UNIVERSITY of LOUISIANA LAFAYETTE

INVITATION TO BID

SOLICITATION FILE No.: 25032

TITLE: INTERNATIONAL STUDENT SICKNESS & ACCIDENT GROUP INSURANCE PLAN (RENEWABLE CONTRACT)

BID SCHEDULE:
1. DUE DATE/TIME *(email only)*: **Tuesday, May 27, 2025 2:00PM**
2. ZOOM BID OPENING: Tuesday, May 27, 2025 3:00PM
MEETING ID: 979 3218 8188 PASSWORD: 25032

SUBMIT BID TO:*
University of Louisiana at Lafayette
Office of Purchasing
ULLafayetteBids@louisiana.edu

To maintain the integrity of the bid process, please do not cc any other University email address when submitting your bid.

BUYER OF RECORD: Martina Howard
BUYER PHONE: (337) 482-1079
EMAIL: bidquestions@louisiana.edu

General Instructions to Bidders

1. Hard copies of sealed bids will no longer be accepted. All bids must be received electronically by the due date and time to be considered.
2. Sealed bids for furnishing the items and/or services specified are hereby solicited, and will be received by the issuing UL Lafayette Campus/Department at the "Submit Bid To" address stated above, until the specified due date and time. Bidder is solely responsible for the timely delivery of bid. The Purchasing Office is not responsible for any delays.
3. Bid submissions must be signed by a person authorized to bind the vendor. In accordance with Louisiana R.S. 39:1594, the person signing the bid must be: (1) any corporate officer listed on the most current annual report on file with the secretary of state, or the signature on the bid is that of any member of a partnership or partnership in commendam listed in the most current partnership records on file with the secretary of state; or (2) an authorized representative of the corporation, partnership, or other legal entity and the Bidder submits or provides upon request a corporate resolution, certification as to the corporate principal, or other documents indicating authority which are acceptable to the public entity, including registration on an electronic Internet database maintained by the public entity; or (3) entity has filed in the appropriate records of the secretary of state in which the public entity is located, an affidavit, resolution, or other acknowledged or authentic document indicating the names of all parties authorized to submit bids for public contracts.
4. When bid is submitted by email, **the subject line must show the Solicitation/File No.** and submission must be received by bid deadline.
5. Read the entire solicitation, including all terms, conditions and specifications.
6. All bid information and prices must be typed or written in ink. Any corrections, erasures or other forms of alteration to unit prices are to be initialed by the Bidder.
7. Bid prices shall include all delivery charges paid by the vendor, F.O.B. UL Lafayette Destination, unless otherwise provided in the solicitation. Any invoiced delivery charges not quoted and itemized on the UL Lafayette purchase order are subject to rejection and non-payment.
8. Payment terms: Net 60 after receipt of properly executed invoice or delivery and acceptance, whichever is later.
9. By signing this solicitation, the Bidder certifies compliance with all general instructions to Bidders, terms, conditions and specifications; and further certifies that this bid is made without collusion or fraud.
10. MANDATORY bid requirements are detailed immediately following the Standard Terms & Conditions section.
11. There will be no pre-bid meeting for this solicitation.
12. Quantities listed in these specifications are approximate and are not guaranteed by the University. The University reserves the right to ***increase or reduce*** quantity as needed if in the best interest of the University.

These standard terms and conditions shall apply to all UL Lafayette solicitations, unless otherwise specifically amended and provided for in the special terms and conditions, specifications, or other solicitation documents. In the event of conflict between the General Instructions to Bidders or Standard Terms & Conditions and the Special Terms & Conditions, the Special Terms & Conditions shall govern.

Bids submitted are subject to provisions of the laws of the State of Louisiana, including but not limited to: the Louisiana Procurement Code (R.S. 39:1551-1736); Purchasing Rules and Regulations (Title 34 of the Louisiana Administrative Code); Executive Orders; and the terms, conditions, and specifications stated in this solicitation.

1. Bid Delivery and Receipt

   To be considered, Bidders may submit bids electronically to ULLafayetteBids@louisiana.edu. When bid is submitted by email, the subject line must show the Solicitation/File No. and must be received by bid deadline.

   Bidders are advised that the U.S. Postal Service does not make deliveries to the Purchasing Office. Bids will no longer be accepted by mail or in person. Bidder is solely responsible for the timely delivery of its bid, and failure to meet the bid due date and time shall result in rejection of the bid.

2. Bid Forms

   Bids are to be submitted on and in accordance with the UL Lafayette solicitation forms provided, and must be signed by an authorized agent of the vendor. Bids submitted on other forms or in other price formats may be considered informal and may be rejected in part or in its entirety. Bids submitted in pencil and/or bids containing no original signature indicating the Bidder's intent to be bound will not be accepted.

3. Interpretation of Solicitation/Bidder Inquiries

   If Bidder is in doubt as to the meaning of any part or requirement of this solicitation, Bidder may submit a written request for interpretation to the Buyer-of-Record at the email address on page 1 of this solicitation. Written inquiries must be received in the UL Lafayette Office of Purchasing no later than five (5) calendar days prior to the opening of bids, and shall be clearly cross-referenced to the relevant solicitation/specification in question.

   No decisions or actions shall be executed by any Bidder as a result of oral discussions with any UL Lafayette employee or consultant. Any interpretation of the documents will be made by formal addendum only, issued by the UL Lafayette Office of Purchasing, and mailed or delivered to all Bidders known to have received the solicitation. UL Lafayette shall not be responsible for any other interpretations or assumptions made by Bidder.

4. Bid Opening

   In-person bid openings have been suspended for the foreseeable future. Bidders may attend the public bid opening of sealed bids and bids conducted on Zoom. No information or opinions concerning the ultimate contract award will be given at bid opening or during the evaluation process. Written bid tabulations will not be furnished. Bids may be examined within 72 hours after bid opening. Information pertaining to completed files may be secured by submitting a written request to the Buyer-of-Record at the email address shown in header.

5. Special Accommodations

   Any "qualified individual with a disability" as defined by the Americans with Disabilities Act, who has submitted a bid and desires to attend the public bid opening, must notify the UL Lafayette Office of Purchasing in writing not later than seven days prior to the bid opening date of their need for special accommodations. If the request cannot be reasonably provided, the individual will be informed prior to the bid opening.

6. Standards of Quality

   Any product or service bid shall conform to all applicable federal, state and local laws and regulations, and the specifications contained in the solicitation. Any manufacturer's name, trade name, brand name, or catalog number used in the specification is for the purpose of describing the standard of quality, performance, and characteristics desired; and is not intended to limit or restrict competition. Bidder must specify the brand and model number of the product offered in his bid. Bids not specifying brand and model number shall be considered as offering the exact product specified in the solicitation.

7. New Products/Warranty/Patents

   All products bid for purchase must be new, never previously used, of the manufacturer's current model and/or packaging, and of best quality as measured by acceptable trade standards. No remanufactured, demonstrator, used or irregular products will be considered for purchase unless otherwise specified.
   The manufacturer's standard published warranty and provisions shall apply, unless more stringent warranties are otherwise required by UL Lafayette and specified in the solicitation. In such cases, the Bidder and/or manufacturer shall honor the specified warranty requirements, and bid prices shall include any premium costs of such coverage.

Bidder guarantees that the products proposed and furnished will not infringe upon any valid patent or trademark; and shall, at its own expense, defend any and all actions or suits charging such infringement, and shall save UL Lafayette harmless.

8. Descriptive Information

Bidders proposing an equivalent brand or model are to submit descriptive information (such as literature, technical data, illustrations, etc.) sufficient for UL Lafayette to evaluate quality, suitability, and compliance with the specifications with the bid submission. Failure to submit descriptive information may cause bid to be rejected. Any changes made by Bidder to a manufacturer's published specifications shall be verifiable by the manufacturer. If items bid do not fully comply with specifications, Bidder must state in what respect items deviate. Bidder's failure to note exceptions in its bid will not relieve the Bidder from supplying the actual products requested.

