally accepted by informed health care providers in the United States as effective in treating the condition, illness or diagnosis for which their use is proposed; or are
2. Not proven by medical or scientific evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed.

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

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

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

**Home Country** means Your country of citizenship. If You have dual citizenship, Your Home Country is the country of the passport You used to enter the United States.

**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 by the state as a Home Health Care Agency..

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

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

Hospital also includes an Ambulatory Surgical Center or ambulatory medical center; and a birthing facility certified and licensed as such under the laws where located. It shall also include Rehabilitation 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. Hospital does not include a place primarily for rest, the aged, a place for educational or Custodial Care or Hospice.

**Immediate Family Member** means You and Your Spouse or the parent, child, brother or sister of You or Your Spouses.

**In-Network Providers** are Physicians, Hospitals and other healthcare providers who have contracted with Us to provide specific medical care at negotiated prices.

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

**Insured Person** means an Insured Student while insured under this Certificate.

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

**International Student** means an international student:

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

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

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

**Medically Necessary** or **Medical Necessity** means health care services including diagnostic testing, preventive services and aftercare that are appropriate, in terms of type, amount, frequency, level, setting and duration to the member's diagnosis or condition. Medically necessary care must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters as recognized by health care professionals in the same specialties as typically provide the procedure or treatment, or diagnosis or manage the medical condition and must be informed by the unique needs of each individual patient and each presenting situation and:

1. Help restore or maintain the member's health; or
2. Prevent deterioration of or palliate the member's condition; or
3. Prevent the reasonably likely onset of a health problem or detect an incipient problem.

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 an Insured 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.

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

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

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

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

**Organ Transplant** means the moving of an organ from one (1) body to another or from a donor site to another

location of the person's own body, to replace the recipient's damaged, absent or malfunctioning organ.

**Out-of-Network Providers** are Physicians, Hospitals and other healthcare providers who have not agreed to any pre-arranged fee schedules.

**Out-of-Pocket Maximum** means the most You will pay during a Policy Year before Your 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 Certificate 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 Certificate, and who is not:

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

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

**Preadmission Testing** means tests done in conjunction with and within 5 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 this Certificate.

**Qualifying Payment Amount** means the median Negotiated Charge for:

1. the same or similar services;
2. furnished in the same or similar facility;
3. by a provider of the same or similar specialty;
4. in the same or similar geographic area.

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

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

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

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

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

1. Mainly provides inpatient care and Treatment for persons who are recovering from 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/Stabilization and Post-Stabilization** means, with respect to an Emergency Medical Condition, to provide such medical Treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

**Substance Use Disorder** means any condition or disorder that substantially limits the life activities of an Insured 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.

**Surprise Billing** is an unexpected balance bill. This can happen when You can't control who is involved in Your care-like when You have an Emergency Medical Condition or when You schedule a visit at an In-Network Hospital or Ambulatory Surgical Center but are unexpectedly treated by an Out-of-Network Provider.

**Telemedicine** means the practice of health care delivery, diagnosis, consultation, Treatment, transfer of medical data, and education using interactive audio, audio-only telephone, video, or data communications involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information. Electronic messaging between a Physician and You does not constitute "Telemedicine".

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

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

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

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

**Urgent Care Center** is a category of walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency department. Urgent Care Centers primarily treat non-life-threatening conditions that require immediate care but are not serious enough to require an emergency department visit. Urgent Care Centers can also provide a variety of routine services like exams, physicals, vaccines, and lab services.

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

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

<b>Service or Supply</b>	<b>Usual and Customary Charge</b>
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 We determine We need more data for a particular service or supply, We may base rates on a wider geographic area such as an entire state.
- “Reasonable amount rate” means Your plan has established a reasonable rate amount as follows:

Service or Supply	Reasonable Amount Rate
Professional services and Inpatient and outpatient charges of hospitals	The lesser of: <ol style="list-style-type: none"> <li>1. The billed charge for the services; or</li> <li>2. An amount determined using current publicly-available data which is usual and customary when compared with the charges made for a) similar services and supplies and b) to persons having similar medical conditions in the geographic area where service is rendered; or</li> <li>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; or</li> <li>4. In the case of Emergency Services from an Out-of-Network Provider or facility, and certain non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, Qualifying Payment Amount</li> </ol>

Our reimbursement policies may affect the Usual and Customary Charge. These policies consider:

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

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

Our reimbursement policies are based on Our review of:

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

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

No payment will be made under this Certificate for any expenses incurred which are in excess of Usual and Customary Charges.

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

**Visa** means the document issued by the United States Government that permits an individual to participate in the educational activities of a college, university or other institution of higher learning either as a student or in another



academic capacity. An International Student must have and maintain a valid Visa, either an F-1 (Academic), J-1 (Exchange) or M-1 (Vocational) in order to continue as a student in the United States.

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

## **SECTION IV – HOW THE PLAN WORKS AND DESCRIPTION OF BENEFITS**

### **Schedule of Benefits**

The following are shown in the Schedule of Benefits:

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

### **How the Deductible Works**

#### **Deductible**

The Deductible amount (if any) is shown in the Schedule of Benefits. This dollar amount is what You have to incur in Covered Medical Expenses before benefits are payable under this Certificate. This amount will apply on an individual basis. The Deductible applies to all Covered Medical Expenses, unless specifically noted. Any expenses that You incur that are not Covered Medical Expenses are not applied toward Your Deductible.

Covered Medical Expenses applied to the In-Network Provider Deductible will not apply to the Out-of-Network Provider Deductible. Covered Medical Expenses applied to the Out-of-Network Provider Deductible will not apply to the In-Network Provider Deductible.

#### **Individual**

The Deductible is an amount the individual must incur for In-Network Provider and Out-of-Network Provider Covered Medical Expenses before the plan pays. This Deductible applies separately to You. After the amount of Covered Medical Expenses You incur reaches the Deductible, this plan will pay for Covered Medical Expenses as shown on the Schedule of Benefits for the rest of the Policy Year.

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

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

### **How Your Out-of-Pocket Maximum Works**

The In-Network Provider and Out-of-Network Provider Out-of-Pocket Maximums are shown in the Schedule of Benefits. The Out-of-Pocket Maximum provides is the amount of Covered Medical Expenses You have to incur before Covered Medical Expense will be paid at 100% for the remainder of the Policy Year. 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 premium do not count toward meeting the Out-of-Pocket Maximum.

Covered Medical Expenses applied to the In-Network Provider Out-of-Pocket Maximum(s) will not be applied to satisfy the Out-of-Network Provider Out-of-Pocket Maximum and Covered Medical Expenses applied to the Out-of-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the In-Network Provider Out-of-Pocket Maximum.

### **Prescription Drug Out-of-Pocket Maximum**

The Prescription Drug Out-of-Pocket Maximum counts toward the overall Out-of-Pocket Maximum.

The Out-of-Pocket Maximum is the maximum amount of Covered Medical Expenses You will incur for Copayments, Coinsurance and Deductibles during the Policy Year. This plan has an individual Out-of-Pocket Maximum. As to the individual Out-of-Pocket Maximum, each of You must meet Your Out-of-Pocket Maximum separately. In no event will the Out-of-Pocket Maximum exceed the limits required by federal law.

