WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

STUDENT HEALTH CERTIFICATE OF COVERAGE

POLICYHOLDER:	University of Maryland, Baltimore (Policyholder)
POLICY NUMBER:	WI2526MDSHIP249
POLICY EFFECTIVE DATE:	August 1, 2025
POLICY TERMINATION DATE:	July 31, 2026
STATE OF ISSUE:	Maryland

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

INSURING AGREEMENTS

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

We will pay the benefits under the terms of the Policy in consideration of:
1. The application for the Policy; and
2. The payment of all Premiums as set forth in the Policy.

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

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

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

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

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

Non-Participating
One Year Term Insurance

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

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SCHEDULE OF BENEFITS

Metallic Level – Actuarial Value:
Platinum – 92.47%

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: The Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through an Out-of-Network Provider. Benefits are paid at 100% of the Usual and Customary Charge. No cost sharing shall apply to services provided by an Out-of-Network Provider for male sterilization.

Medical Deductible*:

In-Network Provider:	Individual:	$100
Out-of-Network Provider:	Individual:	$200

*Medical Deductibles apply towards the Out-of-Pocket Maximum.

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:	$1,500*
	Family:	$3,000*
Out-of-Network Provider:	Individual:	$5,000**
	Family:	No maximum

*This is the most You will incur during a Policy Year. After You incur this amount on Deductibles, Copayments, and Coinsurance, We will begin to pay 100% of the Negotiated Charge for Covered Medical Expenses incurred for Treatment provided by an In-Network Provider. This maximum will never include Premium, balance-billed charges or health care this Certificate does not cover.

**This is the most You will incur during a Policy Year. After You incur this amount on Deductibles, Copayments, and Coinsurance, We will begin to pay 100% of the Usual and Customary Charge for Covered Medical Expenses incurred for Treatment provided by an Out-of-Network Provider. This maximum will never include Premium, balance-billed charges or health care this Certificate does not cover.

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.

Specialty Prescription Drug Copayment Assistance Program - Prior Authorization May Be Required.
Please note: Amounts You pay out-of-pocket for covered Specialty Prescription Drugs will be applied towards the Deductible (if applicable) and Out-of-Pocket Maximum. Copayment Assistance is available to You for certain Specialty Prescription Drugs when Your prescription is filled at a participating network pharmacy. Copayment Assistance dollars paid by the drug manufacturer for covered Specialty Prescription Drugs will not be applied towards the Deductible (if applicable) or Out-of-Pocket Maximum. Any amounts paid by You for a covered Specialty Prescription Drug after Copayment Assistance will be applied to the deductible (if applicable) and Out-of-Pocket Maximum.

Coinsurance Amounts:

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

Out-of-Network Provider: 60% of the Usual and Customary Charge (U&C) for Covered Medical Expenses unless otherwise stated below.

The Usual and Customary Charge for a covered health care service paid to an Out-of-Network Provider will not be less than the Negotiated Charge paid to a similarly licensed In-Network Provider for the same health care service in the same geographic region.

Pre-Certification Requirement:

What types of Inpatient and Outpatient services or supplies require Pre-Certification?

To begin the Pre-Certification process, call Us at the phone number found on Your ID card. Pre-Certification is required for the following :

1. All Inpatient admissions, including length of stay, to a Hospital, Skilled Nursing Facility, a facility established primarily for the Treatment of a Substance Use Disorder, or a residential Treatment facility, surgical procedures;
2. All Inpatient maternity care after the initial 48/96 hours;
3. Home Health Care;
4. Durable Medical Equipment over $500 per item;
5. Outpatient Surgical Procedures;
6. Transplant Services;
7. Diagnostic Testing and Radiology services listed at www.wellfleetstudent.com/providers/. See Prior Authorization Requirements section;
8. Complex Imaging ;
9. Biomarker Testing
10. Chemotherapy/Radiation;
11. Standard Fertility Preservation;
12. Infusions/Injectables;
13. Botox Injections;
14. Genetic Testing, except for BRCA;
15. Prostheses;
16. Orthotics
17. Non-emergency air Ambulance (fixed wing)
18. Acupuncture after the 12th visit;
19. Physical Therapy (Outpatient) Pre-Certification required after the 24th visit;
20. Occupational Therapy (Outpatient) Pre-Certification required after the 24th visit;
21. Speech Therapy (Outpatient) Pre-Certification required after the 24th visit;
22. Chiropractic Services (Outpatient) Pre-Certification required after the 24th visit.

We will approve a request for the Pre-Certification of a Course of Treatment, including for chronic conditions, rehabilitative services, Substance Use Disorders, and Mental Health Disorders, that is:

1. For a period of time that is as long as necessary to avoid disruptions in care; and
2. Determined in accordance with applicable coverage criteria, the Insured Person's medical history, and the health care provider's recommendations.

For newly Insured Persons, We will not disrupt or require reauthorization of a Pre-Certification for a Course of Treatment for a covered service for at least 90 days after the date of enrollment.

As used in the provision:

Course of Treatment means Treatment that:

1. Is prescribed to treat or ordered for the Treatment of an Insured Person with a specific condition;
2. Is outlined and agreed to by the Insured Person and the health care provider before the Treatment begins; and
3. May be part of a treatment plan.

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

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

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

This Certificate provides benefits based on the type of health care provider the Insured Student and the Insured Student's covered Dependent 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. The Usual and Customary Charge for a covered health care service paid to an Out-of-Network Provider will not be less than the Negotiated Charge paid to a similarly licensed In-Network Provider for the same health care service in the same geographic region. No payment will be made under this Certificate for any Covered Medical Expenses incurred for services rendered by an Out-of-Network Provider which are in excess of the Usual and Customary Charge.

When You receive Emergency Services, or Out-of-Network air Ambulance 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 Recognized Amount for the services, which is generally defined either as an amount set by state law or the lesser of the billed charges and 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.

How You Can Request a Cost Estimate for Proposed Covered Services

You may request an estimate of the costs You will have to pay when Your health care provider proposes a procedure, or other covered service. You can request this cost estimate by logging on to the www.wellfleetstudent.com website, typing in the name of Your school and logging into Your secure Wellfleet school webpage. Click the "Cost of Care Estimator" link and follow the steps to perform the following:

- Search for a Provider
- Request a Cost Estimate for health care services, and
- View Ratings and Reviews of Providers

You can also print cost estimate results.

To request a cost estimate by phone, or if You need assistance with creating a cost estimate, call the toll-free phone number shown on Your ID card.

Dental and Vision Benefit Payments

For dental and vision benefits, You may choose any dental or vision provider. For dental, different benefits may be payable based on the type of service, as shown in the Schedule of Benefits.

Preferred Provider Organization:

To locate an In-Network Provider in Your area, consult Your Provider Directory or call toll-free 877-657-5030, TTY 711 or visit Our website at 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 SPECIFIED BELOW, ANY APPLICABLE COPAYMENTS ARE APPLIED AFTER DEDUCTIBLE IS MET.**
6. **UNLESS OTHERWISE SPECIFIED BELOW, ANY DAY OR VISIT LIMITS WILL BE APPLIED TO IN-NETWORK AND OUT-OF-NETWORK COMBINED.**

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK	OUT-OF-NETWORK
INPATIENT SERVICES		
Hospital Care Includes Hospital Room and Board Expenses and Hospital Miscellaneous Expenses. **For Hospitals regulated by the Maryland Health Services Cost Review Commission (HSCRC),** reimbursement for covered Hospital services is limited to the rate set by the HSCRC. **For all other Hospitals**, reimbursement for covered Hospital services will be 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	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% 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	60% 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	60% 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	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physical Therapy, Speech Therapy, and Occupational Therapy while Confined (inpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER BENEFITS In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, and any Pre-Certification requirements that apply to a Mental Health Disorder and Substance Misuse Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness. Day or visit limits do not apply to Mental Health Disorder and Substance Use Disorder Benefits.		
Inpatient Mental Health Disorder and Substance Use Disorder Benefits Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Mental Health Disorder and Substance Use Disorder Benefits Physician's Office Visits including, but not limited to, Physician visits; individual and group therapy; medication evaluation and management All Other Outpatient Services (All Other Outpatient Services does not include Emergency Services in an emergency department, Urgent Care Centers, and Emergency Ambulance Service and Prescription Drugs. Refer to the Emergency Services, Ambulance and Non-Emergency Services, and Prescription Drugs sections of this Schedule of Benefits for benefit information.) Pre-Certification may be required for certain All Other Outpatient Services. To see if Pre-Certification is required, refer to the Pre-Certification Requirement listing	 $15 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	 80% of Usual and Customary Charge after Deductible for Covered Medical Expenses 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

and specific benefit listed in this Schedule of Benefits		
PROFESSIONAL AND OUTPATIENT SERVICES		
Surgical Expenses		
Inpatient and Outpatient Surgery includes: Pre-Certification Required for Surgery only Surgeon Services Anesthetist Assistant Surgeon	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% 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	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Abortion Care Expense	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived, if applicable	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived, if applicable
Bariatric Surgery Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% 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	60% 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	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Other Professional Services		
Home Health Care Expenses Pre-Certification required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% 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	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Office Visits		
Physician's Office Visits including Specialists/Consultants	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telehealth Services Benefit	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telehealth Services Program Behavioral Health Musculoskeletal	 $0 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived $0 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	
Acupuncture Services (Medically Necessary Treatment only) Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% 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	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Shots and Injections, not otherwise considered an Essential Health Benefit under the Maryland Benchmark Plan	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Tuberculosis screening (TB), Titers, QuantiFERON B tests including shots (other than covered under Preventive Services)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
EMERGENCY SERVICES, AMBULANCE AND NON-EMERGENCY SERVICES		
Emergency Services in an emergency department for Emergency Medical Conditions.	$150 Copayment per visit after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Copayment waived if admitted	Paid the same as In-Network Provider subject to the Recognized Amount.

Urgent Care Centers for non-life-threatening conditions	$25 Copayment per visit after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	$25 Copayment per visit after Deductible then the plan pays 100% of Usual and Customary Charge 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 the Recognized Amount.
Non-Emergency Ambulance Expenses ground and/or air (fixed wing) transportation Pre-Certification Required for non-emergency air Ambulance (fixed wing)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	Ground Ambulance transportation: 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses Air Ambulance transportation: Paid the same as In-Network Provider subject to the Recognized Amount
DIAGNOSTIC LABORATORY, RADIOLOGY, TESTING AND IMAGING SERVICES		
Diagnostic Complex Imaging Services Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diagnostic Laboratory, Radiological Services and Testing (Outpatient) Pre-Certification may be required. See Prior Authorization Requirements section listed at www.wellfleetstudent.com/providers/.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
REHABILITATION AND HABILITATION THERAPIES		
Cardiac Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	$40 Copayment per visit after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	$40 Copayment per visit after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
OTHER SERVICES AND SUPPLIES		
Covered Clinical Trials	Same as any other Covered Sickness	
Diabetic Services and Supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Durable Medical Equipment Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Elemental Formulas, Medical Foods, 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	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hearing Aids Coverage for Minor Children Limited to 1 hearing aid per impaired ear per 36 month period	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hearing Aids Coverage for Adults Limited to 1 hearing aid per impaired ear per 36 month period	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infertility Treatment Benefit Pre-Certification Required • Infertility Services • Standard Fertility Preservation Procedures	 80% of the Negotiated Charge after Deductible for Covered Medical Expenses 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	

Prostheses Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Orthotic Devices (Medically Necessary Devices only) Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Non-emergency Care While Traveling Outside of the United States	60% 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	
PEDIATRIC DENTAL AND VISION CARE		
Pediatric Dental Care Benefit (through the end of the month in which the Insured Person turns age 19)	See the Pediatric Dental Care Schedule below for further information.	
Preventive Dental Care – items or services that have an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF). For more information, visit: A and B Recommendations | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)	100% of Usual and Customary Charge for Covered Medical Expenses	
Type A Services - Diagnostic and Preventive Care:		
• Preventive Dental Care not otherwise considered a Preventive Service	100% of Usual and Customary Charge for Covered Medical Expenses	
• Diagnostic Care	100% of Usual and Customary Charge for Covered Medical Expenses	
Type B Services – Basic Restorative Care	50% of Usual and Customary Charge for Covered Medical Expenses	
Type C Services – Major Restorative Care	50% of Usual and Customary Charge for Covered Medical Expenses	
Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	Deductible Waived	

Pediatric Dental Care Schedule

Type A Services - Diagnostic and Preventive Care:

Visits and Images

- Periodic screening in accordance with the periodicity schedule developed by the American Academy of Pediatric Dentistry
- Periodic oral examination, per provider or location (limited to 2 per year)
- Oral exam for Insured Persons under 3 years old (limited to 2 per provider or location)
- Comprehensive oral evaluation
- Oral hygiene instructions, per provider or location (limited to 2 per year)
- Caries risk assessment, per provider or location (limited to 2 per year)
- Routine comprehensive or recall examination, per provider or location (limited to 2 visits per year)
- Problem-focused examination
- Prophylaxis Dental Code D1110 (cleaning) (limited to 2 treatments per Policy Year)
- Prophylaxis Dental Code D1120 (cleaning) (limited to 2 treatments per Policy Year)
- Topical application of fluoride (limited to 2 courses of treatment per year)
- Topical application of fluoride varnish
- Sealants, per tooth (limited to 1 application every 36 months for permanent molars only)
- Preventive resin restoration (limited to 1 application per tooth every 36 months for permanent molars only)
- Bitewing images, per provider or location (limited to 2 sets per year)
- Intraoral periapical images
- Complete image series, including bitewings per provider or location (limited to 1 set every 36 months)
- Panoramic film per provider or location (limited to 1 set every 36 months)
- Vertical bitewing images (limited to 2 sets per year)
- Cephalometric radiographic image
- Sialography
- Temporomandibular joint arthrogram, including injection
- Other temporomandibular joint films
- Pulp vitality tests
- Assessment of Insured Person (limited to 2 per year)
- Home/extended care facility call, as if the visit was rendered in the Dentist's office
- Biopsy and accession of tissue examination of oral tissue
- Emergency palliative treatment, per visit
- Consultation, provided by dentist or physician other than the requesting provider

Space Maintainers

- Fixed (unilateral)
- Fixed (bilateral)-upper
- Fixed (bilateral)-lower
- Removable (unilateral) per quadrant
- Removable (bilateral)-upper
- Removable (bilateral)-lower
- Re-cement or re-bond bilateral space maintainer-upper
- Re-cement or re-bond bilateral space maintainer-lower
- Re-cement or re-bond unilateral space maintainer-per quadrant
- Removal of fixed unilateral space maintainer-per quadrant
- Removal of fixed bilateral space maintainer-upper

- Removal of fixed bilateral space maintainer-lower

Type B Services – Basic Restorative Care:

Visits and Images

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)

Images and pathology

- Extra-oral, occlusal view, maxillary or mandibular

Oral surgery

- Extractions
  - Erupted tooth or exposed root
  - Coronal remnants primary teeth
  - Surgical removal of erupted tooth/root tip
- Impacted teeth
  - Removal of tooth (soft tissue)
- Other surgical procedures
  - Alveoplasty, in conjunction with extractions – per quadrant
  - Alveoplasty, in conjunction with extractions – 1 to 3 teeth or tooth spaces – per quadrant
  - Alveoplasty, not in conjunction with extraction – per quadrant
  - Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces – per quadrant
  - Excision of hyperplastic tissue
  - Removal of exostosis
  - Removal of torus palatinus
  - Removal of torus mandibularis
  - Transplantation of tooth or tooth bud
  - Closure of oral fistula of maxillary sinus
  - Oroantral fistula closure
  - Partial ostectomy/sequestrectomy for removal of non-vital bone
  - Frenectomy
  - Tooth implantation and/or stabilization
  - Root amputation (resection)
  - Excision of periocoronal gingiva

Periodontics

- Periodontal scaling and root planing, 4+ teeth (limited to 4 separate quadrants per 2 years)
- Periodontal scaling and root planing – 1 to 3 teeth per quadrant (limited to 4 separate quadrants per 2 years)
- Periodontal maintenance procedures following active therapy (limited to 2 per 12 months)
- Gingivectomy or gingivoplasty, 4 or more contiguous teeth or tooth bounded spaces per quadrant (limited to 1 per quadrant every 2 years)
- Gingivectomy or gingivoplasty, 1 to 3 contiguous teeth or tooth bounded spaces per quadrant (limited to 1 per quadrant every 2 years)
- Gingival flap procedure, including root planing-for 4 or more contiguous teeth or tooth bounded spaces per quadrant (limited to 1 per quadrant every 2 years)
- Gingival flap procedure, including root planing – 1 to3 contiguous teeth or tooth bounded spaces per quadrant (limited to 1 per quadrants every 2 years)
- Provisional splinting
- Full mouth debridement (limited to 1 every 2 years)