9. Bids/Prices/F.O.B. Point

- The bid price for each item is to be quoted on a "net" basis and F.O.B. UL Lafayette Destination, i.e. title passing upon receipt and inclusive of all delivery charges, any item discounts, etc.
- Bids other than F.O.B. UL Lafayette Destination may be rejected.
- Bids indicating estimated freight charges may be rejected.
- Bids requiring deposits, payment in advance, or C.O.D. terms may be rejected.
- Bidders who do not quote "net" item prices and who separately quote an overall "lump sum" freight cost or discount for all items shall be considered as submitting an "all-or-none" bid for evaluation and award purposes; and risk rejection if award is made on an item basis.
- Prices shall be firm for acceptance for a minimum of 30 days, unless otherwise specified. Bids conditioned with shorter acceptance periods may be rejected.
- Prices are to be quoted in the unit/packaging specified (e.g. each, 12/box, etc), or may be rejected.
- In the event of extension errors, the unit price bid shall prevail.

13. Taxes

Vendor is responsible for including all applicable taxes in the bid price. UL Lafayette is exempt from all Louisiana state and local sales and use taxes. By accepting an award, resident and non-resident firms acknowledge their responsibility for the payment of all taxes duly accessed by the State of Louisiana and its political subdivisions for which they are liable, including but not limited to: franchise taxes, privilege taxes, sales taxes, use taxes, ad valorem taxes, etc.

11. Terms and Conditions

This solicitation contains all terms and conditions with respect to the purchase of the goods and/or services specified herein. Submittal of any contrary terms and conditions may cause your bid to be rejected. By signing and submitting a bid, vendor agrees that contrary terms and conditions which may be included in its bid are nullified; and agrees that this contract shall be construed in accordance with this solicitation and governed by the laws of the State of Louisiana.

12. Vendor Forms/ UL Lafayette Signature Authority

The terms and conditions of the UL Lafayette solicitation, purchase order and contract shall solely govern the purchase agreement, and shall not be amended by any vendor contract, form, etc.

The University's Vice President of Administration and Finance, chief procurement officer, or authorized designee, is delegated sole authority to execute/sign any vendor contracts, forms, etc., on behalf of UL Lafayette. Departments are expressly prohibited from signing any vendor forms.

Any such vendor contracts/forms bearing unauthorized signatures shall be null and void, shall have no legal force, and shall not be recognized by UL Lafayette in any dispute arising therefrom. Vendors who present any such forms to department users for signature without regard to this strict UL Lafayette policy may face contract cancellation, suspension, and/or debarment.

13. Awards

The intent is to award this bid on an all-or-none basis to the lowest responsible and responsive Bidder. UL Lafayette reserves the right: (1) to award items separately, grouped, or on an all-or-none basis, as deemed in its best interest; (2) to reject any or all bids and/or items; and (3) to waive any informalities.

All solicitation specifications, terms and conditions shall be made part of any subsequent award as if fully reproduced and included therein, unless specifically amended in the formal contract.

14. Acceptance of Bid

Only the issuance of an official UL Lafayette purchase order, contract, Notification of Award letter, or a Notification of Intent to Award letter shall constitute the University's acceptance of a bid. UL Lafayette shall not be responsible in any way to a vendor for goods delivered or services rendered without an official purchase order and/or contract.

15. Applicable Law

All contracts shall be construed in accordance with and governed by the laws of the State of Louisiana.

16. Awarded Products/Unauthorized Substitutions

Only those awarded brands and numbers stated in the UL Lafayette contract are approved for delivery, acceptance, and payment purposes. Any substitutions must be reviewed and approved by the UL Lafayette Office of Purchasing prior to awarding the contract. Unauthorized product substitutions are subject to rejection at time of delivery, post-return at vendor's expense, and non-payment.

17. Testing/Rejected Goods

Vendor warrants that the products furnished will be in full conformity with the specification, drawing or sample, and agrees that this warranty shall survive delivery, acceptance, and use. Any defect in any product may cause its rejection. UL Lafayette reserves the right to test products for conformance to specifications both prior to and after any award. Vendor shall bear the cost of testing if product is found to be non-compliant. All rejected goods will be held at vendor's risk and expense, and subject to vendor's prompt disposition. Unless otherwise arranged, rejected goods will be returned to the vendor freight collect.

18. Delivery

Vendor is responsible for making timely delivery in accordance with its quoted delivery terms. Vendor shall promptly notify the UL Lafayette Department and/or UL Lafayette Office of Purchasing of any unforeseen delays beyond its control. In such cases, UL Lafayette reserves the right to cancel the order and to make alternative arrangements to meet its needs.

19. Default of Vendor

Failure to deliver within the time specified in the bid/award will constitute a default and may be cause for contract cancellation. Where the University has determined the vendor to be in default, UL Lafayette reserves the right to purchase any or all goods or services covered by the contract on the open market and to surcharge the vendor with costs in excess of the contract price. Until such assessed surcharges have been paid, no subsequent bids from the defaulting vendor will be considered for award.

20. Vendor Invoices

Invoices shall reference the UL Lafayette purchase/release order number, vendor's packing list/delivery ticket number, shipping/delivery date, etc. Invoices are to be itemized and billed in accordance with the order, show the amount of any prompt payment discount, and submitted on the vendor's own invoice form. Invoices submitted by the vendor's supplier are not acceptable.

21. Delinquent Payment Penalties

Delinquent payment penalties are mandated and governed by Louisiana R.S. 39:1695. Vendor penalties to the contrary shall be null and void, shall have no legal force, and shall not be recognized by UL Lafayette in any dispute arising therefrom.

22. Assignment of Contract/Contract Proceeds

Vendor shall not assign, sublet or transfer its contractual responsibilities, or payment proceeds thereof, to another party without the prior written consent and approval of the UL Lafayette Office of Purchasing. Unauthorized assignments of contract or assignments of contract proceeds shall be null and void, shall have no legal force, and shall not be recognized by UL Lafayette in any dispute arising therefrom.

23. Contract Cancellation/Termination

UL Lafayette has the right to cancel any contract for cause, in accordance with purchasing rules and regulations, including but not limited to: (1) failure to deliver within the time specified in the contract; (2) failure of the product or service to meet specifications, conform to sample quality or to be delivered in good condition; (3) misrepresentation by the vendor; (4) fraud, collusion, conspiracy or other unlawful means of obtaining any contract with the University; (5) conflict of contract provisions with constitutional or statutory provisions of state or federal law; (6) any other breach of contract.

UL Lafayette has the right to cancel any contract for convenience at any time by giving thirty (30) days written notice to the vendor. In such cases, the vendor shall be entitled to payment for compliant deliverables in progress.

24. Prohibited Contractual Arrangements

Per Louisiana R.S. 42:1113.A, no public servant, or member of such a public servant's immediate family, or legal entity in which he has a controlling interest shall bid on or enter into any contract, subcontract, or other transaction that is under the supervision or jurisdiction of the agency of such public servant. See statute for complete law, exclusions, and provisions.

25. Equal Employment Opportunity Compliance

By submitting and signing this bid, vendor agrees to abide by the requirements of the following as applicable: Title VI and VII of the Civil Rights Act of 1964, as amended by the Equal Opportunity Act of 1972; federal Executive Order 11246; federal Rehabilitation Act of 1973, as amended; the Vietnam Era Veteran's Readjustment Assistance Act of 1974; Title IX of the Education Amendments of 1972; the Age Act of 1975; the Americans with Disabilities Act of 1990. Vendor agrees not to discriminate in its employment

practices and will render services under any contract entered into as a result of this solicitation without regard to race, color, religion, sex, age, national origin, veteran status, political affiliation, handicap, disability, or other non-merit factor. Any act of discrimination committed by vendor, or failure to comply with these statutory obligations when applicable, shall be grounds for termination of any contract entered into as a result of this solicitation.