### **Individual**

Once the amount of the Copayments, Coinsurance and Deductibles You have incurred for Covered Medical Expenses during the Policy Year meets the:

- In-Network Provider individual Out-of-Pocket Maximum, this plan will pay:
  - 100% of the Negotiated Charge for In-Network Provider Covered Medical Expenses
- Out-of-Network Provider individual Out-of-Pocket Maximum, this plan will pay:
  - 100% of the Usual and Customary Charge for Out-of-Network Covered Medical Expenses

that apply towards the limits for the rest of the Policy 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 Certificate benefits will be amended to comply with such changes.

### **Treatment of Covered Injury and Covered Sickness Benefit**

If:

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

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

1. For The Usual and Customary Charge or the Negotiated Charge for Covered Medical Expenses that are incurred as the result of a Covered Injury or Covered Sickness; and
2. Subject to the Exclusions and Limitations provision.

### **Medical Benefit Payments for In-Network Provider and Out-of-Network Providers**

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

### **Dental and Vision Benefit Payments**

For dental and vision benefits, You may choose any dental or vision provider.

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

### **Preferred Provider Organization**

If You use an In-Network Provider, this Certificate will pay the Coinsurance percentage of the Negotiated Charge for Covered Medical Expenses shown in the Schedule of Benefits.

If an Out-of-Network Provider is used, this Certificate will pay the Coinsurance percentage of the Usual and Customary Charge for Covered Medical Expenses shown in the Schedule of Benefits. The difference between the provider fee and the Coinsurance amount paid by Us will be Your responsibility.

Note, however, that We will pay at the In-Network level for Treatment by an Out-of-Network Provider, and will calculate Your cost sharing amount at the In-Network Provider level, and Your cost share will be applied to Your In-Network Deductible and Out-of-Pocket Maximum if:

1. there is no In-Network Provider in the Preferred Provider service area available to provide a Preventive Service or treat You for a specific Covered Injury or Covered Sickness; or

2. You have an Emergency Medical Condition and receive Emergency Services from an Out-of-Network Provider or facility. The most the Out-of-Network Provider or facility may bill You is the In-Network cost sharing amount (such as Deductibles, Copayments and Coinsurance). You can't be balance billed for these Emergency Services. This includes services You may get after You're in stable condition, unless the Out-of-Network Provider or facility determines that You can travel using non-medical or non-emergency transportation, the Out-of-Network Provider satisfies the consent and notice requirements, and You are in a condition to receive notice of, and to consent to, Out-of-Network Treatment; or
3. You receive non-Emergency Services from an In-Network Hospital or Ambulatory Surgical Center, but certain providers there may be Out-of-Network Providers. In these cases, the most those Out-of-Network Providers may bill You is the In-Network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, Assistant Surgeon, hospitalist, or intensivist services. These Out-of-Network Providers can't balance bill You and may not ask You to give up Your protections not to be balance billed.

However, if You received notice from the Out-of-Network Provider of their non-network status at least 72 hours in advance, or if You make an appointment within 72 hours of the services being delivered and notice and consent is given on the date of the service, and You gave written consent to Treatment, this Certificate will pay Covered Medical Expenses at the Out-of-Network level as shown in the Schedule of Benefits. This notice and consent exception does not apply to ancillary services, which include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an Out-of-Network Provider in circumstances where there is no In-Network Provider who can furnish the item or service at the relevant facility.

We will respond to, defend against and resolve any request or claim by a Out-of-Network Provider of Emergency Services for payment in excess of the amount paid or reimbursed by Us. You may contact Us if you receive any such request from an Out-of-Network Provider.

You should be aware that In-Network Hospitals may be staffed with Out-of-Network Providers. Receiving services from an In-Network Hospital does not guarantee that all charges will be paid at the In-Network Provider level of benefits. It is important that You verify that Your Physicians are In-Network Providers each time You call for an appointment or at the time of service.

### **Travel and Waiting Time Standards**

Travel times for Insured Students to Preferred Providers, under normal conditions, from their residence, place of business, or School, generally should not exceed the following:

1. Thirty (30) minutes to a primary care provider;
2. Thirty (30) minutes to routine, office-based Mental Health and Substance Abuse services;
3. Sixty (60) minutes for Outpatient Physician specialty care; intensive Outpatient, partial hospital, residential or Inpatient Mental Health and Substance Abuse services; Laboratory; Pharmacy; general Optometry; Inpatient Imaging and Inpatient Medical Rehabilitation services.
4. Ninety (90) minutes for major trauma treatment; neonatal intensive care; and tertiary-level cardiac services, including procedures such as cardiac catheterization and cardiac surgery; and
5. Reasonable accessibility for other specialty services, including major burn care, Organ Transplantation, and specialty pediatric care.

Waiting times for Insured Students to obtain care or appointment with Preferred Providers, should generally not exceed the following:

1. Immediate access to Emergency care for conditions that meet the definition of Emergency Medical Condition;
2. Twenty-four (24) hours or a time frame consistent with the medical urgency of the condition for Urgent Care (for the purposes of this provision, Outpatient Mental Health and Substance Abuse care designated by the Insured Student or provider as non-urgent is not considered to be Urgent Care);
3. Two (2) weeks for non-emergency, non-urgent care;
4. Ninety (90) days for Preventive Services (including routine physical examinations); and

5. Thirty (30) days for routine laboratory, imaging, general optometry, and all other routine services.

### **Continuity of Care**

If You are undergoing an active course of Treatment with an In-Network Provider, You may request continuation of Treatment by such In-Network Provider in the event the In-Network Provider's contract has terminated with the Preferred Provider organization. We shall notify You of the termination of the In-Network Provider's contract at least 60 days in advance. When circumstances related to the termination render such notice impossible, We shall provide affected enrollees as much notice as is reasonably possible. The notice given must include instructions on obtaining an alternate provider and must offer Our assistance with obtaining an alternate provider and ensuring that there is no inappropriate disruption in Your ongoing Treatment. We shall permit You to continue to be covered, with respect to the course of Treatment with the provider, for a transitional period of the lesser of 90 days from the date of the notice to You of the termination, or the date You are accepted by another network provider, except that if You are in the second trimester of pregnancy at the time of the termination and the provider is treating You during the pregnancy. The transitional period must extend through the provision of postpartum care directly related to the pregnancy.

### **Pre-Certification Process**

**In-Network** – Your In-Network Provider is responsible for obtaining any necessary Pre-certification before You receive the care. If Your In-Network Provider does not obtain the required Pre-Certification You will not be penalized. Please read below regarding review and notification.