- Localized delivery of antimicrobial agents
- Occlusal adjustment
- Anatomical crown exposure
- Clinical crown lengthening
- Unscheduled dressing change

Endodontics

- Pulp capping
- Pulpotomy
- Pulpal debridement
- Pulpal therapy anterior and posterior
- Endodontic Therapy
- Root canal therapy including Medically Necessary images
  - Anterior tooth
  - Premolar tooth
- Retreatment of previous root canal therapy
  - Anterior tooth
  - Premolar tooth
- Apexification/recalcification
- Apicoectomy
- Retrograde filling per root
- Root amputation per root
- Intentional re-implantation
- Hemisection
- Periradicular surgery without apicoectomy
- Intentional re-implantation (including necessary splinting)

Restorative Dentistry

Does not include inlays, crowns (other than prefabricated stainless steel or resin) and bridges (multiple restorations in 1 surface are considered as a single restoration) Please see coverage under Type C Services for these services

- Amalgam restorations
- Protective restoration
- Resin-based composite restorations
- Pins
  – Pin retention - per tooth, in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
  - Prefabricated stainless steel-primary tooth
  - Prefabricated stainless steel-permanent tooth
  - Prefabricated steel with resin window
  - Prefabricated resin (excluding temporary crowns)
  - Prefabricated esthetic coated stainless steel -primary tooth
- Adjustment of maxillofacial prosthesis
- Re-cementation
  - Inlay/onlay
  - Crown – Fixed partial denture

Type C Services – Major Restorative Care:

Oral Surgery

- Impacted teeth
  - Removal of impacted tooth – partially impacted
  - Removal of impacted tooth – fully bony impacted
  - Removal of tooth – complication
- Vestibuloplasty
- Surgical repositioning of tooth
  - Incision and drainage of abscess
  - Removal odontogenic cyst or tumor
  - Removal of nonodontogenic cyst or tumor

Periodontics

- Osseous surgery (including flap and closure) 1 to 3 teeth contiguous teeth or tooth bounded spaces per quadrant (limited to 1 per quadrant every 24 months)
- Osseous surgery (including flap and closure) four or more contiguous teeth or tooth bounded spaces per quadrant (limited to 1 per quadrant every 24 months)
- Soft tissue graft procedures

Endodontics

- Endodontic therapy
- Root canal therapy including Medically Necessary images
  - Molar tooth
- Retreatment of previous root canal therapy
  - Molar tooth
- Pulp regeneration
- Gross pulp debridement

Restorative

- Inlays/onlays, labial veneers and crowns (limited to 1 per tooth every 5 years)
- Crowns
  - Metal and/or porcelain/ceramic crowns and crown build-ups limited to one (1) per sixty (60) months per tooth.
  - Metal and/or porcelain/ceramic inlays and onlays limited to one (1) per sixty (60) months per tooth.
  - Stainless steel crowns.
  - Recementation of crowns and/or inlays limited to once in any twelve (12) month period.
- Post and core
- Core build-up

Prosthodontics

- Bridge abutments (See Inlays and Crowns) (limited to 1 per tooth every 5 years)
- Pontics (limited to 1 per tooth every 5 years)
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal – Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal
- Removable bridge (unilateral) (limited to 1 every 5 years)
- One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics (limited to 1 every 5 years)

- Dentures and partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
  - Office reline
  - Laboratory reline
  - Special tissue conditioning, per denture
  - Rebase, per denture
  - Adjustment to denture (more than 6 months after installation
- Full and partial denture repairs
  - Broken dentures, no teeth involved
  - Repair cast framework
  - Replacing missing or broken teeth, each tooth
  - Adding teeth to existing partial denture
    - Each tooth
    - Each clasp
- Complete upper denture/partial (limited to 1 every 5 years)
- Complete lower denture/partial (limited to 1 every 5 years)
- Immediate upper denture/partial (limited to 1 every 5 years)
- Immediate lower denture/partial (limited to 1 every 5 years)
- Overdenture
  - Complete upper
  - Complete lower
  - Partial upper
  - Partial lower
- Partial upper or lower, resin base – including any conventional clasps, rests and teeth (limited to 1 every 5 years)
- Partial upper or lower, cast metal base with resin saddles – including any conventional clasps, rests and teeth (limited to 1 every 5 years)
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Maintenance and cleaning of maxillofacial prosthesis
- Occlusal guard
- Occlusal guard adjustment
- Repairs of occlusal guards
- Repairs: crowns and bridges – repairs necessitated by restorative material failure
- Adjustment to complete dentures-maxillary/mandibular (limited to adjustments made after 6 months of installation)
- Fabrication of athletic mouth guard (limited to 1 per 12 months)

General Anesthesia and Intravenous Sedation

Only when Medically Necessary and only when provided in conjunction with a covered dental surgical procedure

- General anesthesia
- General anesthesia – each subsequent 15 minute increment
- Intravenous sedation
- Intravenous sedation –each subsequent 15 minute increment
- Non-intravenous conscious sedation
- Application of desensitizing medicament

• Nitrous oxide/analgesia **Orthodontic Services:** Limited to severe dysfunctional, handicapping malocclusions. • Medically Necessary orthodontic treatment including retention • Replacement of retainer • Re-cementing/re-bonding fixed retainer • Repair of orthodontic appliance		
Pediatric Vision Care Benefit (through the end of the month in which the Insured Person turns age 19) Limited to 1 vision examination per Policy Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived	
MISCELLANEOUS DENTAL SERVICES		
Accidental Injury Dental Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Sickness Dental Expense Benefit	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders (age 19 and older)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
General Anesthesia for Dental Care	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
PRESCRIPTION DRUGS		
Prescription Drugs Retail Pharmacy We will not impose a Copayment or Coinsurance requirement for a covered Prescription Drug or device that exceeds the retail price of the Prescription Drug or device.		

No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy. Your benefit is limited to a 30 day supply. Coverage for more than a 30 day supply only applies if the smallest package size exceeds a 30 day supply. See "Retail Pharmacy Supply Limits" section for more information. All fills of a Maintenance Prescription Drug after the initial fill will be available up to a 90-day supply.		
TIER 1 (Including Elemental Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. You can request a Prescription Drug reimbursement claim form by calling the number on Your ID Card. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Elemental Formulas, Medical Foods, and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$20 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy.	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$40 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Retail pharmacy.	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$60 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
TIER 2 (Including Elemental Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. You can request a Prescription Drug reimbursement claim form by calling the number on Your ID Card. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$40 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived

General Provisions. See the Elemental Formulas, Medical Foods, and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.		
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy.	$80 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$80 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Retail pharmacy.	$120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$120 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
TIER 3 (Including Elemental Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. You can request a Prescription Drug reimbursement claim form by calling the number on Your ID Card. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Elemental Formulas, Medical Foods, and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$70 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$70 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy.	$140 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$140 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Retail pharmacy.	$210 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$210 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived

Specialty Prescription Drugs		
TIER 1 Out-of-Network Provider benefits are provided on a reimbursement basis. You can request a Prescription Drug reimbursement claim form by calling the number on Your ID Card. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$20 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
TIER 2 Out-of-Network Provider benefits are provided on a reimbursement basis. You can request a Prescription Drug reimbursement claim form by calling the number on Your ID Card. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$40 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
TIER 3 Out-of-Network Provider benefits are provided on a reimbursement basis. You can request a Prescription Drug reimbursement claim form by calling the number on Your ID Card. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	$70 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$70 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
Specialty Prescription Drugs with Copayment Assistance Program Copayment Assistance Program - Prior Authorization May Be Required: Amounts You pay out-of-pocket for covered Specialty Prescription Drugs will not exceed the applicable Tier's cost share per 30 day supply and will be applied towards the Deductible (if applicable) and Out-of-Pocket Maximum. Copayment Assistance may be available to You for certain Specialty Prescription Drugs when Your prescription is filled at a participating network pharmacy. Visit www.wellfleetrx.com/students for the applicable Specialty Prescription Drugs. Copayment Assistance dollars paid by the drug manufacturer for covered Specialty Prescription Drugs will not be applied towards the Deductible (if applicable) or Out-of-Pocket Maximum. Any amounts paid by You for a covered Specialty Prescription Drug after Copayment Assistance will be applied to the deductible (if applicable) and Out-of-Pocket Maximum. For details, contact the Copayment Assistance Program at 636-271-5280.		
For each fill up to a 30 day supply.	75% of the Negotiated Charge for	Not Covered

	Covered Medical Expenses Deductible Waived	
Zero Cost Drugs		
Out-of-Network Provider benefits are provided on a reimbursement basis. You can request a Prescription Drug reimbursement claim form by calling the number on Your ID Card. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	100% of Actual Charge for Covered Medical Expenses Deductible Waived
Orally administered anti-cancer Prescription Drugs (including Specialty Drugs)		
Benefit	If the cost share for the Prescription Drug's Tier is greater than the Chemotherapy Benefit or Infusion Therapy Benefit, the cost share will be calculated as follows: Greater of: • Chemotherapy Benefit; or • Infusion Therapy Benefit	
Diabetic Supplies (for prescription supplies purchased at a pharmacy)		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill, except that the Insured Person's out-of-pocket costs for covered prescription insulin will not exceed $30 per 30-day supply regardless of the amount or type of insulin that is needed to fill the Insured Person's prescription; and no cost share shall apply to diabetic test strips.	
Prescription Drugs to treat Diabetes, HIV or AIDS		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill, except that the Insured Person's cost share shall not exceed $150 for up to a 30-day supply for Prescription Drugs prescribed to treat diabetes, HIV, or AIDS.	
MANDATED BENEFITS		
Breast Cancer Screening	Same as any other Preventive Service, except covered services provided by an Out-of-Network Provider are not subject to the Deductible, if applicable	
Diagnostic Lung Cancer Screening	Same as any other Covered Sickness, unless considered a Preventive Service. If considered a Preventive Services, covered services provided by an Out-of-Network Provider are not subject to the Deductible, if applicable	
Lymphedema Diagnosis, Evaluation, and Treatment	Same as any other Covered Sickness	
Nutritional Counseling	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Patient Centered Medical Home Expense Benefit Pre-Certification Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pediatric Autoimmune Neuropsychiatric Disorders	Same as any other Covered Sickness	

Prostate Cancer Screening	Same as any other Preventive Service, except no cost sharing shall apply to covered services provided by an Out-of-Network Provider
Wellness Program Benefits	Up to $200 per six (6) month period; and up to an additional $100 per six (6) month period for each Dependent
Biomarker Testing	Same as any other Covered Sickness
Accidental Death and Dismemberment	
Principal Sum	$10,000

Loss must occur within 365 days of the date of a covered Accident.

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

SECTION I - ELIGIBILITY

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

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

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

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

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

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

Who is Eligible

Class	Description of Class(es)
1	All Undergraduate Students of the Policyholder taking 12 or more credit hours and all Graduate Students of the Policyholder taking 9 or more credit hours.
2	All Graduate Students of the Policyholder taking 1-9 credit hours.

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 and they do not have the option to waive coverage.

Class 2: All students, as determined by the Policyholder, are eligible for coverage under the Policy. Eligible Students are eligible to enroll in this Student Health Insurance Plan on a voluntary basis. Please visit www.wellfleetstudent.com for enrollment information.

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

Dependent Eligibility
Dependents are eligible for coverage under this plan.

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

SECTION II – EFFECTIVE AND TERMINATION DATES

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

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

Special Enrollment – Qualifying Life Event

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

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

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

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

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

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

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

Termination Dates

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

1. The date this Certificate terminates; or
2. The end of the term of coverage for which Premium has been paid, subject to any Grace Period provision; or
3. The date the Insured Student ceases to be eligible for the insurance; or
4. The date the Insured Student enters military service; or
5. For International Students, the date the Insured Student ceases to meet Visa requirements; or
6. For International Students, the date the Insured Student departs the Country of Assignment for their Home Country (except for scheduled School breaks)); or
7. Except as the result of an inadvertent error, the last day of the Grace Period if the Policyholder fails to pay the required Premium due for the Insured Student by the last day of the Grace Period.

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

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

Dependent Child Coverage

Newly Born Children

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

Adopted Children

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

Such child will be covered for Covered Injury or Covered Sickness, including the necessary care and Treatment of medically diagnosed congenital defects and birth abnormalities for an initial period of 31 days.

To continue coverage beyond the initial 31 days, We must receive:

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

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

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

As it pertains to this provision:

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

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

Grandchildren and Children Under Guardianship - Dependent Child Coverage also applies to any grandchild placed in the Insured Student's or Insured Student's Spouse's court-ordered custody; or any minor child for whom the Insured Student or the Insured Student's Spouse is granted guardianship (other than a temporary guardianship of less than 12 months duration) by court or testamentary appointment.

Such child will be covered for Covered Injury or Covered Sickness, including the necessary care and Treatment of medically diagnosed congenital defects and birth abnormalities for an initial period of 31 days.

To continue coverage beyond the initial 31 days, We must receive:

1. Notification of a child's placement in court-ordered custody within 31 days of the placement; or
2. Notification of a minor child's court or testamentary appointment within 31 days of the appointment; and
3. Any Premium required for the child.

We will provide coverage for the child in court-ordered custody or court or testamentary appointment as long as the Insured Student:

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

Incapacitated Children

If:

1. There is Dependent coverage; and
2. This Certificate provides that coverage of a Dependent child will terminate upon attainment of a specified age,

We will not terminate the coverage of such child due to attainment of that age while the child is and continues to be both:

1. Incapable of self-support by reason of mental or physical incapacity; and
2. Chiefly dependent upon the Insured Student for support and maintenance.

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

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 Totally Disabled due to Covered Injury or Covered Sickness, the coverage for that condition will be extended until the earlier of the date You cease to be Totally Disabled or 12 months from the Termination Date of Your coverage.
2. If You are Hospital Confined for Covered Injury or Covered Sickness on the date Your insurance terminates, We will continue to pay benefits for that Covered Injury or Covered Sickness until the earlier of the date You are discharged from the Hospital or 12 months from the Termination Date of Your coverage.
3. If You are undergoing non-orthodontic dental Treatment due to a Covered Injury or Covered Sickness at the time Your coverage terminates, coverage will continue for a course of Treatment for at least 90 days after the Termination Date of Your coverage if the Treatment begins before the Termination Date and requires two or more visits on separate days to a dentist's office.
4. If You are undergoing orthodontia Treatment that is covered under the Policy, coverage will continue for 60 days after the Termination Date of Your coverage if the orthodontist has agreed to or is receiving monthly payments; or until the later of 60 days after the Termination Date of Your coverage or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.
5. If You have ordered eyeglasses or contact lenses before the Termination Date of Your coverage, We will continue to provide covered benefits for the eyeglasses or contact lenses if You receive them within 30 days after the date of the order.

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

Reinstatement Of Reservist After Release From Active Duty

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

Refund of Premium

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

1. If the Policy is terminated by either the Policyholder or Us prior to the next Premium due date, a pro rata refund of Premium (less any claims paid) will be made for the unexpired term of the Policy. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.
2. If a student ceases to be eligible for the insurance and coverage is terminated prior to the next Premium due date, a pro rata refund of Premium (less any claims paid) will be made for such person. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.
3. For any student who withdraws from School during the first 31 days of the period for which he or she is enrolled for a reason other than withdrawal due to Sickness or Injury. Such a student will not be covered under this Certificate and a full refund of the Premium will be made (less any claims paid) when written request is made within 90 days of withdrawal from School. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.
4. For an Insured Student entering the Armed Forces of any country. Such a student will not be covered under this Certificate as of the date of his/her entry into the service. A pro rata refund of Premium (less any claims paid) will be made upon written request received by Us within 90 days of withdrawal from School. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.
5. 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. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.

SECTION III – DEFINITIONS

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

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

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

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

Ambulance Service means Medically Necessary transportation by an Ambulance, whether a ground, air or water Ambulance, to or from the nearest Hospital where needed medical services can appropriately be provided.

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

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

Ancillary Services means:

1. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
2. Items and services provided by assistant surgeons, hospitalists, and intensivists;
3. Diagnostic services, including radiology and laboratory services; and
4. Items and services provided by an Out-of-Network Provider if there is no In-Network Provider who can furnish such item or service at such facility.

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.

Biomarker testing is the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker, the results of which:

- Provide information that may be used in the formulation of a Treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision; and
- Include both information that is actionable and some information that cannot be immediately used in the formulation of a clinical decision.

Biomarker includes gene mutations, characteristics of genes, or protein expression. Biomarker testing includes single–analyte tests, multi–plex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing.

Body Mass Index means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

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 any Deductible and/or Copayment.

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

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

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

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

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

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

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

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

Covered Medical Expense means those Medically Necessary charges for any Treatment, service, 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 this Certificate is in force, except with respect to any expenses payable under the Extension of Benefits Provision.