26. Mutual Indemnification

Each party hereto agrees to indemnify, defend, and hold the other, its officers, directors, agents and employees harmless from and against any and all losses, liabilities, and claims, including reasonable attorney's fees arising out of or resulting from the willful act, fault, omission, or negligence of the indemnifying party or of its employees, contractors, or agents in performing its obligations under this agreement, provided however, that neither party hereto shall be liable to the other for any consequential damages arising out of its willful act, fault, omission, or negligence.

27. Certification of No Suspension or Debarment

By signing and submitting this bid, Bidder certifies that its company, any subcontractors, or principals thereof, are not suspended or debarred under federal or state laws or regulations. A list of parties who have been suspended or debarred by federal agencies is maintained by the General Services Administration and can be viewed on the internet at www.epls.gov.

28. Substitution of Personnel

If applicable, the University intends to include in any contract resulting from this ITB the following condition:

Substitution of Personnel: If, during the term of the contract, the Contractor or subcontractor cannot provide the personnel as proposed and requests a substitution, that substitution shall meet or exceed the requirements stated herein. A detailed resume of qualifications and justification is to be submitted to the University for approval prior to any personnel substitution. It shall be acknowledged by the Contractor that every reasonable attempt shall be made to assign the personnel listed in the Contractor's bid.

29. Insurance Requirements – Not Applicable

~~Please note insurance requirements section included in these bid specifications.~~

~~If applicable to the services procured in this solicitation, the successful Bidder will be required to furnish a certificate of insurance evidencing required coverages and naming the University of Louisiana at Lafayette as an additional insured on all liability policies~~.

30. Nonperformance

Successful Bidder is required to perform in strict accordance with all contract specifications, terms, and conditions. Successful Bidder will be advised in writing of nonperformance issues and shall be required to promptly implement corrective actions to ensure contract compliance and to prevent recurrences. In the event the successful Bidder is issued three or more complaints of nonperformance, UL Lafayette reserves the right at its sole discretion to cancel the contract with a ten (10) day written notice. Contract cancellations due to nonperformance may be cause to deem vendor non-responsible in future solicitations.

31. Official University Recognized Holidays

The following is a list of officially recognized University Holidays:

New Year's Day	July 4th
Martin Luther King Day	Labor Day
Mardi Gras Day	Thanksgiving Day
Good Friday	Acadian Day
Memorial Day	Christmas Day
Juneteenth	

32. No Smoking Campus

The Successful Bidder shall be responsible for compliance with all University policies, security measures and vehicle regulations. Specifically, the University is a NO SMOKING campus and all prospective Bidders are cautioned that smoking will not be permitted inside or outside on ANY part of this facility at any time. Any employee who is found to be in violation of this policy will be subject to immediate dismissal.

33. Non-Exclusivity

This agreement is non-exclusive and shall not in any way preclude UL Lafayette from entering into similar agreements and/or arrangements with other Vendors or from acquiring similar, equal, or like goods and/or services from other entities or sources.

34. Contract Amendments

Requests for contract changes must be made in writing by an authorized agent/signatory of the Vendor and submitted to UL Lafayette Office of Purchasing for prior approval. Requests shall include detailed justification and supporting documentation for the proposed amendment.

Contract revisions shall be effective only upon approval by UL Lafayette Office of Purchasing and issuance of a formal UL Lafayette

Contract Amendment. The Vendor shall honor purchase orders issued prior to the approval of any contract amendment as applicable.

35. Term of Contract

The duration of this Contract commences from the date specified herein or date of award notification and continues until University accepts final delivery of all deliverables. Total initial contract period not to exceed Twelve (12) months.

Based upon mutual agreement between the University and the successful Bidder, this contract may be extended for four (4) additional twelve (12) month periods. Both parties must agree to any extension, and a decision will be made at each twelve (12) month interval.

All terms of the solicitation shall be firm for the duration of Contract.

36. Notification of Fund Appropriation

The continuation of this contract is contingent upon the appropriation of funds to fulfill the requirements of the contract by the Legislature. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the contract or if such appropriation is reduced by the veto of the Governor or by any means provided in the Appropriations Act to prevent the total appropriations for the year from exceeding revenues for that year or for any lawful purpose and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

All Bidders should be aware that our Legislative process is such that it is often impossible to give prior notice of the non-appropriation of funds.

37. Number of Bid Response Copies

Each Bidder must submit one (1) signed original bid to the Office of Purchasing at the email address specified in this solicitation document. The original must CONTAIN ORIGINAL SIGNATURES of those company officials or agents duly authorized to sign on behalf of the organization. Bidders may be required to mail in the original documents upon award.

38. PROHIBITION OF DISCRIMINATORY BOYCOTTS OF ISRAEL

In accordance with LA R.S. 39:1602:1, for any contract for $100,000 or more and for any contractor with five or more employees, Contractor, or any Subcontractor, shall certify it is not engaging in a boycott of Israel, and shall, for the duration of this contract, refrain from a boycott of Israel.

The State reserves the right to terminate this contract if the Contractor, or any Subcontractor, engages in a boycott of Israel during the term of the contract.

39. PRE-BID MEETING

There will be no pre-bid meeting for this solicitation.

40. SITE VISIT/CONTACT INFORMATION

It is the responsibility of the prospective bidder to visit and examine the jobsite, take measurements to his/her own satisfaction and determine conditions under which work is to be done. Owner will not accept responsibility for conditions which careful examination of premises would have shown existed.

To visit jobsite and for further information, prospective bidder is to contact Madeline Husband at 337-482-6826.

41. PIGGY BACK CLAUSE

University of Louisiana Lafayette is asking all responding vendors to indicate their willingness to extend the terms of resulting contracts, inclusive of price, to other Louisiana state agencies and/or universities. While this clause in no way commits any state agency and/or university to purchase from the awarded vendor, nor does it guarantee any additional orders will result, it does allow state agencies and/or universities, at their discretion, to make use of the University of Louisiana at Lafayette's competitive process (provided said process satisfies their own procurement guidelines) and purchase directly from the awarded contractor. All purchases made by other state agencies and/or universities shall be understood to be transactions between that state agency and/or university and the awarded vendor. The University of Louisiana at Lafayette shall not be responsible for any such purchases.

42. Firearm and Ammunition

Prohibition of Companies That Discriminate Against Firearm and Ammunition Industries: In accordance with La. R.S. 39:1602.2, the following applies to any competitive sealed bids, competitive sealed proposals, or contract(s) with a value of $100,000 or more involving a for-profit company with at least fifty full-time employees: Unless otherwise exempted by law, by submitting a response to this solicitation or entering into this contract, the Bidder, Proposer or Contractor certifies the following:

1. The company does not have a practice, policy, guidance, or directive that discriminates against a firearm entity or firearm trade association based solely on the entity's or association's status as a firearm entity or firearm trade association;
2. The company will not discriminate against a firearm entity or firearm trade association during the term of the contract based solely on the entity's or association's status as a firearm entity or firearm trade association.

The University reserves the right to reject the response of the Bidder, Proposer or Contractor if this certification is subsequently determined to be false, and to terminate any contract awarded based on such a false response or if the certification is no longer true.

END OF SECTION

MANDATORY BID REQUIREMENTS

Failure to meet all of the listed mandatory requirements will result in rejection of bid without further consideration.

1. **CERTIFICATION STATEMENT**
   The Bidder **must** sign and include the Certification Statement as set forth in solicitation document. The signature of Bidder's Authorized Representative **must be an ORIGINAL signature -** not a typed/electronic signature. Documents signed in the DocuSign™ program are the only exceptions to this policy.

2. **BID SHEET/FORM**
   The Bidder must submit bid on the form herein provided. The bid must be signed in ink, and blank space(s) should be filled in for every applicable blank in the UNIT PRICE and EXTENDED TOTAL column. Items left blank will not be awarded to that bidder. It is not necessary to bid on all items. However, if you are not bidding on a particular item, or find a blank that is not applicable to your submission, write "NO BID" or "N/A" in the provided space(s). The Bidder must state the UNIT price (written in ink or typewritten) for each item and shall show the total amount for each item based on the quantities listed.