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

The following Inpatient and Outpatient services or supplies require Pre-Certification:

1. All Inpatient admissions, including length of stay, to a Hospital, Skilled Nursing Facility, a facility established primarily for the Treatment of a Substance Use Disorder, or a residential Treatment facility;
2. All Inpatient maternity care after the initial 48/96 hours;
3. All partial hospitalization in a Hospital, residential Treatment facility, or facility established primarily for the Treatment of a Substance Use Disorder;
4. Home Health Care;
5. Durable Medical Equipment over \$500;
6. Surgery;
7. Transplant Services;
8. Diagnostic testing/radiology;
9. Infusions therapy when administered in the home as part of the home health care.;
10. Botox Injections;
11. Orthognathic Surgery;
12. Genetic Testing, except for BRCA;
13. Orthotics/prosthetics over \$500;;
14. Transcranial Magnetic Stimulation (TMS);
15. Physical Therapy (Outpatient) precertification required after the 12<sup>th</sup> visit.
16. Occupational Therapy (Outpatient) precertification required after the 12<sup>th</sup> visit.
17. Chiropractic Services (Outpatient) precertification required after the 12<sup>th</sup> visit.

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

Additionally, no authorization requirement will apply to obstetrical or gynecological care provided by In-Network Providers.

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

Your Physician will be notified of Our decision as follows:

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

Our agent will make this determination within 24 hours for an urgent request and 2 business days for non-urgent requests following receipt of all necessary information for review. Notice of an Adverse Benefit Determination made by Our agent will be in writing and will include:

1. The reasons for the Adverse Benefit Determination including the clinical rationale, if any.
2. Instructions on how to initiate an appeal.
3. Notice of the availability, upon Your request or Your Authorized Representative, of the clinical review criteria relied upon to make the Adverse Benefit Determination. This notice will specify what, if any additional necessary information must be provided to, or obtained by, Our agent in order to render a decision on any requested appeal.

Failure by Our agent to make a determination within the time periods prescribed will result in Us granting the request.

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

## **COVERED MEDICAL EXPENSES**

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

### **Preventive Services**

The following services shall be covered without regard to any Deductible, Coinsurance or Copayment requirement that would otherwise apply when provided by an In-Network Provider:

1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
4. With respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
5. Outpatient/office contraceptive services are covered, provided that the services are related to the use of FDA approved contraceptives. Examples of covered contraceptive services are: office visits, consultations, examinations and services related to the use of federal legend oral contraception or IUD insertion, diaphragm fitting, vasectomy or contraceptive injections. Self-administered hormonal contraceptives prescribed by a pharmacist will be covered. We will pay for up to a 12-month supply of an FDA-approved prescription contraceptive in a single dispensing or over the course of 12 months, at the discretion of the prescribing Physician. 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.

### **Important Notes:**

1. These Preventive Services recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this plan. The updates will be effective on the first day of the calendar year, one year after the updated recommendation or guideline is issued.

2. Diagnostic testing for the Treatment or diagnosis of a Covered Injury or Covered Sickness will not be covered under the Preventive Services. For those types of tests and Treatment, You will pay the cost sharing specific to Covered Medical Expense for diagnostic testing and Treatment.
3. This plan will not limit gender-specific Preventive Services based on Your gender at birth, Your identity, or according to other records.

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

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

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

## INPATIENT SERVICES

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

- Room and Board 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 Your being admitted to a Hospital. These tests must be performed within 5 working days prior to admission. This benefit is limited to routine tests such as complete blood count, urinalysis, and chest x-rays. Unless otherwise payable under this Certificate, We will pay for major diagnostic procedures under the Hospital Miscellaneous 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 when not related to the surgery Physician's visits will be paid for either inpatient or outpatient visits when incurred on the same day, but not both. Surgeon's fees are not payable under this benefit.

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

### 5. **Inpatient Rehabilitation Facility Expense Benefit** for the services, supplies and Treatments rendered to You in an **Inpatient Rehabilitation** Facility.

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
6. **Registered Nurse Services while confined**, when private duty nursing care is prescribed by the attending Physician. General nursing care provided by the Hospital is not covered under this benefit.
7. **Physical Therapy while Confined** when prescribed by the attending Physician.

#### **MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER BENEFITS**

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

#### **PROFESSIONAL AND OUTPATIENT SERVICES**

##### ***SURGICAL EXPENSES***

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

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

- a. **Through the Same Incision.** If Covered multiple surgical procedures are performed through the same incision, We will pay for the procedure with the highest allowed amount and 50% of the amount We would otherwise pay under this Certificate for the secondary procedures, except for secondary procedures that, according to nationally-recognized coding rules, are exempt from multiple surgical procedure reductions. We will not pay anything for a secondary procedure that is billed with a primary procedure when that secondary procedure is incidental to the primary procedure.
- b. **Through Different Incisions.** If Covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
  - For the procedure with the highest allowed amount; and
  - 50% of the amount We would otherwise pay for the other procedures.
2. **Outpatient Surgical Facility and Miscellaneous** 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. **Abortion Expense** for the expense of an elective, abortion.
4. **Bariatric Surgery** when it is Medically Necessary. This benefit requires prior approval.
5. **Organ Transplant Surgery**  
**Recipient Surgery** for Medically Necessary, non-Experimental and non-investigative solid organ, bone marrow, stem-cell or tissue transplants. We will provide benefits for the Hospital and medical expenses of when You are the recipient of an Organ Transplant.

**Donor's Surgery** for Medically Necessary transplant services required by the Insured Person who serves as an

organ donor only if the recipient is also an Insured Person. We will not Cover the transplant services of a non-Insured Person acting as a donor for an Insured Person if the non-Insured Person's expenses will be Covered under another health plan or program.

**Travel Expenses** when the facility performing the Medically Necessary transplant is located more than 200 miles from Your residence, coverage will be provided for lodging, meals and transportation expenses (coach class only).

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

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

6. **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. This benefit also covers cosmetic surgery specifically and solely for: Reconstruction due to bodily Injury, infection or other disease of the involved part.

#### ***OTHER PROFESSIONAL SERVICES***

1. **Gender Affirmation Services Benefit** for Medically Necessary expenses incurred for surgery, services and supplies provided in connection with gender transition when You have been diagnosed with gender identity disorder or gender dysphoria. Covered services include the following:
  - a. Counseling by qualified mental health professional;
  - b. Hormone therapy, including monitoring of such therapy;
  - c. Gender affirmation surgery; and
  - d. Genital reconstructive surgery
2. **Home Health Care Expenses** for Home Health Care for You when, otherwise, Hospitalization or Confinement in a Skilled Nursing Facility would have been necessary. This does not include Private Duty Nursing. 13
3. **Hospice Care Coverage** when, as the result of a Covered Injury or Covered Sickness, You require Hospice Care, We will pay the expenses incurred for such care. You must have been diagnosed with a terminal illness by a licensed Physician. Their medical prognosis must be death within 6 months. You must have elected to receive palliative rather than curative care. Any required documentation will be no greater than that required for the same services under Medicare.

#### ***OFFICE VISITS***

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



2. **Telemedicine or Telehealth Services** for health care delivery, diagnosis, consultation, Treatment, transfer of medical data, and education using interactive audio, audio only telephone, video, or data communications involving a real time (synchronous) or near real time (asynchronous) 2-way transfer of medical data and information.
3. **Allergy Testing and Treatment including injections** this includes tests that You need such as PRIST, RAST, and scratch tests. Also, includes Treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications and asthma not responding to usual Treatments. This also includes the administration of allergy therapy, injections, allergy serum, and supplies used for allergy therapy.
4. **Chiropractic Care Benefit** for Treatment of a Covered Injury or Covered Sickness and performed by a Physician.
5. **Tuberculosis (TB) screening, Titers, QuantiFERON B tests including shots** (other than covered under Preventive Services) when required by the School for high risk Insured Persons.