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

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

Deductible means the dollar amount of Covered Medical Expenses You must incur before becoming eligible for benefits under this Certificate. The amount of the Deductible, if any, will be shown in the Schedule of Benefits. This includes an Adult Dental Care Benefit Deductible and/or Prescription Drug Deductible, if applicable to the Policyholder's plan.

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

Dependent means:

1. An Insured Student's lawful Spouse (as defined);
2. An Insured Student's or Insured Student's Spouse's dependent biological child or grandchild or adopted child or stepchild or minor child under court or testamentary appointed guardianship under age 26; and
3. An Insured Student's or Insured Student's Spouse's unmarried biological child or grandchild or adopted child or stepchild or minor child under court or testamentary appointed guardianship who has reached age 26 and who is:
   a. primarily dependent upon the Insured Student for support and maintenance; and
   b. incapable of self-support by reason of mental or physical incapacity.

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

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

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

Effective Date means the date coverage becomes effective.

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

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

Emergency Medical Condition means a Sickness or Injury, including a Mental Health Condition or Substance Use Disorder, for which immediate medical Treatment is sought at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:
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:
1. 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 (regardless of the department of the Hospital in which the examination or Treatment is furnished), independent freestanding emergency department, or Physician qualified to furnish those services that are needed to evaluate or Stabilize an Emergency Medical Condition.
2. those services described in paragraph 1. that are provided in specialized facilities that are staffed by behavioral health providers trained to provide crisis services.

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.

Emergency Services, with respect to an Emergency Medical Condition, includes transportation services, including but not limited to Ambulance Services.

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

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

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

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

Formulary means a list of medications or devices 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 or devices. The Formulary indicates the type of drug and tier status.

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

Habilitation Services means health care services and devices that help You keep, learn, or improve skills and functions for daily living. Examples include therapy for a child who is not walking or talking at the expected age. Habilitation Services include such services as Physical Therapy, occupational therapy, speech language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

Home Health Care Agency means an agency that:

1. Is constituted, licensed and operated under the provision of title 19, subtitle 4 of the General Health Article, or qualified to be so operated if application was made, and certified by the jurisdiction in which the Home Health Care plan is established; and
2. Is engaged primarily in providing Skilled Nursing Facility services and other therapeutic services in Your home under the supervision of a Physician or a Nurse; and
3. Maintains clinical records on all patients.

Home Health Care means the continued care and Treatment if:

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

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

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

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

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

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

In-Network Providers are Physicians, Hospitals, Pharmacies, 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 or Dependent of an Insured Student while insured under this Certificate.

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

International Student means an international student:

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

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

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

Maintenance Prescription Drug means a Prescription Drug anticipated to be required for 6 months or more to treat a condition that is considered chronic or long-term and which usually requires daily use of the Prescription Drug. Refer to the Formulary for tier status.

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

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

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

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

Morbid Obesity means a Body Mass Index that is greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

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 incur during a Policy Year before Your coverage begins to pay 100% of the allowed amount for Covered Medical Expenses. Refer to the Out-of-Pocket Maximum in the Description of Benefits section for details on how the Out-of-Pocket Maximum applies. 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 a scheduled surgery where an operating room has been reserved before the tests are done.

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

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.

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

Recognized Amount means:
- an amount determined by an All-Payer Model Agreement under the Social Security Act, if adopted by Your state;
- if there is no applicable All-Payer Model Agreement, an amount determined by a specified state law; or
- if neither of the above apply, the lesser of:
  a. the actual amount billed by the provider or facility; or
  b. the Qualifying Payment Amount.

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

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

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

Skilled Nursing Facility means a facility, licensed, and operated as set forth in applicable state law, which:
1. Mainly provides inpatient care and Treatment for persons who are recovering from a Sickness or Injury;
2. Provides care supervised by a Physician;

3. Provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. Is not a place primarily for the care of the aged, Custodial or Domiciliary Care, or Treatment of alcohol or drug dependency; and
5. Is not a rest, educational, or custodial facility or similar place.

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

Spouse means an eligible individual who is legally married to the Insured Student under the laws of the state or jurisdiction in which the marriage was performed. A Spouse also includes the Insured Student's civil union partner or legal domestic partner with whom an affidavit of domestic partnership has been established, attesting to the relationship with another person pursuant to COMAR 31.10.35.03 of the State of Maryland. Any references herein to Spouse and marriage include a civil union partner or a legal domestic partner.

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

Surgeon means a Physician who actually performs surgical procedures.

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.

Telehealth means, as it relates to the practice of health care delivery, diagnosis, consultation and Treatment by a contracted Telehealth provider (if applicable), the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a location other than the location of the patient. Telehealth includes an audio-only telephone conversation between a health care provider and a patient that results in the delivery of a billable, covered health care service.

Health care services appropriately delivered through Telehealth shall include counseling and Treatment for Substance Use Disorders and Mental Health Disorders.

Telehealth does not include:
1. an electronic mail message between a provider and a patient; or
2. a facsimile transmission between a provider and a patient.

Total Disability or Totally Disabled, as it applies to the Extension of Benefits provision, means:
1) Your inability to engage in most normal activities of a healthy person of the same age and gender;
2) With care and Treatment by a Physician for the Covered Injury or Covered Sickness causing the disability.

We may at any time require You to provide proof of Total Disability.

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

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

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

Usual 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 Usual and Customary Charge for a covered health care service paid to an Out-of-Network Provider will not be less than the Negotiated Charge paid to a similarly licensed In-Network Provider for the same health care service in the same geographic region.

The table below shows the method for calculating the Usual and Customary Charge for specific services or supplies:

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

Special terms used

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

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

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

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

Our reimbursement policies are based on Our review of:

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

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

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

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

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

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

SECTION IV – STANDING REFERRAL

Standing Referral:

A. In-Network Providers:

Although referrals are not required, You may request a standing referral to a specialist or Non-physician specialist if:

- You have a condition or disease that:
  a. Is life threatening, degenerative, chronic, or disabling; and
  b. Requires specialized medical care; and
- The specialist or Non-physician specialist:
  a. Has expertise in treating the life-threatening, degenerative, chronic, or disabling disease or condition; and

b. Is an In-Network Provider.

We shall provide a standing referral to a specialist or Non-physician specialist if Your Physician determines, in consultation with the specialist or Non-physician specialist, You need continuing care from the specialist or Non-physician specialist. A standing referral shall be made in accordance with a written Treatment plan developed by Your Physician, the specialist or Non-physician specialist, and You. The Treatment plan may limit the number of visits, or the period during which the visits are authorized and may require the specialist or Non-physician specialist to communicate regularly with Your Physician regarding Your Treatment and health status.

B. Out-of-Network Providers:

Although referrals are not required, You may request a standing referral to a specialist or Non-physician specialist who is an Out-of-Network Provider if:

1. You are diagnosed with a condition or disease that requires specialized health care services or medical care; and
   a. There are no specialist or Non-physician specialist in the Preferred Provider Organization network with the professional training and expertise to treat or provide health care services for the condition or disease; or
   b. There is no reasonable access to specialist or Non-physician specialist in the Preferred Provider Organization network with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.
2. For purposes of calculating any Deductible, Copayment amount, or Coinsurance payable by You, We will treat the services received by the specialist or Non-physician specialist who is an Out-of-Network Provider as if the service was provided by an In-Network Provider.
3. For a Mental Health Disorder or Substance Use Disorder, services received in accordance with this provision will be provided at no greater cost to You than if the Covered Medical Expenses were received by an In-Network Provider.

Your request for a referral to a specialist or Non-physician specialist who is not an Out-of-Network Provider shall be addressed in a timely manner that is:

1. appropriate for Your condition, and
2. within two (2) working days after receipt of the information necessary to make the determination.

As used in this benefit:

Non-physician specialist means a health care provider who:

a. Is not a Physician;
b. Is licensed or certified under the Health Occupations Article; and
c. Is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the health care provider; or
d. Who is licensed as a behavioral health program under General – Health Section §7.5–401.

SECTION V – HOW THE PLAN WORKS AND DESCRIPTION OF BENEFITS

Schedule of Benefits

The following are shown in the Schedule of Benefits:

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

How the Deductible Works

Medical Deductible

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

This dollar amount is what the Insured Person has to incur in Covered Medical Expenses before becoming eligible for benefits under this Certificate. This amount will apply on an individual basis. The Medical Deductible applies to all Covered Medical Expenses, unless specifically noted. Any expenses that the Insured Person incurs that are not Covered Medical Expenses are not applied toward the Insured Person's Medical Deductible.

Covered Medical Expenses applied to the In-Network Provider Medical Deductible will not apply to the Out-of-Network Provider Medical Deductible. Covered Medical Expenses applied to the Out-of-Network Provider Medical Deductible will not apply to the In-Network Provider Medical Deductible. Refer to the Preferred Provider Organization provision for cost sharing applied for Emergency Services and certain non-emergency Treatment by an Out-of-Network Provider at in In-Network Hospital or Ambulatory Surgical Center.

Individual
The Medical 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 Medical Deductible applies separately to the Insured Student and each of the Insured Student's covered Dependents. After the amount of Covered Medical Expenses the Insured Person incurs reaches the Medical 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 any Deductible and/or Copayment.

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

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

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 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.

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

Individual
Once the amount of the Copayments, Coinsurance, and Deductibles the Insured Student and the Insured Student's covered Dependents have incurred for Covered Medical Expenses during the Policy Year meets the:

- 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.

Family
Once the amount of the Copayments, Coinsurance, and Deductibles the Insured Student and the Insured Student's covered Dependents have incurred for Covered Medical Expenses during the Policy Year meets the:

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

that apply towards the limits for the rest of the Policy Year for all covered family members.

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

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

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

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

Treatment of Covered Injury and Covered Sickness Benefit
If:

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

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

1. For the Negotiated Charge at an In-Network Provider or the Usual and Customary Charge at an Out-of-Network Provider 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 the Insured Student and the Insured Student's covered Dependent 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. The Usual and Customary Charge for a covered health care service paid to an Out-of-Network Provider will not be less than the Negotiated Charge paid to a similarly licensed In-Network Provider for the same health care service in the same geographic region.

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 stablecondition, 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.

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.

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 at least 90 days from the date of the notice to You of the termination 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.

At Your request, or the request of Your parent, guardian, designee or Your Health care provider, We will accept a preauthorization from a relinquishing carrier for procedures, Treatments, medications, or services covered under this Certificate, within the following time periods:

a. The lesser of the course of Treatment or 90 days;
b. The duration of the three trimesters of a pregnancy, including the time required for postpartum care directly related to the delivery.

If You are a new enrollee undergoing an active course of Treatment with an Out-of-Network Provider, You or Your parent, guardian, designee or Your health care provider may request continuation of Treatment by such Out-of-Network Provider for the following conditions:

1. Acute conditions;
2. Serious chronic conditions;
3. Pregnancy; and
4. Mental Health Disorders and Substance Use Disorders; and
5. Any other conditions for which We and the Out-of-Network Provider reach an agreement.

Examples of conditions may include:

1. Bone fractures;
2. Joint replacements;
3. Heart attacks;
4. Cancer;
5. HIV/AIDS; and
6. Organ transplants.

With respect to Covered Medical Expenses, if an Out-of-Network Provider is used for continued Treatment of these conditions, We shall pay the Out-of-Network Provider the rate and method of payment We normally would pay and use for In-Network Providers who provide similar services in the same or similar geographic area.

You shall be allowed to continue to receive services for these conditions during a transitional period; and if the Out-of-Network Provider agrees, We will pay for Treatment at the Negotiated Charge level for up to:

a. The lesser of the course of Treatment or 90 days;
b. The duration of the three trimesters of a pregnancy, including the time required for postpartum care directly related to the delivery.

The Out-of-Network Provider may decline to accept the Negotiated Charge by giving You and Us 10 days' prior notice. If the Out-of-Network Provider does not accept the Negotiated Charge, the Out-of-Network Provider and We may reach agreement on an alternative rate or method of payment. The alternative rate or method payment shall be subject to:

1. Any State or federal requirements; and
2. Ensure that You:
    a. Are not subject to balance billing; and
    b. The Copayments, Deductibles, and Coinsurance required of You for the services rendered are the same as those that would be required if You were receiving the services from an In-Network Provider.

If We and the Out-of-Network Provider do not reach an agreement for payment at the Negotiated Charge level:

1. The Out-of-Network Provider is not required to continue to provide the services;
2. You may assign benefits to an Out-of-Network Provider and benefits will be paid the same as any other Out-of-

Network Provider;
3. Unless You have assigned benefits to an Out-of-Network Provider, We shall facilitate transitioning You to an In-Network Provider.

With respect to any benefit or service provided through the Maryland Medical Assistance fee-for-service program, the following shall apply:
1. Only to enrollees transitioning from the Maryland Medical Assistance Program to coverage under this Certificate; and
2. Only to behavioral health and dental benefits, to the extent they are authorized by a third-party administrator.

At the request of the enrollee or an enrollee's parent, guardian, designee, or health care provider, We shall accept a preauthorization from a relinquishing carrier, managed care organization, or third-party administrator for:
1. The procedures, Treatments, medications, or services covered under this Certificate; and
2. The following time periods:
   a. The lesser of the course of Treatment or 90 days; and
   b. The duration of the three trimesters of a pregnancy and the initial postpartum visit.

Subject to applicable state and federal laws relating to confidentiality of medical records, including 42 C.F.R Part 2, at the request and with the consent of an enrollee or an enrollee's parent, guardian, or designee, a relinquishing carrier, managed care organization, or third-party administrator, shall provide a copy of a preauthorization to Us within 10 days after receipt of the request.

After the time periods above have elapsed, Our designee may elect to perform its own utilization review in order to:
1. Reassess and make their own determination regarding the need for continued Treatment; and
2. Authorize any continued procedure, Treatment, medication, or service determined to be Medically Necessary.

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 Your ID card and starting the Pre-Certification process. For Inpatient services, the call must be made at least 5 working days prior to Hospital Confinement. For Outpatient services, the call must be made at least 5 working days prior to the start of the Outpatient service. In the case of an emergency, the call must take place as soon as reasonably possible.

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

If an Inpatient or Outpatient service or supply has received Pre-Certification, We will not deny reimbursement for the service or supply delivered unless:
1. The information submitted regarding the service or supply was fraudulent or intentionally misrepresentative;
2. Critical information required by Us was omitted such that Our determination would have been different had We known the critical information;
3. A planned course of Treatment for the Insured Person was not substantially followed by the Provider; or
4. On the date the pre-certified service or supply was delivered the Insured Person was not covered by the Policy.

The Private Review Agent will make all initial determinations on whether to authorize or certify:
1. A non-emergency course of Treatment for an Insured Person within 2 working days after receipt of the information necessary to make the determination;
2. An extended stay in a health care facility or additional health care services within 1 working day after receipt of

the information necessary to make the determination;
3. Additional visits or days of care as part of existing Treatment, within 1 working day after receipt of the information necessary to make the determination.

For a step-therapy exception request submitted electronically, the Private Review Agent shall make all determinations on whether to authorize or certify in real time if no additional information is needed and the request meets the criteria for approval. If a request is not approved as noted above, then within 1 business day after all information necessary to make a decision is received.

If within 3 calendar days after receipt of the initial request for health care services, the Private Review Agent does not have sufficient information to make a determination, the Private Review Agent shall inform the health care provider that additional information must be provided.

For non-emergency cases, the Private Review Agent shall provide notice of Adverse Benefit Determination to the Insured Person, the Insured Person's Authorized Representative, and the Insured Person's health care provider within 5 working days after the adverse determination is made.

For an emergency inpatient admission, or an admission for residential crisis services for Treatment of a mental, emotional, or Substance Use Disorder, the Private Review Agent shall make all determinations on whether to authorize or certify the inpatient admission, or the admission for residential crisis services within 2 hours after receipt of the information necessary to make the determination.

If an initial determination is made by the Private Review Agent not to authorize or certify a health care service and the health care provider believes the determination warrants an immediate reconsideration, the Private Review Agent may provide the health care provider the opportunity to speak with the Physician that rendered the determination, by telephone on an expedited basis, within a period to time not to exceed 24 hours of the health care provider seeking the reconsideration. If the Physician is unable to immediately speak with the health care provider seeking reconsideration, the Physician shall provide the health care provider with the following contact information for the health care provider to use to contact the Physician:
1. A direct telephone number that is not the general customer call number; or
2. A monitored email address that is dedicated to communication related to utilization review.

For emergency inpatient admissions, the Private Review Agent will not render an Adverse Benefit Determination solely because the Hospital did not notify Us of the emergency admission within 2 working days after that admission:
1. If the Insured Person's medical condition prevented the Hospital from determining the Insured Person's status; or
2. If the Hospital was not aware of the emergency admission notification requirement.