3. **QUALIFICATIONS OF BIDDERS:**
   The Bidder shall submit, as part of this bid, proof of the following:
   1. Evidence of successful operation in providing insurance coverage at other universities for at least the last five (5) years.
   2. Evidence of sufficient net worth to be able to meet the requirements of the plan as outlined.
   3. A list of Universities and Colleges which are served at the present time, with the number of students insured at each institution.
   4. A list of Universities and Colleges to whom bidder has provided *accident* and *sickness* insurance for *international* students.
   5. Best's Key Rating Guide rating of A- or better, which includes A, A+, and A++.
   6. Evidence the insurance company is authorized to do business in the State of Louisiana.
   7. Insurance Company Declaration", as outlined below.

DEFINITIONS

Agent - The University's representative who is referred to throughout these documents as singular in number.

Contractor - The person/company who contracts with UL Lafayette to perform the work as called for on these documents who is referred to as singular in number.

Owner – The University of Louisiana at Lafayette (UL-Lafayette)

IMPORTANT NOTE: Please submit questions to bidquestions@louisiana.edu prior to the close of business on Tuesday, May 20, 2025. If necessary, clarifications/responses to questions will be addressed via

CONTACT INFORMATION

ELECTRONIC BID SUBMISSIONS (ONLY) *Do not email questions about the bid to this email address.*

ULLafayetteBids@louisiana.edu

Be sure to include the solicitation number in the subject line.

Do not *send your submission to any other University email address.*

QUESTIONS/CONCERNS ABOUT SPECIFICATIONS

bidquestions@louisiana.edu

Do not *email bid submissions to either of these addresses.*

To contact Purchasing by phone: 337.482.1079.

END OF SECTION

IMPORTANT NOTES:

1) VENDOR BIDDING ANYTHING OTHER THAN EXACT GOODS/SERVICES SPECIFIED IN THESE SPECIFICATIONS IS TO SUBMIT DESCRIPTIVE AND ILLUSTRATIVE LITERATURE **WITH BID** FOR CONSIDERATION OF AWARD. FAILURE TO DO SO SHALL BE CAUSE FOR REJECTION OF BID.
2) ALL PRICES QUOTED ARE TO REMAIN FIRM UNTIL ALL DELIVERABLE GOODS OR SERVICES ARE RENDERED TO AND ACCEPTED BY THE UNIVERSITY OF LOUISIANA AT LAFAYETTE.
3) IN THE EVENT OF EXTENSION ERRORS, THE UNIT PRICE ON THE BID FORM SHALL PREVAIL.
4) THE UNIVERSITY OF LOUISIANA AT LAFAYETTE ADHERES TO NET 60 PAYMENT TERMS. ALL OTHER PAYMENT TERMS MUST BE DISCLOSED **WITH BID**. BE ADVISED THAT STRICTER PAYMENT TERMS MAY BE CAUSE FOR REJECTION OF BID.
5) QUANTITIES ARE APPROXIMATE AND ARE NOT GUARANTEED BY THE UNIVERSITY. THE UNIVERSITY RESERVES THE RIGHT TO INCREASE OR REDUCE QUANTITY AS NEEDED IF IN THE BEST INTEREST OF THE UNIVERSITY.
6) THE UNIVERSITY RESERVES THE RIGHT TO AWARD BID ON AN INDIVIDUAL ITEM BASIS, A COMBINATION OF ITEMS BASIS, OR AS A TOTAL PACKAGE TO ONE VENDOR, WHICHEVER IS IN THE BEST INTEREST OF THE UNIVERSITY.
7) BID SUBMISSIONS MUST DISCLOSE ALL FEES INCLUDING SHIPPING, HANDLING, FREIGHT, FUEL SURCHARGES, TARIFFS, ETC. NO ADDITIONAL FEES WILL BE ACCEPTED AFTER AWARD.
8) FAILURE TO COMPLY WITH ANY MANDATORY REQUIREMENTS SHALL BE CAUSE FOR REJECTION OF BID.
9) AUDITS - THE UNIVERSITY RESERVES THE RIGHT TO HAVE REPRESENTATIVES OF THE UNIVERSITY AND/OR THE STATE INSPECT THE RECORDS MAINTAINED BY THE CONTRACTOR CONCERNING THE PRODUCTS AND SERVICES DESCRIBED HEREIN.

The University of Louisiana at Lafayette is a tax exempt State Agency. Vendor is responsible for including all applicable taxes in the bid price. UL-Lafayette is exempt from all Louisiana state and local sales and use taxes. Resident and non-resident firms acknowledge their responsibility for the payment of all taxes duly accessed by the State of Louisiana and its political subdivisions for which they are liable, including but not limited to: franchise taxes, privilege taxes, sales taxes, use taxes, ad valorem taxes, and etcetera.

ADDITIONAL COVERAGE NEGOTIATIONS:

In the event that there is a multiyear contract the Universities may choose to negotiate additional coverage with the successful vendor before February 1st of the renewal year. These negotiations may be discussed between a University representatives and the successful vendor but will require final approval of the President.

REJECTION OF BIDS:

The participating University of Louisiana campuses reserve the right to reject any and all bids and to waive any informalities incident thereto.

NO BIDS MAY BE WITHDRAWN AFTER OPENING HOUR AND DATE AS SHOWN ON COVER PAGE. BIDS MAY BE REJECTED IF ALL PAPERS ARE NOT INCLUDED, SUCH AS THE BID SHEETS, INSTRUCTIONS TO BIDDERS, CONDITIONS, SPECIFICATIONS, SCHEDULE OF ITEMS, ETC.

END OF SECTION

DETAILED SPECIFICATIONS

THE PURPOSE OF THIS SOLICITATION IS TO ESTABLISH A CONTRACT FOR SICKNESS AND ACCIDENT GROUP INSURANCE PLAN FOR INTERNATIONAL STUDENTS AT THE PARTICIPATING UNIVERSITY OF LOUISIANA CAMPUSES AS SHOWN IN THESE SPECIFICATIONS, AUGUST 18, 2025 FOR ONE (1) CALENDAR YEAR, WITH THE OPTION TO RENEW FOR UP TO FOUR (4) ADDITIONAL TWELVE-MONTH PERIODS.

BACKGROUND:

In the interest of premium and claim stabilization going forward, the participating University of Louisiana System campuses are beginning a consortium to have one student health insurance plan for the 25-26 school year. University of Louisiana at Lafayette used Wellfleet insurance to provide a student health plan for their international students. University of Louisiana Monroe has not had an ACA compliant student health plan in place in the past. As such, the attached claim and enrollment data should be viewed in the context. The intent of the consortium is to unify under the current University of Louisiana at Lafayette plan going forward with its plan benefits and eligibility requirements.

OBJECTIVE:

To provide medical and accidental insurance coverage that meets the requirements as set by the Federal Health Care legislation for the *international students (mandatory)* of the University of Louisiana System schools listed below beginning **August 18, 2025.**

BASE BID 1A

BASE BID 1A: SICKNESS and ACCIDENTAL INSURANCE, meeting Affordable Care Act Specifications

For a one (1) year period from **August 18, 2025 through August 17, 2026**

THE CAMPUSES THAT ARE PARTICIPATING IN THIS INVITATION TO BID INCLUDE THE FOLLOWING:

- University of Louisiana at Lafayette
- University of Louisiana Monroe

PRICES QUOTED ARE TO REMAIN FIRM FOR ONE (1) FULL YEAR AFTER AWARD.

Based upon mutual agreement between the Universities and the successful bidder, this contract may be extended for four (4) additional twelve (12) month periods. Both parties must agree to any extension, and the decision must be made by February 1st of renewal year.