### **EMERGENCY SERVICES, AMBULANCE AND NON-EMERGENCY SERVICES**

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

If You receive Emergency Services from an Out-of-Network Provider or facility, the most the Out-of-Network Provider or facility may bill You is the In-Network cost sharing amount. The Post-Stabilization services will no longer qualify as Emergency Services once the Out-of-Network Provider or facility determines that You can travel using non-medical or non-emergency transportation, the Out-of-Network Provider satisfies the consent and notice requirements, and You are in a condition to receive notice of, and to consent to, Out-of-Network Treatment.

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

**In case of a medical emergency:**

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

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

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

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

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

Transportation from a facility to Your home is not covered.

### **DIAGNOSTIC LABORATORY, TESTING AND IMAGING SERVICES**

1. **Diagnostic Imaging Services** for diagnostic X-ray services as shown in the Schedule of Benefits when prescribed by a Physician.
2. **CT Scan, MRI and/or PET Scans** for diagnostic services when prescribed by a Physician.
3. **Laboratory Procedures (Outpatient)** for laboratory procedures as shown in the Schedule of Benefits when prescribed by a Physician.
4. **Chemotherapy and Radiation Therapy** for chemotherapy, oral chemotherapy drugs, and radiation therapy to treat or control a serious illness, including Medically Necessary growth cell stimulating factor injections taken as part of a prescribed chemotherapy regimen, as shown in the Schedule of Benefits.
5. **Infusion Therapy** for the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

### **REHABILITATION AND HABILITATION THERAPIES**

1. **Cardiac Rehabilitation.** Benefits are available for Outpatient cardiac Rehabilitation programs. Covered Medical Expenses are: exercise and education under the direct supervision of skilled program personnel in the intensive Rehabilitation phase of the program. The program must start within 3 months after a cardiac condition is diagnosed or a cardiac procedure is completed. The program must be completed within 6 months of the cardiac diagnosis or procedure.

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

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

### **OTHER SERVICES AND SUPPLIES**

1. **Covered Cancer Clinical Trials** includes coverage for routine costs associated with Your participation in a clinical trial (Phases I, II, III, and IV). Coverage does not include the studied device, equipment or drug, data collection services and any service not associated with direct clinical care to You.
2. **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 glucagon
- 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 You in the self-management of diabetes (including medical nutritional therapy). The training must be provided by an American Diabetes Association Recognized Diabetes Self-Management Education Program or Physician whose scope of practice includes diabetic education or management.

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

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

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

- Homocystinuria

Covered benefits also include 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.

6. **Maternity Benefit** for maternity charges as follows:

- a. Routine prenatal care
- b. **Hospital stays** for mother and newly born child will be provided for up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the caesarean section delivery is the result of Complications of Pregnancy. If the delivery is the result of Complications of Pregnancy, the Hospital stay will be covered the same as for any other Covered Sickness.

**Midwife and Home Birth Coverage** provided for services rendered by a licensed midwife or licensed advanced practice registered Nurse who is certified as a Nurse midwife for services within the licensed midwife’s or certified Nurse midwife’s scope of practice and provided in a Hospital or Health Care Facility or at home.

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

- c. **Inpatient Physician charges or Surgeon charges** will be covered the same as for any other Covered Sickness for both mother and newborn child.
- d. **Physician-directed Follow-up Care** including:
  1. Physician assessment of the mother and newborn;
  2. Parent education;
  3. Assistance and training in breast or bottle feeding;
  4. Assessment of the home support system;
  5. Performance of any prescribed clinical tests; and
  6. Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric obstetrical and nursing professionals.
  7. Home lactation consultations.

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

- e. **Outpatient Physician’s visits** will be covered the same as for any other Covered Sickness.
7. **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.
8. **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 Care Agency.

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

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

11. **Medical Evacuation Expense**

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

If:

- You are unable to continue Your academic program as the result of a Covered Injury or Covered Sickness;
- That occurs while You are covered under this Certificate.

We will pay the necessary Actual Charges for evacuation to another medical facility or Your Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

Payment of this benefit is subject to the following conditions:

- You must have been in a Hospital due to a Covered Injury or Covered Sickness for a Confinement of 5 or more consecutive days immediately prior to medical evacuation;
- Prior to the medical evacuation occurring, the attending Physician must have recommended and We must have approved the medical evacuation;
- We must approve the expenses incurred prior to the medical evacuation occurring, if applicable;
- No benefits are payable for expenses after the date Your insurance terminates. However, if on the date of termination, You are in the Hospital, this benefit continues in force until the earlier of the date the Confinement ends or 31 days after the date of termination;
- Evacuation to Your Home Country terminates any further insurance under the Certificate for You; and
- Transportation must be by the most direct and economical route.

12. **Repatriation Expense**

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

If You die while covered under this Certificate, We will pay a benefit. The benefit will be the necessary charges for preparation, including cremation, and transportation of the remains to Your place of residence Your Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

**PEDIATRIC ADULT DENTAL AND VISION BENEFITS**

1. **Pediatric Dental Care Benefit** for the following dental care services for Insured Persons (to the end of the month in which the Insured Person turns age 21):

- Preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:
  - Dental examinations, visits and consultations once within a 6-month consecutive period (when primary teeth erupt);
  - X-ray, full mouth x-rays at 36-month intervals, bitewing x-rays at 6 to 12-month intervals, or panoramic x-rays at 36-month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
  - Prophylaxis (scaling and polishing the teeth) at 6-month intervals;
  - Topical fluoride application at 6-month intervals
  - Sealants on unrestored permanent molar teeth; and
  - Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.
- Emergency dental care, which includes emergency palliative Treatment required to alleviate pain and suffering caused by dental disease or trauma.
- Routine Dental Care: We Cover routine dental care provided in the office of a Dental Provider, including:

1. Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
  2. In-office conscious sedation;
  3. Amalgam, composite restorations and stainless-steel crowns; and
  4. Other restorative materials appropriate for children.
- d. Endodontic services, including procedures for Treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.
- e. Prosthodontic services as follows:
1. Removable complete or partial dentures, including 6-months follow-up care; and
  2. Additional services include insertion of identification slips, repairs, relines and rebases and Treatment of cleft palate.

Fixed bridges are not Covered unless they are required:

1. For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth
  2. For cleft palate stabilization; or
  3. Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.
- f. Periodontic services include but are not limited to:
1. root planning and scaling at 24-month intervals;
  2. gingivectomy at 36-month intervals;
  3. gingival flap procedures at 36-month intervals; and
  4. osseous surgery (including flap and closure) at 5 year intervals.
- g. Orthodontics when Medically Necessary to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasia's.