With respect to the Insured Person who is in danger due to an involuntary or voluntary psychiatric admission, the following applies:
1. The Private Review Agent will not issue an Adverse Benefit Determination as to voluntary inpatient admission for the Treatment of a mental, emotional or Substance Use Disorder during the first 24 hours after voluntary admission.
2. The Private Review Agent will not render an Adverse Benefit Determination as to involuntary inpatient admission, as determined to be Medically Necessary by the Insured Person's treating Physician and based on a determination that the Insured Person is in imminent danger to self and to others. The Private Review Agent will not render a determination as to the admission for up to 72 hours after involuntary Inpatient admission.

If a course of Treatment has been preauthorized or approved for an Insured Person, the Private Review Agent may not retrospectively render an Adverse Benefit Determination regarding the preauthorization or approved services delivered to the Insured Person.

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

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

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

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

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

Notice of an Adverse Benefit Determination made by the Private Review 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, the Private Review Agent in order to render a decision on any requested appeal.

The Private Review Agent shall send the notice within 5 working days after the Adverse Benefit Determination has been made.

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

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

Covered Medical Expenses

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

Preventive Services

The following services shall be covered without regard to any Deductible, Coinsurance, or Copayment requirement that would otherwise apply 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), except that the current recommendations of the USPSTF regarding breast cancer screening, mammography and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009.
2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided

for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

4. With respect to women, such additional preventive care and screenings not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
5. Outpatient/office contraceptive services are covered, provided that the services are related to the use of FDA approved contraceptives. Examples of covered contraceptive services are: office visits, consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referral, counseling, and services related to the use of federal legend oral contraception or IUD insertion, diaphragm fitting, voluntary sterilization (male and female)or contraceptive injections, and instruction by a licensed health care provider on fertility awareness-based methods. Fertility awareness-based methods means methods of identifying time for fertility and infertility by an individual to avoid pregnancy, including:
   a. cervical mucus methods;
   b. symptom-thermal or symptom-hormonal methods;
   c. the standard days method; and
   d. the lactational amenorrhea method.

   No prior authorization will apply to a contraceptive drug or device that is:
   a. An intrauterine device (IUD); or
   b. An implantable rod;
      i. Approved by the U.S. Food and Drug Administration; and
      ii. Obtained under a prescription written by an authorized 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.
6. Family Planning Services, including:
   a. Prescription contraceptive drugs or devices. Coverage for FDA-approved contraceptive drugs dispensed without a prescription and available by prescription or over-the-counter will be covered the same as FDA-approved contraceptive drugs dispensed under a prescription;
   b. Coverage for insertion or removal of contraceptive devices;
   c. Medically Necessary examination associated with the use of contraceptive drugs or devices;
   d. Voluntary sterilization (male and female). No cost sharing shall apply to services provided by an In-Network or Out-of-Network Provider for male sterilization.

   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.
7. Annual preventive care coverage will be provided once at any time during the Policy Year. Annual preventive care includes:
   a. An annual child wellness visit;
   b. An annual routine gynecological visit; and
   c. A screening test or examination for colorectal cancer, chlamydia, human papillomavirus, prostate cancer, or breast cancer mandated by the Patient Protection and Affordable Care Act (PPACA) shall be payable in accordance with the latest recommendations of the USPSTF A and B Recommendations.

Important Notes:

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

3. This plan will not limit gender-specific Preventive Services based on Your gender at birth, Your identity, or according to other records.

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

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

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

Inpatient Services

1. **Hospital Care** - Covered Medical Expenses include the following:
   - Room and Board Expenses**,** including general nursing care. For Hospitals regulated by the Health Services Cost Review Commission (HSCRC), benefits may not exceed the rate set by the HSCRC. For all other Hospitals, benefits may not exceed the daily semi-private room rate unless intensive care unit is required.
   - Intensive Care Unit**,** including 24-hour nursing care.
   - Hospital Miscellaneous Expenses, while Hospital Confined or as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as:
     a. The cost for use of an operating room;
     b. Prescribed medicines (excluding take-home drugs);
     c. Laboratory tests;
     d. Therapeutic services;
     e. X-ray examinations;
     f. Casts and temporary surgical appliances;
     g. Oxygen, oxygen tent; and
     h. Blood and blood plasma, including derivatives, components, biologics and serums to include autologous services, whole blood, red blood cells, platelets, immunoglobulin, and albumin.

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

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

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

5. **Inpatient Rehabilitation Facility Expense Benefit** for the services, supplies and Treatments rendered to You in an Inpatient Rehabilitation Facility. You must enter an Inpatient Rehabilitation Facility:
   a. After being discharged from a Hospital Confinement for a Covered Sickness or Coverage Injury; and
   b. The services, supplies and Treatments rendered at the Inpatient Rehabilitation Facility must be related to the same Covered Sickness or Covered Injury.

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

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

6. **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, Speech Therapy, and Occupational Therapy while Confined** when prescribed by the attending Physician.

Mental Health Disorder and Substance Use Disorder Benefits

1. **Inpatient Mental Health Disorder and Substance Use Disorder Benefits** for inpatient and residential Treatment of Mental Health Disorders and Substance Use Disorders. We will cover professional services by licensed, registered or certified professional mental health and substance use disorder providers when acting within the scope of their license, registration or certification, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapist. See Treatment of Covered Injury or Covered Sickness. Services include:
    1. Diagnostic evaluation;
    2. Opioid Treatment services;
    3. Crisis intervention and Stabilization for acute episodes;
    4. Medication evaluation and management (pharmacotherapy);
    5. Treatment and counseling (including individual or group visits);
    6. Diagnosis and Treatment of alcoholism and drug use, including detoxification, Treatment and counseling;
    7. Electroconvulsive therapy;
    8. Inpatient professional fees;
    9. Psychological and neuropsychological testing necessary to determine the appropriate psychiatric Treatment; and
    10. Inpatient Hospital and inpatient residential Treatment centers services, which includes room and board such as:
        a. ward, semiprivate or intensive care accommodations. Private room is covered only if Medically Necessary. If a private room is not Medically Necessary, We will only Cover the Hospital's average charge for semiprivate accommodates;
        b. general nursing care; and
        c. meals and special diets.
    11. Other facility services and supplies. Services provided by a Hospital or residential Treatment center.

2. **Outpatient Mental Health Disorder and Substance Use Disorder Benefits** for outpatient diagnosis and Treatment of Mental Health Disorders and Substance Use Disorders. We will cover professional services by licensed, registered or certified professional mental health and Substance Use Disorder Treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, marriage and family therapist. See Treatment of Covered Injury or Covered Sickness. Services include:
    a. Diagnostic evaluation;
    b. Crisis intervention and Stabilization for acute episodes;
    c. Medication evaluation and management (pharmacotherapy);

d. Treatment and counseling (including individual or group visits);
e. Diagnosis and Treatment of alcoholism and drug use, including detoxification, Treatment and counseling;
f. Professional charges for intensive outpatient Treatment in the Physician's office or other professional setting;
g. Electroconvulsive therapy;
h. Outpatient diagnostic tests provided and billed by a licensed, registered or certified mental health and substance use practitioner;
i. Outpatient diagnostic tests provided and billed by a laboratory, Hospital or other covered facility;
j. Psychological and neuropsychological testing necessary to determine the appropriate psychiatric Treatment; and
k. Outpatient services, such as partial hospitalization or intensive day Treatment programs, but they must not be limited to being provided in an outpatient Hospital setting;

Professional and Outpatient Services

SURGICAL EXPENSES

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

   Sometimes 2 or more surgical procedures can be performed during the same operation.
   a. **Through the Same Incision.** If covered multiple surgical procedures are performed through the same incision, We will pay for the procedure with the highest allowed amount and 50% of the amount We would otherwise pay under this Certificate for the secondary procedures, except for secondary procedures that, according to nationally-recognized coding rules, are exempt from multiple surgical procedure reductions. We will not pay anything for a secondary procedure that is billed with a primary procedure when that secondary procedure is incidental to the primary procedure.

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

2. **Outpatient Surgical Facility and Miscellaneous** expenses benefit. Benefits will be paid for services and supplies, including:
   a. Operating room;
   b. Therapeutic services;
   c. Oxygen, oxygen tent; and
   d. Blood and blood plasma including derivatives, components, biologics and serums to include autologous services, whole blood, red blood cells, platelets, immunoglobulin, and albumin.

3. **Abortion Care Expense** for the Covered Medical Expenses of a non-therapeutic, abortion.

4. **Bariatric Surgery** for the Treatment of Morbid Obesity that is recognized by the National Institutes of Health as effective for the long-term reversal of Morbid Obesity and consistent with guidelines approved by the National Institutes of Health. Surgical Treatment of Morbid Obesity shall occur in a facility that is designated by the American Society for Metabolic and Bariatric Surgery as a Bariatric Surgery Center of Excellence.

5. **Organ Transplant Surgery**
   Recipient Surgery for Medically Necessary, non-Experimental and non-Investigational solid organ transplants and

non-solid organ transplant procedures, bone marrow, stem-cell or tissue transplants, including cornea. We will provide benefits for the Hospital and other Covered Medical Expenses when You are the recipient of an Organ Transplant.

This benefit does not cover 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 Certificate, or services for or related to the transplantation of animal or artificial organs or tissues.

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.

Companion Expenses for cost of hotel lodging and air transportation for the covered recipient and a companion (or two companions if covered recipient is under the age of 18) to and from the site of a covered Organ Transplant.

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

Non-Covered Services for transportation and lodging include:

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** as follows:
   a. **Reconstructive Breast Surgery** includes:
      - all stages of reconstruction of the diseased breast on which a necessary mastectomy has been performed;
      - surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance; and
      - Treatment of physical complications at all stages of the mastectomy, including lymphedemas and prostheses in a manner determined in consultation with the Insured Person and the attending Physician.

      Benefits are provided regardless of whether the mastectomy was performed while the Insured Person was covered under this Certificate; and

   b. **Reconstructive Surgery** that is Medically Necessary to improve or restore bodily function or to correct a deformity resulting from disease, trauma, or previous therapeutic intervention.

OTHER PROFESSIONAL SERVICES

1. **Home Health Care Expenses** for Your Home Health Care when, otherwise, hospitalization or Confinement in a Skilled Nursing Facility would have been necessary. This does not include Private Duty Nursing.

   This benefit also provides one home visit, scheduled to occur within 24 hours after discharge from the Hospital or outpatient health care facility; and an additional home visit if prescribed by the attending Physician if You receive less than 48 hours of inpatient hospitalization following a mastectomy or removal of a testicle or if You undergo a mastectomy or removal of a testicle on an outpatient basis.

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

OFFICE VISITS

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

2. **Telehealth Services Benefit** for health care delivery, diagnosis, consultation, or Treatment provided to You by a Physician.

3. **Telehealth Services Program**
   In addition to providing Telehealth Services when You use an In-Network or Out-of-Network Provider, We will cover Telehealth visits between You and a provider who participates in Our Telehealth Services Program for behavioral health and musculoskeletal conditions that are not an Emergency Medical Condition.

   For non-Emergency Medical Conditions, the program allows Insured Persons to have a video or phone visit with a provider. To access the Telehealth Services Program, You can set up an account online at https://www.teladoc.com/wellfleetstudent/. For the musculoskeletal program You can set up an account online at https://hinge.health/wellfleet. Refer to the Schedule of Benefits for applicable cost share.

4. **Acupuncture Services** that are Medically Necessary and provided by a Physician licensed to perform such services.

5. **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.

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

7. **Shots and Injections**, not otherwise considered an Essential Health Benefit under the Maryland Benchmark Plan, when administered in the Physician's office and charged on the Physician's statement. This includes HPV vaccines for Insured Persons over age 26.

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

4. **Non-Emergency Ambulance Expenses** for transportation between facilities by an Ambulance, whether by ground or air Ambulance (fixed wing) (as appropriate), when the transportation is approved by Us and is:

   - From one Hospital to another 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, Radiology, Testing and Imaging Services

1. **Diagnostic Complex Imaging Services**
   Covered Medical Expenses include complex imaging services provided by a provider, including but not limited to:

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

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

3. **Chemotherapy and Radiation Therapy** for chemotherapy, oral chemotherapy drugs, and radiation therapy to treat or control a serious illness.

4. **Infusion Therapy** for the administration of antibiotics, nutrients, or other therapeutic agents by direct infusion.

Rehabilitation and Habilitation Therapies

1. **Cardiac Rehabilitation.** Benefits are available if You have been diagnosed with significant cardiac disease, or You have suffered a myocardial infarction, or have undergone invasive cardiac Treatment immediately preceding referral for cardiac rehabilitation. Cardiac rehabilitation is a comprehensive program involving medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling.

   Covered Medical Expenses include:
   a. Continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, Physician's revision of exercise prescription, and follow up, examination for Physician to adjust medication or change regimen.
   b. Increased outpatient Rehabilitation services (Physical Therapy, speech therapy and occupational therapy) for cardiac rehabilitation.

   Services must be provided at a place of service equipped and approved to provide cardiac rehabilitation.

   Benefits do not include maintenance programs, which consist of activities that preserve Your present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a Treatment plan have been achieved or when no additional progress is apparent or expected to occur.

2. **Pulmonary Rehabilitation.** Benefits are available if You have been diagnosed with significant pulmonary disease. Services must be provided at a place of service equipped and approved to provide pulmonary rehabilitation.

   Benefits do not include maintenance programs, which consist of activities that preserve Your present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a Treatment plan have been achieved or when no additional progress is apparent or expected to occur.

3. **Rehabilitation Therapy** when prescribed by the attending Physician.

4. **Habilitation Services** when prescribed by the attending Physician.

Covered Medical Expenses include inpatient and outpatient services for cleft lip and cleft palate, orthodontics, oral surgery, otologic, audiological, and speech therapy, Physical Therapy, and occupational therapy. Any visit limits on Habilitation Services do not apply.

Benefits do not include Habilitation Services delivered through early intervention or school services.

Other Services and Supplies

1. **Covered Clinical Trials** includes coverage for patient costs associated with Your participation in a controlled clinical trial approved by specified institutions for Treatment provided for life-threatening disease or condition or prevention, early detection, and Treatment studies on cancer. Coverage also includes the routine patient costs for items and services furnished in connection with participation in the trial.

   Covered clinical trials includes:
   (a) Federally funded trials – the study or investigation is approved or funded (which may include funding through in-kind contributions) by one of the following:
      1. The National Institutes of Health (NIH);
      2. The Centers for Disease Control and Prevention;
      3. The Agency for Health Care Research and Quality;
      4. The Centers for Medicare & Medicaid Services;
      5. Cooperative group or center of any of the entities described in items (1) through (4) above or the Department of Defense or the Department of Veterans Affairs;
      6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; and
      7. Any of the following if:
         a) the Secretary of HHS deemed that its system of peer review is comparable to that of NIH; and
         b) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
            i. The Department of Veterans Affairs;
            ii. The Department of Defense; and
            iii. The Department of Energy.
   (b) the study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
   (c) the study or investigation is a drug trial that is exempt from having such an investigational new drug application; and
   (d) the facility and personnel providing the treatment are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise.

   Coverage does not include the studied device, equipment or drug, data collection services and any service not associated with direct clinical care to You.

   As used in this benefit:
   Controlled clinical trial means a Treatment that is:
   (a) Approved by an institutional review board;
   (b) Conducted for the primary purpose of determining whether or not a particular Treatment is safe and efficacious; and
   (c) Approved by:
      (i) An institute or center of the National Institutes of Health;
      (ii) The Food and Drug Administration;
      (iii) The Department of Veteran's Affairs; or
      (iv) The Department of Defense.

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

   This coverage includes the Treatment of insulin (type I) and non-insulin dependent (type II) diabetes and the Treatment of elevated or impaired blood glucose levels during pregnancy, or consistent with the American Diabetes Association's Standards, elevated or impaired blood glucose levels included by prediabetes.

   Benefits include, but are not limited to, the following services and supplies:
   - Insulin preparations
   - Foot care to minimize the risk of infection
   - Injection aids for the blind
   - Diabetic test agents
   - Prescribed oral medications whose primary purpose is to control blood sugar
   - Injectable glucagon
   - Glucagon emergency kits

   Equipment
   - 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.

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

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

4. **Durable Medical Equipment** for the rental or purchase of Durable Medical Equipment, including, but not limited to, Hospital beds, wheelchairs, nebulizers, peak flow meters, prostheses such as leg, arm, back, or neck braces, artificial legs, arms, or eyes, and the training necessary to use these prostheses, 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. **Elemental Formulas, Medical Foods, and Nutritional Supplements** for Covered Medical Expenses when prescribed by a Physician 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
- Branded-chain ketonuria,
- Galactosemia
- Homocystinuria

Medical Food includes coverage for amino acid-based elemental formula, regardless of delivery method, for the diagnosis and Treatment of immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins; severe food protein induced Enterocolitis Syndrome; eosinophilic disorders, as evidenced by the results of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract provided the Physician issues a written order that states the amino acid-based elemental formula is Medically Necessary for Treatment of one or more of the above listed diseases or disorders.