MANDATED FOR F-1 INTERNATIONAL STUDENTS WITH HARD WAIVER, AVAILABLE FOR J-1 EXCHANGE VISITORS

METHOD OF ENROLLMENT:

The University will be the collecting agent at registration. The method of enrollment of each student in the group insurance plan will be as follows:

All *F-1 – non-immigrant graduate and undergraduate international students and non F-1 Intensive English students (IEP)*, regardless of the number of hours enrolled, will be assessed in their tuition through the *International Student Insurance Fees*. Students enrolled for the preceding semester will be covered by the policy during the semester break if the student registers for the following semester. Students registering in the

spring and planning to continue in the fall will be considered a continuing student; in order to keep the policy enforced, they must pay the summer premiums.

HARD WAIVER: Each semester a refund will be considered for those international students with documented insurance coverage by their Sponsors that meet the requirements as set by ACA.

All J-1 International Exchange Visitors will be offered coverage under this policy as these benefits will surpass the current compliance requirements.

GENERAL STUDENT COVERAGE:

BASE BID 1A will provide protection to cover registered F-1 non-immigrant international students, non F-1 Intensive English (IEP) students and the J-1Exchange Visitors. Dependents will not be eligible for the 25-26 school year plan. The participating students of the University of Louisiana System Campuses will be covered at home, school, or while traveling for twenty-four (24) hours a day throughout the school year, provided (s)he is enrolled on a continuous basis, with the following exception:

Coverage shall be on a *continuous basis* commencing approximately three (3) days prior to the opening of the fall semester (see proposed semester coverage dates) and ending at the close of the third day after the end of the summer semester. The coverage is to be in effect during the interim semester break periods. The current Master Policy became **effective at 12:01a.m. August 18, 2024 and will terminate at 11:59p.m. August 17, 2025.**

Effective and termination date on a *non-continuous basis* include six (6) days travel time to school and six (6) days travel time returning from school. Protection is to be in effect during all interim vacation and holiday periods during semester.

Coverage will become invalid for students who voluntarily leave school *within* thirty-one (31) days of their effective date of coverage.

Coverage will remain in effect for the applicable semester if a student leaves *after* the thirty-one (31) days of coverage, unless the insured student enters a military service, in which case coverage would terminate upon such entrance. If an insured student would enter the armed forces, the Company will make a pro-rata refund or premium.

In the event a student should resign before the end of the semester as a result of an accident or illness, (s)he will continue to receive benefits for the particular illness / injury until the treatment is completed, or has received payment of the maximum limits, or the time of the policy has expired, whichever comes first.

When the covered Injury or Sickness requires treatment by a Physician, this Policy will provide benefits for 52 weeks from the date of the Injury or the date of first treatment of a Sickness, for the Preferred Allowance (PA) or Usual and Customary Charges (U&C) scheduled below.

DEPENDENT COVERAGE:

Dependents will not be eligible for the student health insurance plan.

BROKER FEES:

All rates must include annual agent commission fees of $120 per student (with individual coverage periods having their respective percentage of fees included as well) to Student Assurance Services, Inc.

COVERAGE, ENROLLMENT, AND WAIVER DATES:

Each participating University of Louisiana Campus will have their own date-specific dates for coverage periods and eligibility classes. Attached is the proposed dates for each campus.

INSURANCE COMPANY DECLARATION:

Please reply to the following. All items must be answered, and all forms requested must be submitted with bid.

1. Name of insurance company.
2. Insurance company's address.
3. Insurance company's telephone number, toll free and/or collect.
4. Best's policyholder's rating.
5. Best's financial size category classification.
6. List of each university or college insured during previous school year and attach a separate form listing the name for each university or college; approximate premium volume for each university or college; and the name and title of the administrator at each school responsible for the student health program. Denote those schools, which have been insured for three (3) years or more. Individual schools may be contacted.
7. If the insurance company is paying claims, please provide/answer the following:
    a. List the location of the office where claims will be paid;
    b. List the name, title, telephone number, and years of experience in administering student claims, of the persons responsible for the claim service;
    c. List toll free number or a number that can be used to call collect by the University in reference to any claim, questions, or problems;
    d. Will claims' office provide copies of all claims status to the University?
    e. Will claims' office provide information on all claims rejected and the reason(s) for the rejection?
    f. What is the average time for a claim to be processed after the date the insurance company receives it?
8. What are the insurance company's procedures in processing claims when notice of claim is submitted beyond the policy time limit?
9. What are the insurance company's procedures in processing claims when written proof of loss is submitted more than ninety (90) days after the date of such loss?
10. Will the insurance company furnish the school with a monthly listing of all claims paid, including:
    a. Claim
    b. Insured's name
    c. Date of claim incurred
    d. Date of claim paid
    e. Amount of claim
    f. Company paid
11. Provide copies of all claim forms necessary for payment of claims, for both *sickness* and *accident*, in the form of a 'hard copy' to be made available to the Insurance Office at the Student Health Service, and to have the availability of 'on line' access with either providing claim forms or submittal of claim forms.

REPORTING TO THE UNIVERSITY:

Upon request the Company shall report to the University in a manner acceptable to the University a "Statement of Experience" details on any claim received by the Company. These details shall include:

1. Data that would be found in an Explanation of Benefits (EOB), which includes:
    a. Date of receipt of claim.
    b. Amount being claimed itemized by each vendor.
    c. Any payments made, and where differences of amount claimed, and payments made to be clearly indicated.
2. Data that would be needed to evaluate plan and to generate a 'loss ratio'.
    a. General information to include:
        i. Total number of students enrolled per semester
        ii. Enrollment by age
        iii. Total amount of premium paid to Insurance Company
        iv. Total Benefits paid by Diagnosis, by listing in columns
            1. Diagnosis group
            2. Dollar amount of Benefits paid
            3. % of total
        v. Total Benefits paid by Benefit Group, by listing in columns
            1. Benefit Groups
                a. Accidental Death and Dismemberment
                b. Medical evacuation and repatriation
                c. Accident
                d. Maternity
                e. Mental Health
                f. Motor Vehicle
                g. Sickness
                h. Wellness
            2. Dollar amount of Benefits paid
            3. % of total
        vi. List the 25 largest providers by the dollar amount paid, by listing in columns
            1. Provider name
            2. Number of claims
            3. Dollar amount paid
        vii. Claims arranged by size by listing in columns:
            1. Number of claims
            2. Category
                a. Claims pending
                b. No benefits
                c. $1 – 1,000
                d. $1001 – 5,000
                e. $5001 – 15,000
                f. $15,001 – 25,000
                g. >$25,001
            3. Dollar amount paid
    b. Experience data must be in such detail to indicate what is included in the phrase 'loss ratio' and be itemized to report all claims whether incurred or pending and any provision for incurred but not reported, claims paid and any administrative or overhead which is included in the 'loss ratio', a monthly breakdown of claims, by listing in columns:

i. Policy month / year
ii. Actual premium paid YTD
iii. Total projected premium
iv. Claims paid YTD
v. Claims 'Incurred But Not Reported' YTD
vi. Expense Factor
vii. Total Claims paid and expenses
viii. % Total Claims and expenses to Total projected premium

3. The Company shall have printed, at their expense, a brochure which explains to the students the extent of the coverage of this policy. A sample of current brochure can be viewed at the following link: **The current brochure is for reference only; all information in the bid is to be the primary source of information.** The layout and contents of this brochure must be approved by the University so as to ensure that all pertinent data is included. This brochure is to be made available to the Insurance office at the Student Health Service as soon as feasible of the bid year and in the case of a multiyear bid, by February 15th each year thereafter. The Company is to provide 250 brochures. This brochure should also be available by linking from the SHS website to the Vendor's website.

4. The Company will provide a toll-free line or accept collect calls from the University of Louisiana at Lafayette representative and/or students in reference to claims, invoicing, payments or other problems or questions concerning this contract, for the life of the contract.