Procedures include but are not limited to:

1. Rapid Palatal Expansion (RPE);
  2. Placement of component parts (e.g. brackets, bands);
  3. Interceptive orthodontic Treatment;
  4. Comprehensive orthodontic Treatment (during which orthodontic appliances are placed for active Treatment and periodically adjusted);
  5. Removable appliance therapy; and
  6. Orthodontic retention (removal of appliances, construction and placement of retainers).
2. **Pediatric Vision Care Benefit** for Insured Persons (to the end of the month in which the Insured Person turns age 21).  
We will provide benefits for:
- a. 1 vision examinations per Policy Year; and
  - b. 1 pairs of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year.
3. **Adult Vision Care** for Insured Persons age 21 and over. We will provide benefits for one (1) routine eye examination every 12 months.

### MISCELLANEOUS DENTAL SERVICES

1. **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.

2. **Sickness Dental Expense Benefit** when, by reason of Sickness, You require Treatment for impacted wisdom teeth or dental abscesses, We will pay the Covered Percentage of the Covered Medical Expenses incurred for the Treatment.
3. **Treatment for Temporomandibular Joint (TMJ) Disorders** for Treatment provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

## PRESCRIPTION DRUGS

1. **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. For prescription drugs subject to pre-certification, Your provider must contact Us directly by call the pharmacy help desk number on Your ID card to request 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 of the issued Certificate, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
  1. The drug is approved by the FDA, except for drugs which are medically accepted for treatment of cancer;
  2. The drug is prescribed for the Treatment of a life-threatening condition, including cancer, HIV or AIDS;
  3. The drug has been recognized for Treatment of that condition by a nationally recognized drug database or two separate articles in major peer reviewed medical journals/clinical practice guidelines (cancer indications will only require evidence from ONE article or clinical practice guideline).

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

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

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

Specialty prescription drugs are identified in the Formulary posted on Our website at [www.wellfleetstudent.com](http://www.wellfleetstudent.com).

- e. **Self-Administered Prescription Drugs** – Certain self-administered Prescription Drugs are only covered under the Prescription Drug benefit and are excluded from the medical 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](http://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 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 as shown in the 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 Us upon completion of the review if all necessary information to perform the override review has been provided, under the following documented circumstances:
  1. The prescribing practitioner can demonstrate, based on sound clinical evidence, that the preferred Treatment required under step therapy or fail-first protocol has been ineffective in the Treatment of Your disease or medical condition; or
  2. Based on sound clinical evidence or medical and scientific evidence:
    - a. The prescribing practitioner can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the Insured Person and known characteristics of the drug regimen; or
    - b. The prescribing practitioner can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to You.
- 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. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by Us to set these quantity limits.
- i. **Tier Status** – The tier status or inclusion of Prescription Drug under the Formulary may change periodically. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic Prescription Drug) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website at [www.wellfleetstudent.com](http://www.wellfleetstudent.com) or by calling the number on Your 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 Your Provider to obtain



Preauthorization. Compounded Prescription Drugs will be covered as the tier associated with the highest tier ingredient.

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

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

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

- l. **Tobacco cessation prescription and over-the-counter drugs** – Tobacco cessation prescription drugs and OTC drugs will be covered for two 90-day treatment regimens only. Any additional prescription drug treatment regimens will be subject to the cost sharing in Your schedule of benefits. For details on the current list of tobacco cessation prescription drugs and OTC drugs covered with no cost sharing during the two 90-day treatment regimens allowed, refer to the Formulary posted on Our website [www.wellfleetstudent.com](http://www.wellfleetstudent.com) or call the toll free number on Your ID card.

- m. **Zero Cost Medications** – In addition to ACA Preventive Care medications, certain Prescription Drugs are covered at no cost to You. These zero cost medications can be identified in the Formulary posted on Our website at [www.wellfleetstudent.com](http://www.wellfleetstudent.com).

- n. **Preventive contraceptives** - Your 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. Self-administered hormonal contraceptives prescribed by a pharmacist will be covered. Your 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. You can access the list of contraceptive prescription drugs by referring to the Formulary posted on Our website at [www.wellfleetstudent.com](http://www.wellfleetstudent.com) or calling the toll-free number on Your ID card.

We will pay for up to a 12-month supply of an FDA-approved prescription contraceptive in a single dispensing or over the course of 12 months, at the discretion of the prescribing Physician.

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

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

You can access the list of diabetic supplies by referring to the Formulary posted on Our website at [www.wellfleetstudent.com](http://www.wellfleetstudent.com) or by calling the toll-free number on Your ID card. See Your Diabetic services and supplies (including equipment and training) section for coverage of blood glucose monitors 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.

### **Mandated Benefits for Vermont**

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

**Athletic Trainer** coverage for the treatment of particular health services or for medical conditions that are within the scope of practice of license athletic trainers, acting within the scope of practice authorized by law.

**Autism Spectrum Disorders for Children** for coverage for the evidence-based diagnosis and Treatment of early childhood developmental disorders, including applied behavior analysis supervised by a nationally board-certified behavior analyst, for children, beginning at birth and continuing until the child reaches age twenty-one (21).

**Colorectal Cancer Screening** for colorectal cancer screening, including:

- a. Providing an Insured Person fifty (50) years of age or older with the option of:
  - (1) Annual fecal occult blood testing plus one flexible sigmoidoscopy every five (5) years; or
  - (2) One colonoscopy every ten (10) years.
- b. For an Insured who is at high risk for colorectal cancer, colorectal cancer screening examinations and laboratory tests as recommended by the treating Physician. An Insured Person is at high risk for colorectal cancer if the Insured Person has:
  - (1) A family medical history of colorectal cancer or a genetic syndrome predisposing the Insured Person to colorectal cancer;
  - (2) A prior occurrence of colorectal cancer or precursor polyps;
  - (3) A prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or
  - (4) Other predisposing factors as determined by the Insured Person's treating Physician.

**Craniofacial Disorders** for diagnosis and Medically Necessary Treatment, including surgical and nonsurgical procedures, for a musculoskeletal disorder that affects any bone or joint in the face, neck or head and is the result of Accident, trauma, congenital defect, developmental defect, or pathology. This benefit shall not be construed to require coverage for dental services for the diagnosis or Treatment of dental disorders or dental pathology primarily affecting the gums, teeth, or alveolar ridge.

**Dental Coverage for Anesthesia and Hospitalization Benefit** for anesthesia expenses including anesthesia practitioner expenses for the administration of the anesthesia, and Hospital and Ambulatory Surgical Center expenses associated with any Medically Necessary dental procedure when provided to an Insured Person who is severely disabled. We do not pay for the Physician's expenses unless otherwise covered under federal law.

**Mammography Screening** for the expenses incurred for a mammography screening for the presence of breast cancer. Screening will also include breast tomosynthesis, and an ultrasound when results are inconclusive or for dense breast tissue or both. Screening also includes the mammography test procedure, the physician's interpretation of the results including additional views and interpretation as necessary.

**Naturopathic Physicians Coverage** for Vermont licensed naturopathic Physicians who practice primary care to be primary care Physicians for Medically Necessary services.

**Prostate Screening** for prostate cancer screenings consistent with the recommendations by the Centers for Disease Control and Prevention or upon recommendation of a health care provider. Benefits shall be at least as favorable as coverage for other cancer screening procedures and subject to the same dollar limits, deductibles, and coinsurance factors within the provisions of the Certificate .

**Sexual Assault Services Benefit** for medical expenses incurred for the care and treatment if You are a victim of a sexual assault.