This benefit also includes coverage for medical food for Insured Persons with metabolic disorders when ordered by a Physician qualified to provide diagnosis and treatment in the field of metabolic disorders. There is no limit to the number of visits covered.

6. **Hearing Aids Coverage for Minor Children** who are Insured Persons under this Certificate, if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist**.** Benefits are limited as shown in the Schedule of Benefits.

   As used in this benefit:
   Hearing aid means a device that is:
   a. of a design, and circuitry to optimize audibility and listening skills in the environment commonly experienced by children; and
   b. non disposable.

7. **Hearing Aids Coverage for Adults** who are Insured Persons under this Certificate if the hearing aids are medically appropriate and necessary and prescribed, fitted, and dispensed by a licensed audiologist**.** Benefits are limited as shown in the Schedule of Benefits.

   As used in this benefit:
   Hearing aid means a device that is:
   a. of a design, and circuitry to optimize audibility and listening skills in the environment commonly experienced by adults; and
   b. non disposable.

8. **Infertility Treatment Benefit**
   a. **Infertility Services** will be paid for the diagnosis and Medically Necessary Treatment of infertility and in vitro fertilization services.

      Benefits shall include all outpatient expenses arising from in vitro fertilization procedures performed on You or Your Spouse.

      Benefits for infertility services will be provided if:
      (1) The patient is You or Your Spouse;

(2) For a patient whose Spouse is of the opposite sex, the patient's oocytes are fertilized with the patient's Spouse's sperm, unless:
    a. The patient's Spouse is unable to produce and deliver functional sperm; and
    b. The inability to produce and deliver functional sperm does not result from:
        i. A vasectomy; or
        ii. Another method of voluntary sterilization;

(3)
    a. The patient and the patient's Spouse have a history of involuntary infertility, which may be demonstrated by a history of:
        i. If the patient and the patient's Spouse are of opposite sexes, intercourse of at least one year duration failing to result in pregnancy; or
        ii. If the patient and the patient's Spouse are of the same sex, 3 attempts of artificial insemination over the course of one year failing to result in pregnancy; or
        iii. If You are unmarried, You have had 3 attempts of artificial insemination over the course of one year that failed to result in pregnancy; or
    b. The infertility is associated with any of the following medical conditions:
        i. Endometriosis;
        ii. Exposure in utero to diethylstilbestrol, commonly known as DES;
        iii. Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
        iv. Abnormal male factors, including oligospermia, contributing to the infertility;

(4) The patient has been unable to attain a successful pregnancy through a less costly infertility Treatment for which coverage is available under this Certificate; and

(5) The in vitro fertilization procedures are performed at medical facilities that conform to applicable guidelines or minimum standards issued by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine.

We are not responsible for any costs incurred by You or Your covered Dependent in obtaining donor sperm.

b. **Standard Fertility Preservation Procedures.** We will provide coverage for standard fertility preservation procedures:
(1) Performed on You or Your covered Dependent; and
(2) That are Medically Necessary to preserve fertility for You or Your covered Dependent due to a need for medical treatment that may directly or indirectly cause iatrogenic infertility.

As used in this benefit:
Iatrogenic infertility means an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment affecting the reproductive organs or processes.

Medical Treatment that may directly or indirectly cause iatrogenic infertility means medical Treatment with a likely side effect of infertility as established by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology.

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

a) Standard fertility preservation procedures includes sperm and oocyte cryopreservation and evaluations, laboratory assessments, medications, and treatments associated with sperm and oocyte cryopreservation.

b) Standard fertility preservation procedures does not include the storage of sperm or oocytes.

8. **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 uncomplicated vaginal delivery and 96 hours (not including the day of surgery) for an uncomplicated caesarean section delivery. If the delivery is the result of Complications of Pregnancy, the Hospital stay will be covered the same as for any other Covered Sickness. Services of a licensed Nurse midwife are covered when rendered in a Hospital or licensed outpatient facility rendering maternity services. Whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the Hospital, We shall pay the cost of additional hospitalization for the newborn for up to 4 days.

      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. Inpatient Physician visits also include routine examinations and evaluations of the newborn child, including an audiology screening.

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

      This benefit will apply to services provided in a medical setting or through Home Health Care visits. Any Home Health Care visit must be provided by an individual knowledgeable and experienced in maternity and newborn care. One Home Health Care visit that is made necessary by early discharge from the Hospital must be performed within 24 hours after discharge and an additional home visit if prescribed by the attending Physician. When a mother and 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 and newborn. Home visits for mother and newborn are not subject to Deductible, Copayment or Coinsurance.

   e. **Outpatient Physician’s visits** will be covered the same as for any other Covered Sickness.

   f. **Birthing classes** will be covered, limited to one course per pregnancy.

   g. **Home Births** will be covered the same as any other Covered Sickness when services are rendered by a licensed and certified nurse midwife.

9. **Prosthesis Benefit** to replace, in whole or in part, a leg, an arm, or an eye. This includes a custom designed, fabricated, fitted, or modified device to treat partial or total limb loss for purposes of restoring physiological function. We will provide, once per Policy Year, coverage for:
   a. Prostheses;

b. Components of prosthesis; and
c. Repairs to prosthesis.

Covered Medical Expenses include prosthesis determined by a treating health care professional to be Medically Necessary for:

- Completing activities of daily living;
- Essential job–related activities; or
- Performing physical activities, including running, biking, swimming, strength training, and other activities to maximize the whole–body health and lower or upper limb function of the insured or enrollee.

We will provide coverage for replacements of prosthesis if an ordering health care provider determines that the provision of a replacement prosthesis or component of the prosthesis is necessary:

- Because of a change in the physiological condition of the Insured Person;
- Unless necessitated by misuse:
  - because of an irreparable change in the condition of the prosthesis or a component of the prosthesis; or
  - because the condition of the prosthesis or the component of the prosthesis requires repairs and the cost of the repairs would be more than 60% of the cost of replacing the prosthesis or the component of the prosthesis.

We may require an ordering health care provider to confirm that the prosthesis or component of the prosthesis being replaced meets these requirements if the prosthesis or component is less than three years old.

We will also provide coverage for one Medically Necessary hair prosthesis when prescribed by the attending Physician.

10. **Orthotic Devices** will be a Covered Medical Expense when Medically Necessary for the Treatment of a Covered Injury or Covered Sickness.

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

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

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

Payment of this benefit is subject to the following conditions:

a. You must have been in a Hospital due to a Covered Injury or Covered Sickness for a Confinement of 5 or more consecutive days immediately prior to medical evacuation;
b. Prior to the medical evacuation occurring, the attending Physician must have recommended, and We must have approved, the medical evacuation;
c. We must approve the expenses incurred prior to the medical evacuation occurring, if applicable;
d. No benefits are payable for expenses after the date Your insurance terminates. However, if on the date of termination, You are in the Hospital, this benefit continues in force until the earlier of the date the Confinement ends or 12 months after the date of termination;
e. Evacuation to Your Home Country terminates any further insurance coverage under this Certificate for You; and

f. Transportation must be by the most direct and economical route.

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

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

Pediatric Dental and Vision Benefits

1. **Pediatric Dental Care Benefit** for Insured Persons (through the end of the month in which the Insured Person turns age 19), in accordance with the Maryland Children's Health Insurance Plan, which includes benefits for:
   - Periodic screening in accordance with the periodicity schedule developed by the American Academy of Pediatric Dentistry; and
   - Treatment of all dental services determined to be Medically Necessary for problems identified during screening or diagnostic evaluations. Benefits include diagnostic services, preventive services, restorative services, endodontic services, periodontic services, removeable prosthodontics, maxillofacial prosthetics, fixed prosthodontics, oral and maxillofacial surgery, orthodontics for children with severe dysfunctional, handicapping malocclusion, and adjunctive general services.

   Please refer to the Schedule of Benefits section of this Certificate for cost-sharing requirements.

2. **Pediatric Vision Care Benefit** for Insured Persons (through the end of the month in which the Insured Person turns age 19).
   We will provide benefits for:
   a. 1 vision examination, including dilation if professionally indicated, per Policy Year; and
   b. 1 pair of prescribed lenses and frames per Policy Year; or
   c. 1 pair of contact lenses (in lieu of eyeglasses) per Policy Year; and
   d. Low vision services, including one comprehensive low vision evaluation every 5 years, 4 follow-up visits in any 5-year period, and prescribed optical devices, such as high-power spectacles, magnifiers and telescopes.

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. This benefit will not be covered if the Treatment does not commence within 6 months of the Accident or, if due to the nature of the Injury, Treatment could not begin within 6 months of the Accident, Treatment began after 6 months of the earliest date that it would be medically appropriate to begin such Treatment.

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 Medical Expenses incurred for the Treatment.

3. **Treatment for Temporomandibular Joint (TMJ) Disorders** for Insured Persons age 19 and older, We will cover surgical services for TMJ and CPS if Medically Necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or Injury.

4. **General Anesthesia for Dental Care** will be provided, and associated Hospital or Ambulatory Surgical Center charges in conjunction with the dental care provided to an Insured Person, if the Insured Person:

a. Is 7 years of age or younger or is developmentally disabled; is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the Insured Person; and is an individual for whom a superior result can be expected from dental care provided under general anesthesia; or
b. Is an extremely uncooperative, fearful, or uncommunicative child who is 17 years of age or younger with dental needs of such magnitude that Treatment should not be delayed or deferred; and is an individual for whom lack of Treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

Prescription Drugs

1. **Prescription Drugs** are medications filled in an outpatient pharmacy for which a Physician's written prescription is required. This benefit is limited to medication necessary for the Treatment of the Covered Injury or Covered Sickness for which a claim is made. Some outpatient Prescription Drugs are subject to pre-certification. No prior authorization will apply to prescription drugs used as postexposure prophylaxis for the prevention of HIV if the drug is prescribed for use in accordance with Centers for Disease Control and Prevention Guidelines.

   If prior authorization is required for a Prescription Drug, the prior authorization request will allow a health care provider to indicate whether a Prescription Drug is to be used to treat a chronic condition. If a health care provider indicates that the Prescription Drug is to treat a chronic condition, We will not request a reauthorization for a repeat prescription for the Prescription Drug for 1 year or for the standard course of Treatment for the chronic condition, whichever is less.

   For newly Insured Persons with a previously approved prior authorization, We will accept the approved prior authorization with documentation from the Insured Person or the Insured Person's health care provider for the lesser of 90 days or the course of Treatment.

   We will not require a health care provider to submit a request for another prior authorization for the Prescription Drug:
   1. if You change health benefit plans that are both covered by Us and the Prescription Drug is a covered benefit under the current health benefit plan; or
   2. except for a change in dosage for an opioid, when the dosage for the approved Prescription Drug changes and the change is consistent with federal Food and Drug Administration labeled dosages.

   If We implement a new prior authorization requirement for a Prescription Drug, We will provide notice of the new requirement at least 60 days before the implementation of a new prior authorization requirement:
   1. In writing to any Insured Person who is prescribed the Prescription Drug; and
   2. Either in writing or electronically to all contracted health care providers.

   The notice will indicate that You may remain on the Prescription Drug at the time of reauthorization.

   We will not require more than one prior authorization if two or more tablets of different dosage strengths of the same Prescription Drug are:
   (1) prescribed at the same time as part of Your treatment plan; and
   (2) manufactured by the same manufacturer.

   We will not issue an Adverse Benefit Determination on a reauthorization for the same Prescription Drug or request additional documentation from the prescriber for the reauthorization request if:
   (1) the Prescription Drug is:
      (a) an immune globulin (human) (a sterile solution containing antibodies derived from human plasma); or

(b) used for the Treatment of a Mental Health Disorder

(2) We previously approved a prior authorization for Your Prescription Drug;

(3) You have been treated with the Prescription Drug without interruption since the initial approval of the prior authorization; and

(4) the prescriber attests that, based on their professional judgment, the Prescription Drug continues to be necessary to effectively treat Your condition.

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 under this 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 the drug is recognized for Treatment in any of the Standard Reference Compendia or in the Medical Literature. Coverage of an off-label drug includes Medically Necessary services associated with the administration of the drug. This benefit does not cover:

(1) Drugs that have not been approved by the FDA;

(2) A drug if the FDA has determined use of the drug to be contraindicated; or

(3) Experimental drugs not approved for any indication by the FDA.

As used in this benefit:

1. Medical Literature means scientific studies published in a peer-reviewed national professional medical journal.
2. Standard Reference Compendia means any authoritative compendia as recognized periodically by the federal Secretary of Health and Human Services or the Commissioner.

b. **Dispense as Written (DAW)** – If a prescriber prescribes a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available and specifies: "Dispense as Written" (DAW), You will pay the cost sharing for the Brand-Name Prescription Drug. If a prescriber does not specify DAW and You request a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available, You will be responsible for the cost difference between the Brand-Name Prescription Drug and the Generic Prescription Drug equivalent, and the cost sharing that applies to Brand-Name Prescription Drugs. This DAW penalty does not apply to Your Out-of-Pocket Maximum 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** may have limited access or distribution and are limited to no more than a 30 day supply , unless prescribed as a Maintenance Drug, which is limited to no more than a 90-day supply. You may fill maintenance Specialty Prescription Drugs up to a 90-day supply in a single dispensing.

Specialty Prescription Drugs means a prescription drug that:

(1) is prescribed for an individual with a complex or chronic medical condition or a rare medical condition;

(2) costs $600 or more for up to a 30–day supply;

(3) is not typically stocked at retail pharmacies; and

(4) (a) requires a difficult or unusual process of delivery to the patient in the preparation, handling, storage, inventory, or distribution of the drug; or

(b) requires enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug.

Specialty Prescription Drug does not include a prescription drug prescribed to treat diabetes, HIV, or AIDS.

As used in the benefit:
Complex or chronic medical condition means a physical, behavioral, or developmental condition that:
1. may have no known cure;
2. is progressive; or
3. can be debilitating or fatal if left untreated or undertreated.

Complex or chronic medical condition includes:
1. multiple sclerosis;
2. hepatitis C; and
3. rheumatoid arthritis.

Rare medical condition means a disease or condition that affects fewer than:
1. 200,000 individuals in the United States; or
2. approximately 1 in 1,500 individuals worldwide.

Rare medical condition includes:
1. cystic fibrosis;
2. hemophilia; and
3. multiple myeloma.

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

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

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.

We will allow and apply a prorated daily cost sharing amount for a partial supply of a Prescription Drug dispensed by a participating retail pharmacy if:
(1) the prescriber or the pharmacist determines dispensing a partial supply of a Prescription Drug to be in Your best interest;
(2) the Prescription Drug is anticipated to be required for more than 3 months;
(3) You request or agree to a partial supply for the purpose of synchronizing the dispensing of Your Prescription Drugs;
(4) the Prescription Drug is not a Schedule II controlled dangerous substance; and
(5) the supply and dispensing of the Prescription Drug meets all prior authorization and utilization management requirements specific to the Prescription Drug at the time of the synchronized

dispensing.

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.

   We will waive step therapy or fail-first protocol if any of the following conditions is met:
   - The step therapy or fail-first protocol drug is not approved by the FDA for Your medical condition; or
   - Your prescriber provides supporting medical information showing that a covered Prescription Drug;
     - Was ordered for You within the past 180 days, and
     - In their professional judgment, was effective in treating Your disease or condition.

   We will not impose a step therapy or fail-first protocol or impose preauthorization for a Prescription Drug approved by the FDA if:
   - The Prescription Drug is used to treat Your stage four advanced metastatic cancer; and
   - Use of the Prescription Drug is:
     - Consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs and Biologics Compendium indication for the Treatment of stage four advanced metastatic cancer; and
     - Supported by peer-reviewed medical literature.

   We will not impose a step therapy or fail-first protocol or impose preauthorization for an opioid antagonist:
   - When used for Treatment of an opioid use disorder; and
   - That contains methadone, buprenorphine, or naltrexone.

   As used in this benefit:
   Opioid antagonist means naloxone hydrochloride; or another other similarly acting and equally safe drug approved by the FDA for the Treatment of drug overdose.