BASE BID 1B

BASE BID 1B: SICKNESS and ACCIDENTAL INSURANCE, meeting Affordable Care Act Specifications

Specifications Includes all of the coverage specified in the base bid with the following exceptions:

- **Deductible from $0 to $100**
- **Out-of-Pocket Expense from $1,500 to $3,000**

MANDATED FOR F-1 INTERNATIONAL (GRADUATE, UNDERGRADUATE AND INTENSIVE ENGLISH PROGRAM) STUDENTS WITH HARD WAIVER, AVAILABLE FOR J-1 EXCHANGE VISITOR

For a one (1) year period from **August 18, 2025 through August 17, 2026**

BASE BID 1C

BASE BID 1C: SICKNESS and ACCIDENTAL INSURANCE, meeting Affordable Care Act Specifications

Specifications Includes all of the coverage specified in the base bid with the following exceptions:

- **Deductible from $0 to $500**
- **Out-of-Pocket Expense from $1,500 to $3000 (no more than $5000)**

MANDATED FOR F-1 INTERNATIONAL (GRADUATE, UNDERGRADUATE AND INTENSIVE ENGLISH PROGRAM) STUDENTS WITH HARD WAIVER, AVAILABLE FOR J-1 EXCHANGE VISITOR

For a one (1) year period from **August 18, 2025 through August 17, 2026**

ALTERNATE BID

ALTERNATE BID:

Bidder may choose to submit an Alternate bid for coverage. The alternate bid must be equal or better than the stated bids in this bid. Vendor is to submit complete benefits package information for all alternate bids with bid package. The University reserves the right to reject or consider same in awarding contract.

BID SHEET

I/WE PURPOSE TO ESTABLISH A CONTRACT FOR SICKNESS AND ACCIDENT GROUP INSURANCE PLAN FOR INTERNATIONAL STUDENTS AT THE PARTICIPATING UNIVERSITY OF LOUISIANA CAMPUSES AS SHOWN IN THESE SPECIFICATIONS, IN STRICT ACCORDANCE WITH THE REQUIREMENTS IN THESE BID SPECIFICATIONS FOR THE FOLLOWING SUM…

INTERNATIONAL STUDENT SICKNESS AND ACCIDENTAL INSURANCE		BASE BID - 1A	BASE BID - 1B Deductible $0-$100 Out of Pocket $1500-$3000	BASE BID - 1C Deductible $0-$500 Out of Pocket $1500-$3000 (no more than $5000)
STUDENT COVERAGE	FALL			
	SPRING			
	SUMMER			
ALTERNATE 1				
STUDENT COVERAGE	FALL			
	SPRING			
	SUMMER			
	FALL			
	SPRING/SUMMER			

PRICES SUBMITTED FOR THIS BID ARE TO REMAIN FIRM FOR ONE (1) FULL YEAR AFTER AWARD.

Payment terms: NET 60

PAYMENT OF TAXES

The University of Louisiana at Lafayette is exempt from all Louisiana state and local sales and use taxes and will not pay taxes delineated on invoices for this or any other project.

BID SUBMISSION DEADLINE:
Bid submissions for this solicitation are **due on Tuesday, May 27, 2025 at 2:00PM CST** – must be received electronically at ULLafayetteBids@louisiana.edu. There are no exceptions to this deadline.

BID OPENING:
The public bid opening will take place on **Tuesday, May 27, 2025 at 3:00PM CST on Zoom**, which is available for viewing by registering at:
https://ullafayette.zoom.us/meeting/register/JcjHmYeDTLG31E_4ZMynLw

ZOOM MEETING ID: 979 3218 8188 **PASSWORD: 25032**

Opening of the bid submissions begins at five (5) minutes past the hour.

For further information about the bid or to view job/delivery site, prospective bidder is to email, *bidquestions@louisiana.edu.*

***In lieu of a certificate of insurance the following information will be accepted review until bid is awarded.**

Policy number	Name(s) and address(es) Carrier(s) and Agent(s)	Amount(s) of coverage	Type(s) of coverage	Effective date(s)

When applicable, the actual certificate of insurance shall be due from the successful bidder within ten (10) days of request.

ADDENDA ACKNOWLEDGEMENT(S)

BIDDER ACKNOWLEDGES RECEIPT OF THE FOLLOWING ADDENDA (if applicable):

ADDENDUM NO. _____ DATED: _____

ADDENDUM NO. _____ DATED: _____

ADDENDUM NO. _____ DATED: _____

FIRM NAME _____

SIGNED BY (signature)_____

SIGNED BY (printed) _____

By submitting your bid, you are acknowledging that you understand and agree that your company is capable of supplying the products/services in the timeline you have provided for the price(s) submitted in your bid.

The University of Louisiana at Lafayette reserves the right to reject any or all bids submitted.

BID AWARD: The University reserves the right to award proposal on an individual item basis, a combination of items basis, or as a total package to one vendor, whichever is in the best interest of the University. Quantities are approximate and are not guaranteed by the University. The University reserves the right to *increase or reduce* quantity as needed if in the best interest of the University.

Bidder's comments: _____

_____

_____

CERTIFICATION STATEMENT

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Invitation to Bid (ITB), including any attachments.

OFFICIAL CONTACT. The University requests that the Bidder designate one person to receive all documents and the method in which the documents are best delivered. Identify the Contact name and fill in the information below: (Print Clearly)

Date _____ Official Contact Name: _____

A. E-mail Address: _____

B. Telephone Number with area code: ( ) _____

C. Facsimile Number with area code: ( ) _____

Bidder certifies that the above information is true and grants permission to the University to contact the above named person or otherwise verify the information provided. By its submission of this Proposal and authorized signature below, Bidder certifies that:

1. The information contained in its response to this ITB is accurate;
2. Bidder complies with each of the mandatory requirements listed in the ITB and will meet or exceed the requirements specified therein;
3. Bidder agrees to provide all tasks, services, and deliverables listed in Scope of Services for the total cost stated on Bid Form;
4. Bidder accepts the procedures, evaluation criteria, mandatory contract terms, and all other administrative requirements set forth in this ITB.
5. Bidder confirms that its bid will be considered valid until award is made.
6. In making this bid, each Bidder represents that: They have read and understand the bid documents and the bid is made in accordance herewith, and the bid is based upon the specifications described in the bid documents without exception.
7. Bidder certifies, by signing and submitting a proposal for $25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in OMB Circular A-133. (A list of parties who have been suspended or debarred can be viewed via the internet at www.epls.gov .)

Professional Job Title: _____

Official Company Name: _____

Federal Identification Number. _____

Street Address: _____

City: _____ State: _____ Zip: _____

SIGNATURE of Bidder's Authorized Representative: _____

(Signature MUST be HAND SIGNED and should be in Blue ink)

Date: _____

ATTACHED EXHIBITS

Exhibit 1: Individual Campus Information
(Location, Enrollment, Etc.)

Exhibit 2: Current Year Summary, Policy and Certificate
(UL at Lafayette)

- Assist America Travel Assistance

Exhibit 3: 3-Year Claim and Premium History

Exhibit 4: High Claimants

Exhibit 5: Top 25 Providers

Exhibit 6: Student Assurance Services Role

EXHIBIT 1: Individual Campus Information (Location, Enrollment, Etc.)

LAFAYETTE CAMPUS INFORMATION: The following data is obtained from previous and our current policy. All information pertaining to numbers of insured is supplied for the use of the bidder as an aid in preparing a bid but should in no way be considered a guarantee on the part of the University.

LAFAYETTE CAMPUS LOCATION:

104 E. University Circle

Lafayette, LA 70503

LAFAYETTE STUDENT HEALTH CENTER LOCATION:

Saucier Wellness Center

220 Hebrard Blvd

Lafayette, LA 70503

LAFAYETTE DATES OF SEMESTERS

Coverage shall be on a continuous basis commencing three (3) days prior to the opening of the Fall semester and ending at the close of the third day after the end of the Summer semester.

Fall 2025	August 25, 2025 - December 12,2025
Spring 2026	January 14, 2026 - May 8, 2026
Summer 2026	June 8, 2026 - July 31, 2026
Fall 2026	August 24, 2026 – December 11, 2026
Spring 2027	January 13, 2027 – May 7, 2027
Summer 2027	June 7, 2027 – July 30, 2027
Fall 2027	August 23, 2027 – December 10, 2027
Spring 2028	January 12, 2028 – May 5, 2028
Summer 2028	June 5, 2028 – July 28, 2028

LAFAYETTE CAMPUS INTENSIVE ENGLISH PROGRAM (IEP)

Coverage shall begin 3 days prior to the start of the IEP session and end at the close of the third day following the end of the session.