## SECTION V - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

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

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

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

## SECTION VI - EXCLUSIONS AND LIMITATIONS

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

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

### General Exclusions

- **International Students Only** - Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible.
- Treatment, service or supply which is not Medically Necessary for the diagnosis, care or Treatment of the sickness or injury involved. This applies even if they are prescribed, recommended or approved by Your attending Physician or dentist.
- Medical services rendered by a provider employed for or contracted with the Policyholder, including team Physicians or trainers, except as specifically provided in the Schedule of Benefits.
- Professional services rendered by an Immediate Family Member or anyone who lives with You.

- Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services covered by Student Health Fees.
- Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
- Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which You are required to pay.
- Services that are duplicated when provided by both a certified Nurse midwife and a Physician.
- Expenses paid under any prior policy which was in force for the person making the claim.
- Loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority.
- Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
- Expenses incurred after:
  - The date insurance terminates as to an Insured Person, except as specified in the extension of benefits provision; and
  - The end of the Policy Year specified in the Policy.
- Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
- You are:
  - committing or attempting to commit a felony, or
  - participating in a riot.
- Custodial Care service and supplies.
- Charges for hot or cold packs for personal use.
- Services of private duty Nurse except as provided in the Certificate.
- Expenses that are not recommended and approved by a Physician.
- Experimental or Investigative drugs, devices, Treatments or procedures unless otherwise covered under Covered Cancer Clinical Trials or covered under clinical trials (routine patient costs). See the Other Benefits section for more information.
- 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.
- Non-chemical addictions.
- Non-physical, occupational, speech therapies (art, dance, etc.).
- Modifications made to dwellings.
- General fitness, exercise programs.
- Hypnosis.
- Rolfing.
- Biofeedback.
- Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
- Sleep Disorders, except for the diagnosis and Treatment of obstructive sleep apnea.
- Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary because of Injury, infection or disease.

**Activities Related:**

- Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.

**Weight Management/Reduction**

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

fat.

### **Family Planning:**

- Infertility Treatment (male or female)-this includes but is not limited to:
- Procreative counseling; (except for the evaluation to determine if and why a couple is infertile);
- 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 Investigative, unless Our denial is overturned by an External Appeal Agent.

### **Vision**

- Expenses for radial keratotomy.
- Adult Vision unless specifically provided in the Certificate.
- 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.

### **Dental**

- Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.

### **Hearing**

- 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 Certificate.

### **Cosmetic**

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

### **Prescription Drugs**

- Any drug or medicine which does not, by federal or state law, require a prescription order, i.e. over-the-counter drugs, even if a prescription is written, except as specifically provided under Preventive Services or in the Prescription Drug Benefit section of this Certificate. Insulin and OTC preventive medications required under ACA are exempt from this exclusion;
- Drugs with over-the-counter equivalents except as specifically provided under Preventive Services;

- Allergy sera and extracts administered via injection;
- Vitamins, and minerals, except as specifically provided under Preventive Services;
- Food supplements, dietary supplements; except as specifically provided in the Certificate;
- Cosmetic drugs or medicines including, but not limited to, products that improve the appearance of wrinkles or other skin blemishes;
- Refills in excess of the number specified or dispensed after 1 year of date of the prescription;
- Drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
- Any drug or medicine purchased after coverage under the Certificate terminates;
- Any drug or medicine consumed or administered at the place where it is dispensed;
- If the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
- Bulk chemicals;
- Non-insulin syringes, surgical supplies, Durable Medical Equipment/medical devices, except as specifically provided in the Prescription Drug Benefit section of the Certificate;
- Repackaged products;
- Blood components except factors;
- Any drug or medicine for the purpose of weight control;
- Fertility drugs;
- Sexual enhancements drugs;
- Vision correction products.

**Third Party Refund - When:**

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

We are entitled to a refund by You of all Certificate benefits paid as a result of the Injury.

The refund must be made to the extent that You receive payment for the Injury from the third party or that third party's insurance carrier. We may file a lien against that third-party payment. Reasonable pro rata charges, such as legal fees and court costs, may be deducted from the refund made to Us. You must complete and return the required forms to Us upon request.

**COORDINATION OF BENEFITS**

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

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

**DEFINITIONS**

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

supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

4. Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

- a. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless 1 of the Plans provides coverage for private hospital room expenses.
  - b. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of Usual and Customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
  - c. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
  - d. If a person is covered by 1 Plan that calculates its benefits or services on the basis of Usual and Customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's Policy permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
  - e. The amount of any benefit reduction by the Primary plan because You failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, Pre-Certification of admissions, and preferred provider arrangements.
5. Closed panel plan is a Plan that provides health care benefits to Insured Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
  6. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

## ORDER OF BENEFIT DETERMINATION RULES

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

- A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
- B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.  
(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the Policyholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network Provider benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

- 1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, Policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two (2) Plans is reversed so that the Plan covering the person as an employee, member, Policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
- 2. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
  - a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
    - i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
    - ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), We will follow the rules of that plan.

- b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
  - i. If a court decree states that one (1) of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
  - ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
  - iii. If a court decree states that the parents have joint custody without specifying that 1 parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
  - iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    - The Plan covering the Custodial parent;
    - The Plan covering the spouse of the Custodial parent;
    - The Plan covering the non-custodial parent; and then
    - The Plan covering the spouse of the non-custodial parent.
- c. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.



- d.
  - a. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.
  - b. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.
3. Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
4. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
5. Longer or shorter length of coverage. The Plan that covered the person as an employee, member, Policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

#### **EFFECT ON THE BENEFITS OF THIS PLAN**

- A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.
- B. If an Insured Person is enrolled in 2 or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by 1 Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

#### **RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

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

#### **FACILITY OF PAYMENT**

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, Our Agent or We may pay that amount to the organization that made that payment. That amount will then be treated

as though it were a benefit paid under This plan. Our Agent or We will not have to pay that amount again. The term payment made includes providing benefits in the form of services, in which case payment made means the reasonable cash value of the benefits provided in the form of services.

## **RIGHT OF RECOVERY**

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

## **SECTION VII - GENERAL PROVISIONS**

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

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

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

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

**Time of Payment:** Indemnities payable under this Certificate will be paid immediately upon receipt of due proof of such Loss. Interest of 12% will be added to indemnities paid after this thirty (30) day period.

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

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

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

**Assignment:** The Insured Person may assign Out-of-Network benefits payable under this Certificate. In-network benefits are billed directly by the provider. We are not bound by an assignment unless it is in writing and until a duplicate of the original assignment has been filed with Us. We assume no responsibility regarding the validity of any assignment or payment made without notice of a prior assignment.

**Physical Examination :** We, at Our own expense, will have the right and opportunity to examine the person of an individual whose Injury or Sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder.

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

**Conformity with State Statutes:** Any provision of this Certificate which, on its Effective Date, is in conflict with the statutes of the state of Vermont is hereby amended to conform to the minimum requirements of such statutes.