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 of a Prescription Drug or device may change periodically. These changes may occur without prior notice to You. However, if You have a prescription for a drug or device that is being moved to a higher tier (other than a Brand-Name Prescription Drug that becomes available as a Generic Prescription Drug) or is being removed from Our Formulary, We will notify You at least 30 days before the change to the

Formulary is effective. When such changes occur, Your out-of-pocket expense may change. You may request an exemption from the Formulary change. The notification will include the process by which You may: (a) receive a Prescription Drug or device that is not on Our Formulary or that has been removed from Our Formulary; or (b) continue the same cost sharing requirements if the Prescription Drug or device has moved to a higher tier. You may access the most up to date tier status on Our website at www.wellfleetrx.com/students 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, including a contraceptive Prescription Drug or device, is not on or has been removed from Our Formulary, You, Your Authorized Representative or Your prescribing Physician may request a Formulary exception:
   (1) there is no equivalent Prescription Drug or device in the Formulary in a lower tier; or
   (2) there is an equivalent Prescription Drug or device in the Formulary in a lower tier that has been ineffective in treating Your disease or condition or has caused or is likely to cause an adverse reaction or other harm to You; or
   (3) for a contraceptive Prescription Drug or device, the Prescription Drug or device that is not on the formulary is Medically Necessary for You to adhere to the appropriate use of the prescription drug or device.

   If You have a prescription for a drug or device that has been moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic Drug), You, Your Authorized Representative, or Your prescribing Physician may request a Formulary exception from the Formulary change allowing You to continue receiving the same cost sharing requirements.

   The request for a Formulary Exception may be made in writing, electronically or telephonically.

   When an exception is approved, the Prescription Drug is treated as an Essential Health Benefit and any cost sharing must apply toward the Out-of-Pocket Maximum for Essential Health Benefits.

   Refer to the Formulary posted on Our website at www.wellfleetrx.com/students or call the number on Your ID card to find out more about this process.

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

   To ask for a standard review of a formulary exception, You, or Your Authorized Representative, or the prescribing Physician should contact the pharmacy help desk by calling the number on Your ID card. You, or Your Authorized Representative, or Your prescribing Physician may also send a written request to:

   Wellfleet Insurance Company
   Attention: Wellfleet Group, LLC
   PO Box 15369
   Springfield, MA 01115-5369

Refer to the Formulary posted on Our website at www.wellfleetstudent.com or call the number on Your ID card to find out more about this non-Formulary drug exception process.

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 or Your Authorized Representative and the prescribing Health Care Professional 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.

If the initial request is denied, You, or Your Authorized Representative, or Your prescribing Physician may request an independent review. To request an independent review, You, or Your Authorized Representative, or Your prescribing Physician should contact the pharmacy help desk by calling the number on Your ID card. You, or Your Authorized Representative, or Your prescribing Physician may also send a written request to:

Wellfleet Insurance Company
Attention: Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369

Refer to the Formulary posted on Our website at www.wellfleetrx.com/students 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** – when prescribed and used in accordance with FDA approval, tobacco cessation Prescription Drugs and OTC drugs will be covered with no cost sharing for two treatment regimens only. Any additional Prescription Drug Treatment regimens will be subject to the cost sharing as shown in the Schedule of Benefits. For details on the current list of tobacco cessation Prescription Drugs and OTC drugs covered with no cost sharing during the two treatment regimens allowed, refer to the Formulary posted on Our website www.wellfleetrx.com/students or call the toll-free number on Your ID card.

m. **Zero Cost Drugs** – In addition to ACA Preventive Care medications, certain Prescription Drugs are covered at no cost to You. These zero cost drugs can be identified in the Wellfleet Rx Pharmacy Formulary posted on Our website at www.wellfleetrx.com/students.

n. **Contraceptive Drugs and Devices -** Your Outpatient Prescription Drug benefits cover certain Prescription drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a Physician and the prescription is submitted to the pharmacist for processing. Your outpatient Prescription Drug benefits also cover related services and supplies needed to administer covered devices. At least 1 form of contraception in each of the methods identified by the FDA is included.

Coverage for FDA-approved contraceptive drugs and devices dispensed without a prescription and available by prescription or over-the-counter will be covered the same as FDA-approved contraceptive drugs and devices dispensed under a prescription.

We will pay for up to a 12-month supply of an FDA-approved prescription contraceptive in a single dispensing.

You can access the list of contraceptive prescription drugs and applicable supply limits by referring to the Formulary posted on Our website at www.wellfleetrx.com/students or calling the toll-free number on Your ID card.

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.

A Copayment or Coinsurance may be applied to a contraceptive drug or device that is therapeutically equivalent to another contraceptive drug or device available under the Formulary without a Copayment or Coinsurance.

We may not impose a Copayment or Coinsurance requirement for a covered Prescription Drug or device that exceeds the retail price of the Prescription Drug or device.

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 (not subject to cost sharing)
- Lancets
- Alcohol swabs
- Blood glucose monitors with special feature (Continuous Glucose Monitors (CGM) are an example of a blood glucose monitor with special features)

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

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.

r. **Prescription Eye Drops** refills will be covered in accordance with guidance for early refills of topical ophthalmic products provided to Medicare Part D plan sponsors by the Centers for Medicare and Medicaid Services; and if:
1. The prescribing Physician indicates on the original prescription that additional quantities of the prescription eye drops are needed;
2. The refill requested by You does not exceed the number of additional quantities indicated on the original prescription by the prescribing Physician; and
3. The prescription eye drops prescribed by the Physician are a covered benefit under this Certificate.

Mandated Benefits for Maryland

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

1. **Breast Cancer Screening** in accordance with the latest screening guidelines issued by the American Cancer Society, shall be a Covered Medical Expense. Benefits include digital tomosynthesis that, under accepted standards in the practice of medicine, the treating Physician determines is medically appropriate and necessary for an Insured Person. Coverage also includes Medically Necessary and appropriate diagnostic and supplemental breast examinations and biopsies for breast cancer. Supplemental breast examination includes an examination using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound, or image-guided breast biopsy.

   As used in this benefit:
   Digital tomosynthesis means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross–sectional digital three–dimensional images of the breast.

   Supplemental breast examination means a Medically Necessary examination of the breast that is used to screen for breast cancer when:
   a. there is no abnormality seen or suspected from a prior examination; and
   b. there is a personal or family medical history or additional factors that may increase an individual's risk of breast cancer.

2. **Diagnostic Lung Cancer Screening** for Insured Persons aged 50 to 80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years. Covered Medical Expenses includes recommended lung cancer screening or follow-up diagnostic imaging to assist in the diagnosis of lung cancer. Coverage includes:
   - Diagnostic ultrasound;
   - MRI;
   - Computed tomography; and
   - Image-guided biopsy.

   No prior authorization will apply for these screenings or imaging.

3. **Lymphedema Diagnosis, Evaluation, and Treatment** includes coverage for the Medically Necessary diagnosis, evaluation, and Treatment of lymphedema, including equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education.

   As used in this benefit:
   Gradient compression garment means a garment that:
   a. is used for the Treatment of lymphedema;
   b. requires a prescription; and
   c. is custom fit for the individual for whom the garment is prescribed.

   Gradient compression garment does not include disposable medical supplies, including over–the–counter compression or elastic knee–high or other stocking products.

4. **Nutritional Counseling** for the Treatment of cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, or kidney disease. We shall provide unlimited nutritional counseling that is Medically Necessary provided by a licensed dietician-nutritionist, Physician, Physician assistant or Nurse practitioner for an Insured Person at risk due to nutritional history, current dietary intake, medication use or chronic illness or condition. This includes unlimited medical nutrition therapy provided by a licensed dietician-nutritionist, working in coordination

with the Insured Person's Physician, to treat a chronic illness or condition.

5. **Patient Centered Medical Home Expense Benefit** for Insured Persons with chronic conditions, serious illnesses or complex health care needs who agree to participate in a patient centered medical home program. This includes associated costs for coordination of care, such as:
   a. Liaison services between the Insured Person and the health care provider, Nurse coordinator, and the care coordination team;
   b. Creation and supervision of a care plan;
   c. Education of the Insured Person and the Insured Person's Immediate Family Members regarding the Insured Person's disease, Treatment compliance and self-care techniques; and
   d. Assistance with coordination of care, including arranging consultations with specialists and obtaining Medically Necessary supplies and services, including community resources.

6. **Pediatric Autoimmune Neuropsychiatric Disorders**. Benefits include Medically Necessary diagnosis, evaluation and Treatment of:
   a. Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS); and
   b. Pediatric acute-onset neuropsychiatric syndrome (PANS).

   Coverage includes the use of intravenous immunoglobulin therapy.

7. **Prostate Cancer Screening** as set forth in the current recommendations of the American Cancer Society for Covered Medical Expenses incurred in conducting a medically recognized diagnostic examination which shall include a digital rectal exam and a blood test called the prostate-specific antigen (PSA) test:
   a. For men who are between 40 and 75 years of age;
   b. When used for the purpose of guiding patient management in monitoring the response to prostate cancer Treatment;
   c. When used for staging in determining the need for a bone scan in patients with prostate cancer; or
   d. When used for male Insured Persons who are at high risk for prostate cancer.

8. **Wellness Program Benefits:**
   Exercise Facility Reimbursement. We will partially reimburse the Insured Student and his or her Dependents for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities which maintain equipment and programs that promote cardiovascular wellness.

   If it is unreasonably difficult for the Insured Person to go to an Exercise Facility, We will reimburse fees or subscriptions paid for online, virtual, or live-streamed fitness classes.

   Membership in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual workout visits. We will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages, etc.).

   In order to be eligible for reimbursement, the Insured Person must be an active member of the exercise facility or online, virtual, or live-streamed fitness classes.

   In order to obtain reimbursement, at the end of the six (6)-month period, the Insured Person must submit:
   a. Documentation of the visits from the facility or online, virtual, or live-streamed fitness provider; and
   b. A copy of the Insured Person's current bill which shows the fee paid for his or her membership or classes.

   Once We receive the completed documentation of the visits, the Insured Student will be reimbursed the lesser of $200 for his or her visits and $100 for each Dependent or the actual cost of the membership per six (6)-month

period. Reimbursement must be requested within 120 days of the end of the six (6)-month period. Reimbursement will be issued only after the Insured Person has completed each six (6)-month period.

In addition, each Insured Person has access to a voluntary health risk assessment. We will provide written feedback to an Insured Person who chooses to complete the assessment, with recommendations for lowering risks identified in the completed health risk assessment. For additional information, contact Us at the number on Your ID card.

9. **Biomarker Testing** will be covered for the purpose of diagnosis, Treatment, appropriate management, or ongoing monitoring of the Insured Person's disease or condition when the test is supported by medical and scientific evidence.

SECTION VI - 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 VII - 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

- Services that are not Medically Necessary and Elective Surgery or Elective Treatment.
- Services performed or prescribed under the direction of a person who is not a health care practitioner.
- Services that are beyond the scope of practice of the health care practitioner performing the service.
- Services to the extent they are covered by any government unit, except for veterans in Veterans' Administration or armed forces facilities for services received for which the recipient is liable.
- Services for which an Insured Person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan.
- Personal care services and domiciliary care services.
- Services rendered by a health care practitioner who is an Insured Person's Spouse, mother, father, daughter, son, brother, or sister.
- Experimental services.
- Services incurred before the Effective Date of coverage for an Insured Person.
- Services incurred after an Insured Person's Termination Date of coverage, including any Extension of Benefits.
- Services for injuries or diseases related to an Insured Person's job to the extent the Insured Person is required to

be covered by a workers' compensation law.
- Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.
- Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment.
- Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form, except as provided in the Telehealth Services benefit.
- Inpatient admissions primarily for diagnostic studies.
- Except for Emergency Services, services received while the Insured Person is outside the United States, except as otherwise covered under the Non-Emergency Care While Traveling Outside of the United States benefit.
- Immunizations related to foreign travel except as otherwise covered under the Shots and Injections benefit.
- Services that duplicate benefits provided under federal, State, or local laws, regulations, or programs.
- Non-replacement fees for blood and blood products.
- Wigs or cranial prosthesis, except as provided for a Medically Necessary hair prosthesis prescribed by the attending Physician.
- Weekend admission charges, except for emergencies and maternity.
- Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements.
- Services for conditions that State or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution.
- Physical examinations required for obtaining or continuing employment, insurance, or government licensing.
- Nonmedical Ancillary Services such as vocational rehabilitation, employment counseling, or educational therapy.
- Private Hospital room.
- Private Duty Nursing, except as otherwise covered under the Registered Nurse Services benefit.
- Payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines was provided as a result of a prohibited referral.

In addition, for International Students Only, the following are not covered services:
- Expenses incurred within Your Home Country or country of regular domicile.
- Covered Medical Expenses received within Your Home Country or country of origin that are covered under Your governmental or national health plan.

Weight Management/Reduction
- Medical or surgical Treatment or regimen for reducing or controlling weight, unless otherwise specified in the covered services for Bariatric Surgery.
- Lifestyle improvements, including nutrition counseling, or physical fitness programs, except as provided under the Nutrition Counseling and Wellness Benefits.

Family Planning
- Ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.
- Services to reverse a voluntary sterilization procedure.
- Services for sterilization or reverse sterilization for a Dependent minor, except for FDA approved sterilization procedures for women with reproductive capacity as required under the Affordable Care Act.
- Treatment of sexual dysfunction not related to organic disease.

Vision
- The purchase, examination, or fitting of eyeglasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for use in the Treatment of a disease or injury. This exclusion does not apply to the Pediatric Vision Care Benefit.

- Practitioner, Hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.

Dental

- Treatment to the teeth, including orthodontic braces and orthodontic appliances unless otherwise covered under the Adult Dental Care Benefit;
- Accidents occurring while and as a result of chewing, except as provided in the Pediatric Dental Care Benefit.
- Temporomandibular joint syndrome (TMJ) Treatment and Treatment for craniomandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if Medically Necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or Injury.

Hearing

- The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, except as required as a covered service under Hearing Aids.

Cosmetic

- Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies.

Foot Care:

- 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.
- Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be Medically Necessary.

Organ Transplants:

- Except for covered Ambulance Services, travel, whether or not recommended by a health care practitioner, except for the cost of air transportation for the recipient and a companion (or two companions if recipient is under the age of 18) to and from the site of a covered Organ Transplant.
- Nonhuman organs and their implantation.
- Services for, or related to, the removal of an organ from an Insured Person for purposes of transplantation into another person, unless the:
  - Transplant recipient is covered under the plan and is undergoing a covered transplant, and
  - Services are not payable by another carrier.

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. Our recovery amount will be reduced by Our share of Your court cost and attorney's fees. 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; 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; intensive care 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 <u>not</u> 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 VIII - GENERAL PROVISIONS

Entire Contract Changes

The Policy, this Certificate, including the application, endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in the Policy or Certificate will be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon. No agent has authority to change the Policy or Certificate or waive any of its provisions. All statements made by the Policyholder will, in the absence of fraud, be treated as representations and not warranties.

Contestability of Coverage
The validity of the Policy will not be contested after it has been in force for 2 years from the Policy Effective Date, except for non-payment of Premium or fraud. A statement made by any Insured Person covered under the Policy relating to insurability may not be used in contesting the validity of the Policy with respect to which the statement was made after the Policy has been in force before the contest for a period of 2 years during the Insured Person's lifetime. Absent fraud, each statement made by an Insured Person or Policyholder is considered to be a representation and not a warranty. A Statement made to effectuate insurance may not be used to avoid the insurance or reduce benefits under the Policy, unless: (a) the statement is contained in a written instrument signed by the Policyholder or Insured Person; and (b) a copy of the statement is given to the Policyholder, the Insured Person or beneficiary of the Insured Person. We reserve the right to contest coverage at any time of defenses based upon the Insured Person's ineligibility for coverage under the Policy or upon other provisions of the Policy.

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.

If written notice is not received within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:
1. it can be shown that it was not possible, within reason, to submit notice within the 90-day period; and
2. it is further shown that notice was given as soon as possible.

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 after notice of claim is received, 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 by first-class mail, facsimile transmission or through a website that allows for the secure transmission of information within one year after the date of such Loss. Failure to submit a claim within one year after the date of services does not invalidate or reduce the amount of the claim if: (1) it was not reasonably possible to submit the claim within one year after the date of services; and (2) the claim is submitted within two years after the date of service. The proof required must be given no later than two years from the time specified unless the Insured Person was legally incapacitated. If the Insured Person was legally incapacitated, the time frame for submitting a claim is suspended until legal capacity has been regained. Providers have 180 days from the date a covered service is rendered to submit a claim for reimbursement.

Time of Payment
Benefits payable under this Certificate will be paid not more than 30 days after receipt of due proof of such Loss.

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 $5,000.00, 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.

If the Department of Health notifies Us that the Department has paid for or provided services to an Insured Person under this Certificate, We shall reimburse the Department for the cost of the services, regardless of any provisions in this Certificate that requires payment to the Policyholder, the Insured Person or another payee.

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

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

Statements in Policyholder Application
All statements made in an application by the Policyholder are, in the absence of fraud, representations and not warranties. A statement made to effectuate insurance may not be used to avoid the insurance or reduce benefits under this Certificate, unless: (a) the statement is contained in a written instrument signed by the Policyholder or Insured Person; and (b) a copy of the statement is given to the Policyholder, the Insured Person or beneficiary of the Insured Person.