Session	Session Dates
Fall I 2025	August 15 – October 10
Fall II 2025	October 17 – December 12
Spring I 2026	January 9 – March 13
Spring II 2026	March 20 – May 22
Summer 2026	June 5 – July 31
Fall I 2026	August 14 – October 9
Fall II 2026	October 16 – December 11

Spring I 2027	January 8 – March 12
Spring II 2027	March 13 – May 21
Summer 2027	June 4 – July 30
Fall I 2027	August 13 – October 8
Fall II 2027	October 15 - December 10
Spring I 2028	January 7 – March 10
Spring II 2028	March 17 – May 19
Summer 2028	June 2 – July 28
Fall I 2028	August 11 – October 6
Fall II 2028	October 13 – December 8

LAFAYETTE STUDENT HEALTH SERVICE

DESCRIPTION OF SERVICES

- Performs 'in-house' CLIA waived lab, minor procedures and administers IV fluids
- Collects specimens and pays an external lab monthly for all lab services
- Collects for services
  - Cash payment
  - File claims for lab charges with the students primary and then secondary insurance carrier for reimbursement

STUDENT HEALTH SERVICE BENEFITS

- To write on brochure: **various services may be provided, please inquire at the Student Health Service**.
- A list of those services that will be provided or can be viewed on our website

External lab – SHS collects specimens and pays an external laboratory monthly for all lab services. SHS then files claims for lab charges with the student's insurance carrier for reimbursement.

LAFAYETTE CAMPUS ENROLLMENT HISTORY:

International Students	(Number on campus)	Fall	Spring	Summer
2021-2022		632	586	
2022-2023				
2023-2024				
2024-2025				

International Students	(Enrolled in SHIP)	Fall	Spring	Summer
2021-2022		403	386	81
2022-2023		464	408	105
2023-2024		455	425	76
2024-2025		495		

IEP: (Enrolled in SHIP)	
FALL 1 2021	3

FALL 2 2021	4
SPRING 1 2022	7
SPRING 2 2022	6
SUMMER 2022	7
FALL 1 2022	3
FALL 2 2022	4
SPRING 1 2023	4
SPRING 2 2023	0
SUMMER 2023	0
FALL 1 2023	1
FALL 2 2023	5
SPRING 1 2024	2
SPRING 2 2024	1
SUMMER 2024	5
FALL 1 2024	5
FALL 2 2024	6

MONROE CAMPUS INFORMATION: The following data is obtained from previous and our current policy. All information pertaining to numbers of insured is supplied for the use of the bidder as an aid in preparing a bid but should in no way be considered a guarantee on the part of the University.

MONROE CAMPUS LOCATION:

700 University Ave.

Monroe, LA 71209

MONROE STUDENT HEALTH CENTER LOCATION:

ULM Health Clinic (Managed by Affinity Health Group, L.L.C. in Partnership with UL Monroe)

1140 University Avenue

Monroe, LA 71209

MONROE DATES OF SEMESTERS

Coverage shall be on a continuous basis commencing three (3) days prior to the opening of the Fall semester and ending at the close of the third day after the end of the Summer semester.

Fall 2025	August 18 – December 9, 2025
Spring 2026	January 20 – May 12, 2026
Summer 2026	June 1 – August 3, 2026

MONROE STUDENT HEALTH SERVICE

DESCRIPTION OF SERVICES

STUDENT HEALTH SERVICE BENEFITS

- To write on brochure: **various services may be provided, please inquire at the Student Health Service**.
- A list of those services that will be provided.

MONROE CAMPUS ENROLLMENT HISTORY:

International Students	(Number on campus)	Fall	Spring	Summer
2021-2022		363	281	
2022-2023		366	344	
2023-2024		495	401	
2024-2025				

International Students	(Enrolled in SHIP)	Fall	Spring	Summer
2021-2022				
2022-2023				
2023-2024				
2024-2025				

IEP: (Enrolled in SHIP)	
FALL 1 2021	
FALL 2 2021	
SPRING 1 2022	
SPRING 2 2022	
SUMMER 2022	
FALL 1 2022	
FALL 2 2022	
SPRING 1 2023	
SPRING 2 2023	
SUMMER 2023	
FALL 1 2023	
FALL 2 2023	
SPRING 1 2024	
SPRING 2 2024	
SUMMER 2024	

Exhibit 2: Current Year Summary, Policy and Certificate (UL-Lafayette)

LAFAYETTE PLAN DOCUMENTS: The following data is obtained from previous and our current policy. All information pertaining to numbers of insured is supplied for the use of the bidder as an aid in preparing a bid but should in no way be considered a guarantee on the part of the University.

ATTACHMENTS:

- 2022-23 Plan Summary
- 2023-24 Plan Summary
- 2024-25 Plan Summary
- 2024-25 Plan Certificate

Exhibit 3: 3-Year Claim and Premium History

LAFAYETTE CLAIM HISTORY: The following data is obtained from previous and our current policy. All information pertaining to numbers of insured is supplied for the use of the bidder as an aid in preparing a bid but should in no way be considered a guarantee on the part of the University.

	Premium	Paid	Loss Ratio
2021-22	$607,851	$598,968	98.54%
2022-23	$699,784	$549,134	78.47%
2023-24	$689,826	$436,319	63.25%

Exhibit 4: High Claimants

LAFAYETTE CLAIM HISTORY: The following data is obtained from previous and our current policy. All information pertaining to numbers of insured is supplied for the use of the bidder as an aid in preparing a bid but should in no way be considered a guarantee on the part of the University.

Claimants Exceeding $50,000 in Paid Claims

Year	Masked ID	Highest Paid Diagnosis	Relationship	Grand Total	Inpatient Amount	Outpatient Amount	RX Amount
2021	000151162038	PRESCRIPTION DRUGS	Member	$66,199		$54	$66,145
	000173610100	HB-SS DISEASE WITH CRISIS, UNSPECIFIED	Member	$70,418	$47,064	$14,007	$9,346
	000197479491	ABNLT IN FETAL HEART RATE AND RHYTHM COMP LABOR AND ..	Member	$54,641	$41,002	$12,171	$1,467
	Total			$191,257	$88,067	$26,232	$76,958
2022	000151147660	SPINAL STENOSIS, LUMBAR REGION WITH NEUROGENIC CLAUD..	Member	$69,534	$57,750	$8,971	$2,813
	000194502790	CEREBRAL ANEURYSM, NONRUPTURED	Member	$102,720	$8,902	$92,242	$1,576
	Total			$172,254	$66,652	$101,213	$4,389
2023	000151162038	PRESCRIPTION DRUGS	Member	$62,248		$1,330	$60,918
	Total			$62,248		$1,330	$60,918
Grand Total				$425,759	$154,719	$128,775	$142,265

Exhibit 5: Top 20 Providers

LAFAYETTE CLAIM HISTORY: The following data is obtained from previous and our current policy. All information pertaining to numbers of insured is supplied for the use of the bidder as an aid in preparing a bid but should in no way be considered a guarantee on the part of the University.