### **SECTION VIII - ADDITIONAL PROVISIONS**

1. We do not assume any responsibility for the validity of assignment.
2. You will have free choice of a legally qualified Physician with the understanding that the Physician-patient relationship will be maintained.
3. Our acknowledgment of the receipt of notice given under this Certificate, or the furnishing of forms for filing proofs of loss or acceptance of such proof, or the investigation of any claim hereunder will not operate as a waiver of any of Our rights in defense of any claim arising under this Certificate.
4. This Certificate is not in lieu of and does not affect any requirement of coverage by Workers' Compensation Insurance.
5. All new persons in the groups or classes eligible to and applying for this insurance will be added in the respective groups or classes in which they are eligible.
6. The insurance of any Insured Person will not be prejudiced by the failure on the part of the Policyholder to transmit reports, pay premium or comply with any of the provisions of this Certificate when such failure is due to inadvertent error or clerical mistake.
7. All books and records of the Policyholder containing information pertinent to this insurance will be open to examination by Us during the Certificate term and within one year after the termination of this Certificate.
8. Benefits are payable under this Certificate only for those expenses incurred while You are covered. No benefits are payable for expenses incurred after the date Your insurance terminates, except as may be provided under an Extension of Benefits.

### **SECTION IX – APPEALS PROCEDURE**

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

If You receive Emergency Services from an Out-of-Network Provider, or You incur non-emergency Covered Medical Expenses from an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, and You believe those services should have been paid at the In-Network level, You have the right to appeal that claim. If Your appeal of a Surprise Billing claim is denied, You have a right to seek an external review by an Independent Review Organization (IRO) as set out in the Standard External Review and Expedited External Review provisions appearing in this section.

For purposes of this Section, the following definitions apply:

**Adverse Benefit Determination** means:

- A determination by Us or Our designee Utilization review organization that, based upon the information provided, a request for a benefit under the Policy upon application of any utilization review technique does not meet Our

requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be Experimental or Investigative and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;

- The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by Us or Our designee Utilization review organization of Your eligibility under the Policy;
- 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.

**Authorized Representative** means:

- A person to whom have given express written consent to represent You;
- A person authorized by law to provide substituted consent for You;
- A family member of Yours or Your treating health care professional when You are unable to provide consent;
- A health care professional when the Policy requires that a request for a benefit under the Policy be initiated by the health care professional; or
- In the case of an Urgent Care claim, a health care professional with knowledge of Your medical condition.

**Concurrent claim** means a request for a plan benefit(s) by You that is for an ongoing course of treatment or services over a period of time or for the number of treatments.

**Concurrent review** means Utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting or other ongoing Treatment.

**Health care professional** means a Physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

**Pre-service claim** means the request for a plan benefit(s) by You prior to a service being rendered and is not considered a concurrent claim.

**Post-Service Claim** means any claims for a plan benefit(s) that is not a Pre-Service Claim.

**Prospective review** means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with Our requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

**Retrospective review** means any review of a request for a benefit that is not a prospective review request. Retrospective review does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

**Urgent Care request** means a request for a health care service or course of Treatment with respect to which the time periods for making a non-urgent care request determination:

1.
  - a. Could seriously jeopardize Your life or health or Your ability to regain maximum function; or
  - b. In the opinion of a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the health care service or Treatment that is the subject of the request.
  - c. For a substance use disorder or for a co-occurring mental disorder, or mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to prevent an inpatient setting
2.
  - a. Except as provided in (b) of this paragraph, in determining whether a request is to be treated as an Urgent Care request, an individual acting on Our behalf shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
  - b. Any request that a Physician with knowledge of Your medical condition determines is an Urgent Care Request shall be treated as an urgent care request.

**Utilization review** means a set of formal techniques designed to monitor the use of, or evaluate the Medical Necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, Prospective review, second opinion, certification, Concurrent review, case management, discharge planning or Retrospective review.

**Utilization review organization** means an entity that conducts Utilization review, other than Us performing utilization review for Our own health benefit plans.

There are 3 types of claims: Pre-Service, Concurrent Care, and Post-Service Claims. In addition, certain Pre-Service or Concurrent Care Claims may involve Urgent Care. If the Company makes an Adverse Benefit Determination, then You may appeal according to the following steps.

**Step 1:**

If Your claim is denied, You will receive written notice from Us that Your claim is denied (in the case of Urgent Claims, notice may be oral). The period in which You will receive this notice will vary depending on the type of claim. In addition, We may take an extension of time in which to review Your claim for reasons beyond Our control. If the reason for the extension is that You need to provide additional information, You will be given a certain amount of time in which to obtain the requested information (it will vary depending on the type of claim). The period during which We must make a decision will be suspended until the earlier of the date that You provide the information or the end of the applicable information-gathering period.

<b>Type of Claim</b>	<b>You will be notified by Us that a claim is denied as soon as possible but no later than:</b>	<b>Extension period allowed for circumstances beyond Our control:</b>	<b>If additional information is needed, You must provide within:</b>
Pre-Service Claim	72 hours from receipt of claim (whether adverse or not) 24 hours after receipt of claim if additional information is needed from You	One extension of 15 days	48 hours (We must notify You of determination within 48 hours of receipt of Your information)
Pre-Service Claim involving Urgent Care	24 hours from receipt of claim (whether adverse or not) (24 hours after receipt of claim if additional information is needed from You)	None	48 hours (We must notify You of determination within 48 hours of receipt of Your information)
Concurrent:  To end or reduce Treatment prematurely (other than by policy amendment or termination)  Pending the outcome of an appeal, benefits for an ongoing course of	Notification to end or reduce Treatment will allow sufficient time in advance to allow You to appeal and obtain a determination on the adverse benefit determination prior to the end or reduction of prescribed Treatment	N/A	N/A

Treatment will not be reduced or terminated.			
Concurrent: To deny Your request to extend Treatment	15 days from receipt of claim for Pre-Service Claim; or 60 days from receipt of claim for Post-Service Claim	On extension of 15 days	45 days of the date of extension notice
Concurrent: Involving Urgent Care	24 hours from receipt of claim (whether adverse or not) (24 hours after receipt of claim if additional information is needed from You; or 24 hours after receipt of claim provided that any such claim is made at least 24 hours prior to the end or reduction of prescribed Treatment)	None	48 hours (We must notify You of determination within 24 hours of receipt of Your information)
Post-Service Claim	30 days from receipt of claim	One extension of 15 days	45 days of the date of extension notice

Once You have received notice from Us, You should review it carefully. The notice will contain:

1. The reason(s) for the denial and the Policy provisions on which the denial is based.
2. A description of any additional information necessary for You to perfect Your claim, why the information is necessary, and Your time limit for submitting the information.
3. A description of the Policy's appeal procedures and the time limits applicable to such procedures, including a statement of Your right to bring a civil action following a final denial of Your appeal.
4. A statement indicating whether an internal rule, guideline or protocol was relied upon in making the denial and a statement that a copy of that rule, guideline or protocol will be made available upon request free of charge.
5. If the denial is based on a Medical Necessity, Experimental Treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request; and
6. If the claim was an Urgent Care request, a description of the expedited appeals process. The notice may be provided to You orally within 24 hours; however, a written or electronic notification will be sent to You no later than 3 days after the oral notification. If the claim was/is an Urgent Care request, You may initiate an Internal Appeal and an External Review simultaneously.
7. Information sufficient to identify the claim (including the date of service, the health care provider, and the claim amount (if applicable)).
8. An explanation of how to request diagnosis and treatment codes (and their corresponding meanings).
9. The contact information for all relevant review agency contacts and the office of health insurance consumer assistance to assist You with Your claims, appeals and external review within 3 days of the date of receipt of the appeal.
10. Notification that culturally and linguistically appropriate services are available.