SECTION IX - 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 X – GRIEVANCE PROCEDURES

NOTICE REQUIRED BY THE STATE OF MARYLAND:

THERE IS HELP AVAILABLE TO THE INSURED PERSON IF THE INSURED PERSON WISHES TO DISPUTE THE DECISION OF THIS CERTIFICATE ABOUT PAYMENT FOR HEALTH CARE SERVICES.

The Insured Person may contact the Health Advocacy Unit of Maryland's Consumer Protection Division at: Health Education and Advocacy, Unit Office of the Attorney General, 200 St. Paul Place, Baltimore, MD 21202 , Mon-Fri 9 am-4:30 pm at (410) 528-1840, facsimile (410) 576-6571 or Toll-free in Maryland 1-877-261-8807, e-mail at heau@oag.state.md.us, or web address at www.oag.state.md.us.

The Health Advocacy Unit can help the Insured Person, the Insured Person's Authorized Representative, or the Insured Person's Health Care Provider prepare a Grievance to file under the Company's Internal Grievance procedure. That unit can also attempt to mediate a resolution to the Insured Person's dispute. The Health Advocacy Unit is not available to represent or accompany the Insured Person during any proceeding of the Internal Grievance Process.

Additionally, the Insured Person, the Insured Person's Authorized Representative, or the Insured Person's Health Care Provider may file a Complaint with the Maryland Insurance Administration, without having to first file a Grievance with the Policy, if: (1) the Policy has denied authorization for a Health Care service not yet provided to the Insured Person; and (2) the Insured Person, the Insured Person's Authorized Representative, or the Insured Person's Health Care Provider can show a Compelling Reason to file a Complaint, including that a delay in receiving the Health Care Service could result in loss of life, serious impairment to a bodily function, or serious dysfunction of a bodily organ or part, or the Insured Person remaining seriously mentally ill or using intoxicating substances with symptoms that cause the Insured Person to be in danger to self or others, or the Insured Person continuing to experience severe withdrawal symptoms. **INFORMATION DESCRIBED IN THIS NOTICE MAY ALSO BE FOUND IN** policy, certificate, enrollment material, or other evidence of coverage.

DEFINITIONS

As used herein:

Adverse Decision means:
A Utilization Review determination made by a Private Review Agent that:
1. a proposed or delivered Health Care Service:
   a. which would otherwise be covered under the Policy is not or was not Medically Necessary, appropriate, or efficient; and
   b. may result in noncoverage of the Health Care Service.
2. A denial by the Private Review Agent or a request by an Insured Person for an alternative standard or a waiver of

a standard to satisfy the requirements of the Wellness Program Benefits.

Adverse Decision includes a Utilization Review determination based on a prior authorization or step therapy requirement.

Adverse Decision does not include a decision concerning the Insured Person's status as an Insured Person under this Certificate.

Authorized Representative means an individual who has been authorized by the Insured Person to file a Grievance or a complaint on the Insured Person's behalf.

Compelling Reason means a Complaint that may be filed without first exhausting the Internal Grievance Process if the Complaint demonstrates a compelling reason to the satisfaction of the Maryland Commissioner of Insurance to do so, including a showing that the potential delay in receipt of a health care service until after the Insured Person or Health Care Provider exhausts the Internal Grievance Process and obtains a final decision under the Grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the Insured Person remaining seriously mentally ill or using intoxicating substances with symptoms that cause the Insured Person to be in danger to self or others if the Insured Person is unable to function in activities of daily living or care for self without imminent dangerous consequences.

Complaint means a protest filed with the Maryland Commissioner of Insurance involving an Adverse Decision or Grievance Decision concerning the Insured Person.

Emergency Case means a case involving an Adverse Decision for which an expedited review is required. An expedited review of an Adverse Decision is required if the: (a) Adverse Decision is rendered for health care services that are proposed but have not been delivered; and (b) services are necessary to treat a condition or illness that, without immediate medical attention would: (i) seriously jeopardize the life or health of the Insured Person or the Insured Person's ability to regain maximum function; or (ii) cause the Insured Person to be in danger to self or others; or cause the Insured Person to continue using intoxicating substances in an imminently dangerous manner.

Filing Date means the earlier of: (a) 5 days after the date of mailing; or (b) the date of receipt.

Grievance means a protest filed by an Insured Person, an Insured Person's Authorized Representative or a Health Care Provider on behalf of an Insured Person, with the Company through the Company's Internal Grievance process regarding an Adverse Decision concerning the Insured Person.

Grievance Decision means a final determination by the Private Review Agent that arises from a Grievance filed with the Private Review Agent under its Internal Grievance Process regarding an Adverse Decision concerning an Insured Person.

Health Advocacy Unit means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General established under Title 13, Subtitle 4A of the Commercial Law Article.

Health Care Provider means:

1. an individual who is licensed under the Health Occupations Article to provide Health Care Services in the ordinary care of business or practice of a profession and is a treating provider of the Insured Person; or
2. a Hospital as defined by the laws of the state to operate as a health care facility.

Internal Grievance Process: means a formal process, in accordance with Maryland statutes, established and maintained by the Company, its designee, or agent whereby the Insured Person, or the Insured Person's Authorized Representative, or a Health Care Provider acting on the Insured Person's behalf may contest an Adverse Decision

rendered by the Company or its designee.

INTERNAL GRIEVANCE PROCESS

The Insured Person, or the Insured Person's Authorized Representative, or Health Care Provider acting on the Insured Person's behalf, has the right to file an Internal Grievance when the Company's designee gives notice of an Adverse Decision regarding the Health Care Services furnished to the Insured Person. The Internal Grievance Process may be initiated by the Insured Person, or the Insured Person's Authorized Representative, or Health Care Provider acting on the Insured Person's behalf at least 180 days of receipt of an Adverse Decision.

If the Insured Person receives Emergency Services from an Out-of-Network Provider, or the Insured Person incurs non-emergency Covered Medical Expenses from an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, and the Insured Person believes those services should have been paid at the In-Network level, the Insured Person has the right to file an Internal Grievance of that claim. If the Insured Person's Internal Grievance of a Surprise Billing claim is denied, the Insured Person has a right to file a Complaint with the Maryland Commissioner of Insurance as set out in the Complaints Procedures provision appearing in this Section.

If within 5 working days of the Filing Date of a Grievance, the Company's designee is unable to complete its investigation without further information, the Company's designee will, after confirming through a complete review of any information already submitted by the Health Care Provider:

(a) notify the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf, that it cannot proceed with reviewing the Grievance unless additional information is provided;
(b) request the specific information, including any lab or diagnostic test or other medical information that must be submitted to complete the Internal Grievance Process; and
(c) provide the specific reference, language, or requirements from the criteria and standards used by the Company's designee to support the need for additional information; and
(d) assist the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf in gathering the necessary information without further delay.

The Internal Grievance Process will include adequate and reasonable procedures for review and resolution of appeals concerning Adverse Determination, including procedures for reviewing appeals if the Insured Person's medical condition requires expedited review.

For non-Emergency Cases

I. When the Company's designee, renders an Adverse Decision, the Company's designee shall:

(a) Inform the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf of the Adverse Decision:
    (1) orally by telephone; or
    (2) with the affirmative consent of the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf, by text, facsimile, e-mail, an online portal, or other expedited means; and
(b) send, within 5 working days after the Adverse Decision has been made, a written notice to the Insured Person, the Insured Person's Authorized Representative and the Health Care Provider acting on the Insured Person's behalf that:
    (1) states in detail in clear, understandable language the specific factual bases for the Company's designee's decision and the reasoning used to determine that the health care service is not Medically Necessary and did not meet the Company's designee's criteria and standards used in conducting the Utilization Review;
    (2) provides the specific reference, language, or requirements from the criteria and standards, including interpretive guidelines, on which the decision was based, and may not solely use:
        a. generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered",

"service included under another procedure", or "not medically necessary"; or

b. language directing the Insured Person to review the additional coverage criteria in the Policy or plan documents;

(3) states the name, business address, and business telephone number to contact the designated employee or representative of the Company's designee who has responsibility for the Company's designee's Internal Grievance Process, and the Physician who is required to make all Adverse Decisions. To contact the Company Representative responsible for Internal Grievance Process: Wellfleet Group, LLC, PO Box 15369, Springfield MA 01115-5369, telephone (800) 633-7867 or facsimile (413) 452-5329;

(4) gives written details of the Company's designee's Internal Grievance Process and procedures; and

(5) include the following information:

a. that the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf has the right to file a Complaint with the Commissioner with 4 months after receipt of the Company's designee's Grievance decision;

b. that the Complaint may be filed without first filing a Grievance if the Insured Person, the Insured Person's Authorized Representative or Health Care Provider filing a Grievance on behalf of the Insured Person can demonstrate a Compelling Reason to do so as determined by the Commissioner;

c. the Commissioner's address, telephone number, and facsimile number: Maryland Insurance Administration, Consumer Compliant Investigation, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202-2272, (410) 468-2000, facsimile (410) 468-2020 or Toll-free 1-800-492-6116;

d. a statement that the Health Advocacy Unit is available to assist the Insured Person, the Insured Person's Authorized Representative in both mediating and filing a Grievance under the Company's designee's Internal Grievance Process; and

e. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit: Health Advocacy Unit of Maryland's Consumer Protection Division at Health Education and Advocacy, Unit Office of the Attorney General, 200 St. Paul Place, Baltimore, MD 21202; (410) 528-1840, facsimile (410) 576-6571 or Toll-free in Maryland 1-877-2618807, email at consumer@oag.state.md.us, or web address at www.oag.state.md.us

II. When the Health Care Services under review is a mental health or substance use service, the Adverse Decision shall be made by a Physician, or a panel or other appropriate Health Care Services reviewers with at least one Physician, selected by the Private Review Agent who:

(A) is board certified or eligible in the same specialty as the treatment under review; or

(B) is actively practicing or has demonstrated expertise in the substance use or mental health service or treatment under review.

III. When the Health Care Services under review is a dental service, the Adverse Decision shall be made by a licensed dentist, or a panel of other appropriate Health Care Services reviewers with at least one licensed dentist on the panel.

IV. When the Health Care Services under review is for other than a mental health or substance use service, or dental service, the Adverse Decision shall be made by a Physician, or a panel of other appropriate Health Care Services reviewers with at least one Physician on the panel who is board certified or eligible in the same specialty as the treatment under review.

V. When the Grievance Decision involves a mental health or substance use service, the Grievance Decision shall be made based on the professional judgment of:

(A) who is a licensed Physician who is board certified or eligible in the same specialty as the treatment under review; or

(B) is actively practicing or has demonstrated expertise in the substance use or mental health service or treatment under review; or

(C) a panel of other appropriate Health Care Services reviewers with at least one Physician, selected by the Private Review Agent who is board certified or eligible in the same specialty as the treatment under review; or is actively practicing or has demonstrated expertise in the substance use or mental service or treatment under review.

VI. When the Grievance Decision involves a dental service, the Grievance Decision shall be made based on the professional judgment of a licensed dentist, or a panel of appropriate Health Care Services reviewers with at least one dentist on the panel who is a licensed dentist, who shall consult with a dentist who is board certified or eligible in the same specialty as the service under review.
VII. When the Grievance Decision involves services other than a mental health or substance use service or a dental service, the Grievance Decision shall be made based on the professional judgment of a Physician who is board certified or eligible in the same specialty as the treatment under review; or a panel of other appropriate Health Care Services reviewers with at least one Physician on the panel who is board certified or eligible in the same specialty as the treatment under review.

For Emergency Cases
An expedited review is deemed necessary when, in the opinion of the treating Health Care Provider, review under a standard time frame could, in the absence of immediate medical attention, result in any the following for the Insured Person:
(1) serious jeopardy of the life or health or the ability to regain maximum function;
(2) severe pain;
(3) serious impairment to such person's bodily functions;
(4) serious disfigurement of such person;
(5) being a danger to him or herself or others; or.
(6) such person using intoxicating substances in an imminently dangerous manner.

The Company will initiate an expedited review for an emergency case if the Insured Person or the Insured Person's Authorized Representative requests the expedited review or the health care provider or the Insured Person or the Insured Person's Authorized Representative attests that:
(1) the Adverse Decision was rendered for health care services that are proposed but have not been provided; and
(2) the services are necessary to treat a condition or illness that, without immediate medical attention, would:
   a. seriously jeopardize the life or health of the Insured Person or the Insured Person's ability to regain maximum functions;
   b. cause the Insured Person to be in danger to self or others; or
   c. cause the Insured Person to continue using intoxicating substances in an imminently dangerous manner.

The Company's designee shall render a decision not later than 24 hours after receipt of the request for an expedited review of the Adverse Decision or Grievance Decision and within 1 day of orally providing the decision to the Insured Person, the Insured Person's Authorized Representative or the Insured Person's Health Care Provider, the Company's designee will send written notice of any Adverse Decision or Grievance Decision to:
(1) the Insured Person and the Insured Person's Authorized Representative, if any, and
(2) if the Grievance was filed on the Insured Person's behalf, to the Insured Person's Health Care Provider.

For an Adverse Decision:
Within 5 working days after the Adverse Decision has been made, a written notice will be sent to the Insured Person, the Insured Person's Authorized Representative and the Health Care Provider acting on the Insured Person's behalf that:
   (1) states in detail in clear, understandable language the specific factual bases for the Company's designee's decision and the reasoning used to determine that the health care service is not Medically Necessary and did not meet the Company's designee's criteria and standards used in conducting the Utilization Review;
   (2) provides the specific reference, language, or requirements from the criteria and standards, including interpretive guidelines, on which the decision was based, and may not solely use:
   a. generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary"; or
   b. language directing the Insured Person to review the additional coverage criteria in the Policy or plan documents;

(3) states the name, business address, and business telephone number to contact the designated employee or representative of the Company's designee who has responsibility for the Company's designee's Internal Grievance Process, and the Physician who is required to make all Adverse Decisions. To contact the Company Representative responsible for Internal Grievance Process: Wellfleet Group, LLC, PO Box 15369, Springfield MA 01115-5369, telephone (800) 633-7867 or facsimile (413) 452-5329;
(4) gives written details of the Company's designee's Internal Grievance Process and procedures; and
(5) include the following information:

a. that the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf has the right to file a Complaint with the Commissioner with 4 months after receipt of the Company's designee's Grievance decision;
b. that the Complaint may be filed without first filing a Grievance if the Insured Person, the Insured Person's Authorized Representative or Health Care Provider filing a Grievance on behalf of the Insured Person can demonstrate a Compelling Reason to do so as determined by the Commissioner;
c. the Commissioner's address, telephone number, and facsimile number: Maryland Insurance Administration, Consumer Compliant Investigation, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202-2272, (410) 468-2000, facsimile (410) 468-2020 or Toll-free 1-800-492-6116;
d. a statement that the Health Advocacy Unit is available to assist the Insured Person, the Insured Person's Authorized Representative in both mediating and filing a Grievance under the Company's designee's Internal Grievance Process; and
e. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit: Health Advocacy Unit of Maryland's Consumer Protection Division at Health Education and Advocacy, Unit Office of the Attorney General, 200 St. Paul Place, Baltimore, MD 21202; (410) 528-1840, facsimile (410) 576-6571 or Toll-free in Maryland 1-877-2618807, email at consumer@oag.state.md.us, or web address at www.oag.state.md.us

For a Grievance Decision:
When the Company's designee renders a Grievance Decision, the Company's designee will:

(1) document the Grievance Decision in writing after the Company's designee has provided oral communication of the decision to the Insured Person, the Insured Person's Authorized Representative and the Health Care Provider acting on the Insured Person's behalf; and
(2) send, within 5 working days after the Grievance Decision has been made, a written notice to the Insured Person, the Insured Person's Authorized Representative and the Insured Person's Health Care Provider acting on the Insured Person's behalf that:
   (a) states in detail in clear, understandable language the specific factual bases for the Company's designee's decision and the reasoning used to determine that the health care service is not Medically Necessary and did not meet the Company's designee's criteria and standards used in conducting Utilization Review;
   (b) provides the specific reference, language, or requirements from the criteria and standards, including an interpretive guideline used by the Company's designee, on which the Grievance Decision was based;
   (c) states the name, business address, and business telephone number of:
      1. the designated employee or representative of the Company's designee who has responsibility for the Company's designee's Internal Grievance Process and the designated employee or representative's title and clinical specialty; and
      2. includes the following information:
         (a) that the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf has the right to file a Complaint with the Commissioner with 4 months after receipt of the Company's designee's Grievance decision;
         (b) the Commissioner's address, telephone number, and facsimile number: Maryland Insurance Administration, Consumer Compliant Investigation, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202-2272, (410) 468-2000, facsimile (410) 468-2020 or Toll-free 1-800-492-6116;
         (c) a statement that the Health Advocacy Unit is available to assist the Insured Person, the Insured Person's Authorized Representative in both mediating and filing a Grievance under the Company's

designee's Internal Grievance Process; and

(d) the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit: Health Advocacy Unit of Maryland's Consumer Protection Division at Health Education and Advocacy, Unit Office of the Attorney General, 200 St. Paul Place, Baltimore, MD 21202; (410) 528-1840, facsimile (410) 576-6571 or Toll-free in Maryland 1-877-2618807, email at consumer@oag.state.md.us, or web address at www.oag.state.md.us

For an Emergency Case, a Complaint may be filed with the Commissioner if a Grievance Decision is not received within 24 hours after filing the Grievance pursuant to the Internal Grievance Process.