## **INTERNAL APPEAL**

### **Step 2:**

If You do not agree with Our decision and wish to appeal, You must file a written appeal with Us at the address below within 180 days after receipt of the Adverse Benefit Determination notification (or oral notice if an Urgent

Care request) referenced in Step 1. If the claim involves Urgent Care, Your appeal may be made orally.

You should submit all information referenced in Step 1 with Your appeal. You should gather any additional information that is identified in the notice as necessary to perfect Your claim and any other information that You believe will support Your claim.

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

<b>Type of Claim</b>	<b>You must file Your appeal within:</b>	<b>You will be notified of Our determination as soon as possible but no later than:</b>
Pre-Service Claim	180 days after receipt of Adverse Benefit Determination	30 days of receipt of appeal
Pre-Service Claim involving Urgent Care	180 days after receipt of Adverse Benefit Determination	24 hours of receipt of appeal
Concurrent: To end or reduce Treatment prematurely	180 days after receipt of Adverse Benefit Determination  Pending the outcome of the appeal, benefits for an ongoing course of Treatment will not be reduced or terminated.	24 hours of receipt of appeal
Concurrent: To deny Your request to extend Treatment	180 days after receipt of Adverse Benefit Determination for Pre-Service or Post-Service Claim	24 hours of receipt of appeal for Pre-Service Claim; or 30 days of receipt of appeal for Post-Service Claim
Concurrent: Involving Urgent Care	180 days after receipt of Adverse Benefit Determination	24 hours hours of receipt of appeal
Post-Service Claim	180 days after receipt of Adverse Benefit Determination	60 days of receipt of appeal

**Step 3:**

If Your appeal is denied based on medical judgement such as Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or Treatment and You wish to seek an external review from an Independent Review Organization (IRO), You must file a written request for external review.

You may also seek an external review by an IRO for a denial of an Urgent Care request based on medical judgement provided that (1) You have also filed an internal appeal in accordance with the terms described herein; and (2) the time frames for completion of an Urgent Care appeal will seriously jeopardize Your life or health or would seriously jeopardize Your ability to regain maximum function.

## **STANDARD EXTERNAL REVIEW**

Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination, You may file a request for an external review with Us or Your state's Commissioner of Insurance.

You must file Your written request for an external review with Us at the address below within 4 months of the date You received the applicable denial.

Within 5 business days of receiving Your request for an external review, We will complete a preliminary review of the request to determine whether You were covered under the Policy at the time the expense was incurred and whether You have exhausted the Internal Appeal process where required.

In most cases, You should complete Our Internal Appeals process before You:

- Contact Your state's Department of Insurance to request an investigation of a claim determination or appeal;
- File a complaint or appeal with Your state's Department of Insurance;
- File a request for an External Review;
- Pursue arbitration, litigation or other type of administrative proceedings.

However, in some cases, You do not have to exhaust the Internal Appeal process before You move on to an External Review. These situations are:

- We waive the Internal Appeal process;
- You have an Urgent Care situation or a claim that involves ongoing treatment. In these situations, You may have Your claim go through the External Review at the same time as the Internal Appeal process; and
- We did not follow all of the State or Federal claim determination and appeal requirements. However, You will not be able to proceed directly to an External Review if:
  - The rule violation was minor and not likely to influence a decision or harm You;
  - The violation was for a good cause or a matter beyond Our control;
  - The violation was part of an ongoing good faith exchange of information between You and Us.

Within 1 business day of making a determination, You will be notified if the external review request is denied and You will be provided with: (1) the reasons why the claim is initially ineligible for external review; or (2) the information or materials needed for a complete request. In the event Your request is denied due to lack of information or materials, You must perfect Your claim by the later of the end of the 4-month period following the final internal Adverse Benefit Determination or 48 hours following notification that Your request for external review was denied.

If initially eligible for an external review, We will assign the request to an IRO. The IRO will make a determination and provide You and Us with notice of its determination within 45 days of receiving the review request.

## **EXPEDITED EXTERNAL REVIEW**

If, due to Your medical condition, the time frame for completion of the standard external review process would seriously jeopardize Your life or health or Your ability to regain maximum function, You may request an expedited external review, the preliminary review will be completed immediately. If determined to be initially eligible, We will assign the request to an IRO and the IRO will complete the review as expeditiously as Your medical condition requires, but in no event more than 72 hours after receiving the request. If the notice is provided to You orally, a written or electronic notification will be sent to You no later than 48 hours after the oral notification.

## **IMPORTANT INFORMATION**

- Each level of appeal will be independent from the previous level (i.e., the same person(s) involved in a prior level of appeal will not be involved in the appeal).
- The claims reviewer will review relevant information that You submit even if it is new information. In addition, You have the right to request documents or other records relevant to Your claim.
- If a claim involves medical judgement, then the claims reviewer will consult with an independent health care professional that has expertise in the specific area involving medical judgment.



- You may review the claim file and present evidence and testimony at each state of the appeals process.
- You may request, free of charge, any new or additional evidence considered, relied upon, or generated by Us in connection with Your claim.
- If a decision is made based on new or additional rationale, You will be provided with the rationale and be given a reasonable opportunity to respond before a final decision is made.
- If You wish to submit relevant documentation to be considered in reviewing Your claim for appeal, it must be submitted with Your claim and/or appeal.
- You should exhaust these appeals procedures before filing a complaint or appeal with Your state’s Department of Insurance.
- You should raise all issues that You wish to appeal during Our Internal Appeal process and during the External Review.

### **RESOURCES TO ASSIST YOU**

For questions concerning a Member’s rights or assistance, contact:

- State of Vermont’s Health Care Advocate – (800)917-7787 or (802)863-3302
- Vermont Department of Financial Regulation – (800)964-1784 or (802)828-3302
- Wellfleet Insurance Company – Customer Service – (877)657-5030 or (413)733-4540

The **Department of Financial Regulation’s Health Insurance Consumer Services Unit** can provide assistance if the Member is in need of general information regarding health insurance, have concerns about Our services, or is not satisfied with how we have resolved a complain.

The **Vermont Office of Health Care Advocate** can provide assistance, at no charge, with concerns or questions about health care of health insurance.

**Wellfleet Insurance Company’s customer service call center** can answer many of the member’s questions regarding their insurance plan and resolve most issues.

**Translation Services** are available when You call the customer service number. Upon request, we will provide interpreter and translation services and other assistance related to administrative procedures.

### **CONTACT INFORMATION**

If You have any questions or concerns, You can contact Us at:

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

State of Vermont  
 Office of the Commissioner of Insurance  
**Department of Financial Regulation**  
 89 Main Street, Montpelier, VT 05620 – 3101  
 (800) 964-1784 or (802) 828-2900