Responses and Timelines

I. Initial Determination. The Company's designee will make all initial determinations on whether to authorize or certify:

(a) a non-emergency course of Treatment or health care service, including pharmaceutical services not submitted electronically, for an Insured Person within 2 working days after receipt of the information necessary to make the determination;

(b) an extended stay in a health care facility or additional health care services within 1 working day after receipt of the information necessary to make the determination; and

(c) additional visits or days of care submitted as part of existing course of Treatment or Treatment plan, within 1 working day after receipt of the information necessary to make the determination.

The Company's designee will promptly notify the Health Care Provider of the determination.

The Company's designee will make all initial determinations on whether to authorize or certify an emergency course of Treatment or health care service for an Insured Person within 24 hours after the initial request after receipt of the information necessary to make the determination. If the Company's designee determines that additional information is need after confirming through a complete review of the information already submitted by the Health Care Provider, the Company's designee will:

(a) Promptly request the specific information needed, including an lab or diagnostic test or other medical information; and

(b) Promptly, but not later than 2 hours after receipt of the information, notify the Health Care Provider of the authorization or certification determination when made by the Company's designee.

The Company's designee will initiate the expedited procedure for an emergency case if the Insured Person or the Insured Person's Authorized Representative requests or if the Health Care Provider attests that the services are necessary to treat a condition or illness that, without immediate medical attention, would:

(a) Seriously jeopardize the life or health of the Inured Person or the Insured Person's ability to regain maximum functions;

(b) Cause the Insured Person to be in danger to self or others; or

(c) Cause the Insured Person to continue using intoxicating substances in an imminently dangerous manner.

If the Company's designee fails to make a determination within the time limits required, the request will be deemed approved.

If within 3 calendar days after receipt of the initial request for health care services and confirming through a complete review of information already submitted by the Health Care Provider, the Company's designee determines that the Company's designee does not have sufficient information to make a determination, the Company's designee shall promptly, but not later than 3 calendar days after receipt of the initial request, inform the Health Care Provider that additional information must be provided by specifying:

(a) The information, including any lab or diagnostic test or other medical information, that must be submitted to complete the request; and

(b) The criteria and standards to support the need for additional information.

II. Grievance Decisions. The Insured Person's Grievance will be reviewed by a Physician who was not involved in the initial Adverse Decision, or a panel or appropriate Health Care Services reviewers with at least one Physician on the panel who is a licensed Physician, who shall consult with a Physician who is board certified or eligible in the same specialty as the service under review.

If within 5 working days of the Filing Date of a Grievance, the Company's designee is unable to complete its investigation without further information, the Company's designee will, after confirming through a complete review of any information already submitted by the Health Care Provider:

(a) notify the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf, that it cannot proceed with reviewing the Grievance unless additional information is provided;
(b) request the specific information, including any lab or diagnostic test or other medical information that must be submitted to complete the Internal Grievance Process; and
(c) provide the specific reference, language, or requirements from the criteria and standards used by the Company's designee to support the need for additional information; and
(d) assist the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf in gathering the necessary information without further delay.

The Company's designee will render a final decision in writing on a Grievance within:

(a) 45 working days after the Filing Date when the Grievance involves a retrospective denial, unless the Insured Person, the Insured Person's Authorized Representative of Health Care Provider acting on the Insured Person's behalf, agree in writing to an extension for a period of no longer than 30 working days; or
(b) 30 working days after the Filing Date when the Grievance involves a non-emergency prospective denial; unless the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf, agree in writing to an extension for a period of no longer than 30 working days.
(c) 24 hours of the date a Grievance is filed with the Company's designee for an Emergency Case benefit decision. Written Adverse Decision will be provided within 24 hours of the oral communication.

The final Grievance Decision will be communicated orally to the Insured Person, the Insured Person's Authorized Representative, or Health Care Provider acting on the Insured Person's behalf. Written notice of the final decision will be sent to the Insured Person, and if the Grievance was filed by the Insured Person's Authorized Representative or Health Care Provider, to either of them within 5 working days after the final decision has been made. The written notice shall:

(a) state in detail in clear, understandable language the specific factual bases for the Company's designee's decision;
(b) state the name, business address, and business telephone number to contact the designated employee or representative of the Company's designee who has responsibility for the Company's designee's Internal Grievance Process. To contact the Company Representative responsible for Internal Grievance Process: Wellfleet Group, LLC, PO Box 15369, Springfield MA 01115-5369, telephone (800) 633-7867 or facsimile (413) 452-5329;
(c) include the following information:
    1. that the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf has the right to file a Complaint with the Commissioner with 4 months after receipt of the Company's designee's Grievance decision;
    2. the Commissioner's address, telephone number, and facsimile number: Maryland Insurance Administration, Consumer Compliant Investigation, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202-2272, (410) 468-2000, facsimile (410) 468-2020 or Toll-free 1-800-492-6116;
    3. a statement that the Health Advocacy Unit is available to assist the Insured Person, the Insured Person's Authorized Representative in both mediating and filing a Complaint with the Commissioner; and

4. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit: Health Advocacy Unit of Maryland's Consumer Protection Division at Health Education and Advocacy, Unit Office of the Attorney General, 200 St. Paul Place, Baltimore, MD 21202; (410) 528-1840, facsimile (410) 576-6571 or Toll-free in Maryland 1-877-2618807, email at consumer@oag.state.md.us, or web address at www.oag.state.md.us.

The written decision will reference the specific criteria and standards, including interpretive guidelines, on which the decision was based and will not use generalized terms such as "experimental procedure not covered", cosmetic procedure not covered", "service including under another procedure", or not Medically Necessary".

III. Coverage Appeal Decisions. Coverage denial appeals will be reviewed by claim analysts who were not involved in the original benefit decision. Claims analysts will have the expertise needed for the benefits in question. Review may be performed by escalating levels of management as necessary for each case.

The Company's designee will render a final decision in writing within 60 working days after the filing of an appeal. Within 30 calendar days after the appeal decision has been made, the Company's designee will send to the Insured Person, the Insured Person's Authorized Representative and/or Health Care Provider acting on the Insured Person's behalf, a written notice of the appeal decision. The Company's designee will reference the plan provision(s) on which the decision was based.

COMPLAINT PROCEDURES

The Insured Person, Insured Person's Authorized Representative or a Health Care Provider on behalf of the Insured Person may file a Complaint with the Maryland Commissioner of Insurance. The Insured Person, the Insured Person's Authorized Representative, or Health Care Provider acting on the Insured Person's behalf, have the right to file a Complaint with the Commissioner within 4 months after receipt of the Company's designee's Grievance Decision or Adverse Decision. The Insured Person or the Insured Person's Authorized Representative will be required to authorize the release of any medical information that may be needed in the review in order to reach a decision on the Complaint.

The Internal Grievance Process should be exhausted prior to filing a Complaint with the Commissioner unless: (a) the Company's designee waives the requirement that its Internal Grievance Process be exhausted before filing a Complaint with the Commissioner; (b) the Company's designee has failed to comply with any of the requirements of the Internal Grievance Process; (c) the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf, provides sufficient information and supporting documentation in the Complaint that demonstrates Compelling Reason to do so, including a showing that the potential delay in receipt of a Health Care Service until after the Insured Person, the Insured Person's Authorized Representative or Health Care Provider acting on the Insured Person's behalf, exhausts the Internal Grievance Process and the obtainment of a final decision under the Grievance Process could result in loss of life, serious impairment to body function, serious dysfunction of a bodily organ; or (d) the Insured Person remains seriously mentally ill or using intoxicating substances with symptoms that cause the Insured Person to be a danger to self or others, or the covered person continuing to experience severe withdrawal symptoms.

In cases involving a retrospective denial, there is no Compelling Reason to allow the Insured Person, the Insured Person's Authorized Representative or a Health Care Provider on behalf of the Insured Person to file a Complaint without first exhausting the Internal Grievance Process of the Company's designee.

If the internal procedures are exhausted or other circumstances above have occurred, a Complaint may be filed with the Commissioner by the Insured Person, the Insured Person's Authorized Representative, or Health Care Provider acting on the Insured Person's behalf, within 4 months after the date of receipt of a Grievance Decision.

For a non-emergency prospective denial, a Complaint may be filed with the Commissioner if a Grievance Decision is

not received on or before the 30th working day after the Filing Date of the Grievance. For emergency prospective denials, a Complaint may be filed with the Commissioner of Insurance if a Grievance Decision is not received within 24 hours after filing the Grievance.

For a retrospective denial, a Complaint may be filed if a Grievance Decision is not received on or before the 45th working day after the Filing Date of the Grievance.

If the Commissioner allows, the Insured Person, the Insured Person's Authorized Representative, or Health Care Provider acting on the Insured Person's behalf, may submit additional information related to the Complaint within 5 working days.

If the Complaint to the Commissioner involves a benefit decision based on Medical Necessity, the Commissioner will select an independent review organization or medical expert to advise on the Complaint.

The Insured Person will always have the right to contact the Maryland Insurance Administration if he or she has questions or concerns regarding coverage under the Policy. The Insured Person will always have the right to ask the Company's designee to review its decision involving the Insured Person's request for service or request to have a claim paid.

Consent Form
The Commissioner shall request the Insured Person's signed consent, or signed consent of the Insured Person's legally authorized designee, authorizing the release of the Insured Person's medical records to the Commissioner or the Commissioner's designee that are needed in order for the Commissioner to make a final decision on the Complaint. The Commissioner may refuse to investigate a Complaint if the Insured Person or the Insured Person's Authorized Representative fails to sign the consent form.

In the case of alcohol and drug misuse, the Insured Person shall deliver the medical records to the Health Advocacy Unit or to the Commissioner, or to both, pursuant to federal law and regulations.

Notification of the Company's Designee
Within 5 working days after receipt of a Complaint, the Commissioner shall send written notice to the Company's designee that is the subject of the Complaint that the Complaint has been filed.

Except for an Emergency Case, within 7 working days after the date the Company's designee is notified of a Complaint, the Company's designee shall provide to the Commissioner any information requested by the Commissioner in the written notice.

Review of Complaint
During the review of a Complaint, the Company's designee shall have the burden of persuasion that its Adverse Decision or Grievance Decision, as applicable, is correct.

In responding to a Complaint, the Company's designee may not rely on any basis not stated in its Adverse Decision of Grievance Decision.

The Commissioner may allow the Company's designee, the Insured Person or a Health Care Provider filing a Complaint on behalf of the Insured Person to provide additional information as may be relevant for the Commissioner to make a final decision on the Complaint. The Commissioner's use of additional information may not delay the Commissioner's decision on the Complaint by more than 5 working days.

The Commissioner may refer Complaints not within the Commissioner's jurisdiction to the Health Advocacy Unit or any other appropriate federal or state agency or unit for disposition or resolution.

In cases considered appropriate by the Commissioner, the Commissioner may seek advice from an independent review organization or medical expert.

The Commissioner shall make and issue in writing a final decision on all Complaints filed within the Commissioner's jurisdiction and provide written notice to all parties to a Complaint of the opportunity and time period for requesting a hearing to be held.

The Insured Person or the Insured Person's Authorized Representative may contact a representative of the Company at any time at:
Wellfleet Insurance Company
Attention: Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369

The Insured Person or the Insured Person's Authorized Representative can contact the Maryland Insurance Administration or the Office of the Commissioner of Insurance at any time at:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health/Appeals and Grievance
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Telephone: 410-468-2000 or 1-800-492-6116
Fax: 410-468-2270 or 410-468-2260
www.mdinsurance.state.me.us/sa/consumer/appeals-and-grievances.html

Office of the Commissioner of Insurance
Maryland Insurance Administration
200 St. Paul Place, Suite 2700,
Baltimore, MD 21202-2272
Telephone: 410-468-2000
Toll Free: 1-800-492-6116
Fax Number: 410-468-2020

The Company wants to make sure that notices of Adverse Decisions or Grievance Decisions are provided in a culturally and linguistically appropriate manner to the Insured Person, or the Insured Person's Authorized Representative, or the Insured Person's Health Care Provider acting on behalf of the Insured Person. The Company can provide interpreting services through its toll-free Customer Service line. The Insured Person, or the Insured Person's Authorized Representative, or the Insured Person's Health Care Provider acting on behalf of the Insured Person, may call 1-800-633-7867 for assistance.

HIPAA Notice of Privacy Practices

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

PLEASE REVIEW IT CAREFULLY

Effective: August 01, 2019

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

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

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

Our Responsibilities

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

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

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

Overview of this Notice

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

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

YOUR HEALTH INFORMATION

How We Acquire Your Information

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

How We use Your Health Information

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

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

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

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

Additionally:

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

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

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

Authorizations

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

YOUR RIGHTS

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

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

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

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

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

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

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

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

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

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

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

CONTACT

For all inquiries, requests and complaints, please contact:

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

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

This Notice is Subject to Change

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

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

Gramm-Leach-Bliley ("GLB") Privacy Notice

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

COLLECTING YOUR INFORMATION

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

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

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

SHARING YOUR INFORMATION

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

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

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

HEALTH INFORMATION

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

SAFEGUARDING YOUR INFORMATION

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

ACCESSING YOUR INFORMATION

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

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

CORRECTING YOUR INFORMATION

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

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

CONTACTING US

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

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

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

NOTICE OF NON-DISCRIMINATION AND ACCESSIBIILITY REQUIREMENTS

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

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

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

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

1. Interpreters
2. information translated into other languages

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

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

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

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
800-868-1019; 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

ADVISORY NOTICE TO POLICYHOLDERS

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

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

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

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

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

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

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

Women's Health & Cancer Rights Act

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

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

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

LANGUAGE ASSISTANCE PROGRAM

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

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

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

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

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

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

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

هيبنت: اذإ تنكتدحتت **ةيبرعلا (Arabic)**، نإف تامدخ ةدعاسملا ةيوغللا ةيناجملا ةحاتم كل. ءاجرلا لاصتلاأ بـ 657-5030 (877).

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

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

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

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

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

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

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

ىسراف (Farsi) هجوت :امشن ابز رگا دشاب ىم امش رايتخا رد نگيار روط هب ىنابز دادما تامدخ ،تسا.
(877) 657-5030 تمسا بيگريد.

कृपया ध्या द□: य□द आप □**हंद**□ **(Hindi)** भाषी ह□ तो आपके □लए भाषा सहायता सेवाएं□न:शुल् उपलब् ह□। कृपया पर काल कर□ (877) 657-5030

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

ប្រយ័ត្ន៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ**(Khmer)** សេវាកម្មភាសាជំនួយឥតគិតថ្លៃមានសម្រាប់អ្នក។

សូមទូរស័ព្ទមកលេខ (877) 657-5030 ។

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

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

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

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

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

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

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ(877) 657-5030

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

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

NOTICE OF PROTECTION PROVIDED BY MARYLAND LIFE AND HEALTH INSURANCE GUARANTY CORPORATION

This notice provides a brief summary of the Maryland Life and Health Insurance Guaranty Corporation (the Corporation) and the protection it provides for policyholders. This safety net was created under Maryland law, which determines who and what is covered and the amounts of coverage.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

The Corporation was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Corporation will typically arrange to continue coverage and pay claims, in accordance with Maryland law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Corporation are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 for basic hospital, medical, and surgical insurance or major medical insurance provided by health benefit plans
  - $300,000 for disability insurance
  - $300,000 for long-term care insurance
  - $100,000 for a type of health insurance not listed above, including any net cash surrender and net cash withdrawal values under the types of health insurance listed above
- Annuities
  - $250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash surrender values
  - With respect to each payee under a structured settlement annuity, or beneficiary of the payee, $250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is:

- $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
- $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Maryland law.

To learn more about the above protections, please visit the Corporation's website at www.mdlifega.org, or contact:

Maryland Life and Health Insurance Guaranty Corporation
8817 Belair Road, Suite 208
Perry Hall, Maryland 21236
410-248-0407

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
1-800-492-6116, ext. 2170

Insurance companies and agents are not allowed by Maryland law to use the existence of the Corporation or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Corporation coverage. If there is any inconsistency between this notice and Maryland law, then Maryland law will control.