Subset Labels	Provider	Paid	Claimants	Services	Running Total
Top 20 Providers	OUR LADY OF LOURDES RMC INC	$283,785	90	440	$283,785
	LAFAYETTE GENERAL MED CTR	$282,537	58	886	$566,321
	UNIV OF LOUISIANA AT LAFAYETTE	$55,434	369	2,451	$621,755
	PARK PLACE SURGICAL HOSPITAL	$40,933	9	92	$662,688
	UNIVERSITY HOSPITAL AND CLINIC	$37,890	64	614	$700,578
	LOUISIANA ORTHOPAEDIC SPECIAL	$32,210	30	424	$732,789
	SOUTHWEST LOUISIANA HOSP ASS..	$30,516	1	20	$763,304
	ACADIANA WOMEN HEALTH GROUP	$25,283	25	123	$788,587
	AMERICAN SPECIALTY PHYSICAL ME	$23,618	32	718	$812,205
	CARDIOVASCULAR INSTITUTE OF	$23,034	19	132	$835,239
	COOLIDGE EMERGENCY GROUP LLC	$18,677	27	47	$853,916
	MEDSOLUTIONS INC	$18,555	34	69	$872,471
	OCHSNER CLINIC LLC NO	$18,197	6	58	$890,668
	LABORATORY CORP OF AMERICA	$15,933	80	682	$906,601
	ACADIANA ACUTE CARE ASSOCIATES	$12,838	17	25	$919,440
	LAFAYETTE SURGICAL SPECIALTY H	$12,382	2	38	$931,822
	ACADIAN AMBULANCE	$11,933	7	31	$943,755
	SOUTHERN OBGYN LLC	$11,444	8	60	$955,198
	PREFERRED ANATOMIC PATHOLOG..	$9,500	44	303	$964,699
	LHVI DBA CARDIO SERVICES	$9,218	23	70	$973,916

Exhibit 6: Student Assurance Services Role and Current Fee Table

ADMINISTRATIVE SERVICES PROVIDED BY STUDENT ASSURANCE SERVICES (SAS)

ENROLLMENT:

- SAS maintains a secure file transfer system to accept enrollment files directly from individual schools. The file transfer system data is also regularly backed up at a secure off-site facility.
- The enrollment files submitted to the SAS FTP site are reviewed for compliance with the carrier's required file layout, then the file is uploaded to the carrier's secured eligibility system.
- SAS works with individual campuses to finalize the student rosters and records roster changes that are uploaded to SAS FTP site or communicated by email. All enrollment changes are uploaded to the carrier's eligibility system.
- SAS provides support to the carrier's enrollment department for queries concerning a student's enrollment data or eligibility.
- SAS audits the carrier's enrollment roster with the enrollment on SAS's internal system each coverage term. SAS works with the carrier or the individual campus to resolve any enrollment discrepancies.

INVOICING:

- SAS prepares an invoice for payment for each individual school, including separate invoices for satellite campuses, for the specific coverage term (such as Fall or Spring/summer) based on the enrollment roster received. Invoices are emailed to each individual campus. Note, that invoicing is done once the campus confirms the enrollment roster is complete or finalized for the coverage term.
- For some individual campuses SAS prepares separate invoices for scholars, special visiting groups, etc. and forwards the invoice for the campus for payment.
- SAS collects enrollment forms and premium payment for OPT students or students with qualifying events.
- SAS responds to campus questions concerning the invoice or revises the invoice due to any enrollment changes made by the campus.
- SAS follows up with individual campuses on any outstanding invoices over 30 days old.

PREMIUM REPORTING AND FEE ACCOUNTING:

- SAS processes all premium payments received from individual campuses or directly from students/scholars.
- On monthly basis, SAS pays the carrier for premium paid and provides the carrier with an accounting report.

CUSTOMER SERVICE – ACCOUNT MANAGEMENT

- SAS is the first-line customer service to campus administrators and insured students/scholars for queries concerning student eligibility, enrollment instructions, ID cards, preferred provider lookups, and general plan information.
- SAS is a liaison between the campus administrator and the carrier assigned account manager when SAS must refer a question concerning claims, eligibility or enrollment to assist in timely responses and resolution.
- SAS requests coverage term dates and other information needed for plan implementation from individual campuses. This plan implementation information is provided to the carrier upon renewals.
- SAS drafts the plan summary and calculates the premium rates for each individual campus. Coordinates the review process with the carrier so the plan summary can be finalized and posted online.

University of Louisiana at Lafayette
2024-2025 Student Health Plan
for International Students and Scholars
Group No: ST0312SH
Policy No: WI2425LASHIP51

Dear International Students and Scholars:
We are pleased to provide you with this summary of the Student Health Plan for University of Louisiana at Lafayette. This plan is fully compliant with the Affordable Care Act.

Who is Eligible to Enroll?
All registered F-1 non-immigrant graduate, undergraduate, Intensive English Program (IEP) students taking 1 or more credit hours and J-1 exchange visitors are eligible to enroll in this plan. Dependents of eligible students are **NOT** eligible to enroll.

How Do I Enroll?
All registered F-1 non-immigrant graduate, undergraduate, and Intensive English Program (IEP) students are automatically enrolled in this insurance plan at registration, and premium is added to your tuition and fees, unless you waive coverage.

J-1 exchange visitors may enroll on a voluntary basis by enrollment period deadline dates.

How Do I Waive Coverage?
F-1 non-immigrant graduate, undergraduate, and Intensive English Program (IEP) students can waive coverage by providing proof of other comparable medical insurance coverage.

Go to website www.wellfleetstudent.com and complete the online waiver form by the waiver period deadline dates below.

Waiver/Enrollment Period Deadline Dates	
Fall	September 18, 2024
Spring	February 9, 2025
Summer	June 29, 2025

Cost & Periods of Coverage			
	Fall 8/18/24 to 1/8/25	Spring 1/9/25 to 5/28/25	Summer 5/29/25 to 8/17/25
Student	$916	$893	$538

The above rates include an administrative fee. Dependent rates are in addition to student rate.

HEALTH INSURANCE BENEFIT SUMMARY FOR COVERED MEDICAL EXPENSES* UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE (IF APPLICABLE) WILL ALWAYS APPLY.		
BENEFIT	**IN-NETWORK**	**OUT OF NETWORK**
Policy Year Deductible	$0 Individual	$0 individual
Out-of-Pocket Maximum	$1,500 Individual	$6,000 Individual
Coinsurance	100% of NC**	80% of U&C**
Student Health Center	100% of U&C for Covered Medical Services	
Preventive Care	100% of NC (no cost sharing)	80% of U&C
Hospital Room & Board (Inpatient)	100% of NC	80% of U&C
Surgery (Inpatient or Outpatient)	100% of NC	80% of U&C
Physician Office Visits OR Consultant/Specialist	$15 copay per visit then plan pays 100% of NC	80% of U&C
Emergency Services Expense (copay waived if admitted)	$100 copay per visit then plan pays 100% of NC	Paid the same as In-Network, provider subject to U&C
Urgent Care Centers	$25 copay per visit then plan pays 100% of NC	80% of U&C
Imaging Services & Laboratory Procedures (Outpatient)	100% of NC	80% of U&C
Outpatient Prescription Drugs (Copay per drug; copay per 30-day supply)	**Generic**: $15 copay **Preferred Brand:** $30 copay **Non-Preferred Brand:** $50 copay **Specialty**: $50 copay then the plan pays 100% of NC	Not Covered
Mental Health & Substance Use Disorder (Outpatient)	100% of NC	80% of U&C
**NC= Negotiated Charge for Covered Medical Expenses **U&C=Usual and Customary for Covered Medical Expenses		
*This is only a brief description of the coverage(s) available under Certificate form LA SHIP CERT (2023). The Certificate will contain the reductions, limitations, exclusions and termination provisions. Full details of coverage are contained in the Certificate. If there are any conflicts between this document and the Certificate, the Certificate shall govern in all cases.		
Pre-certification is required for inpatient hospital, surgery and selected outpatient services. 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.		

Underwritten By:
Wellfleet Insurance Company

Plan Administrator:
Wellfleet Group, LLC
P.O. Box 15369
Springfield, MA 01115
www.wellfleetstudent.com
(877) 657-5030

Servicing Agent:
Student Assurance Services, Inc.
P.O. Box 196
Stillwater, MN 55082
(800) 328-2739
ryand@sas-mn.com

Where Can I Obtain more Information about the Plan?	
Waive Coverage	Wellfleet Group, LLC www.wellfleetstudent.com
Enroll in the plan as J-1 Visitor or Enroll my F-2/J-2 Dependents	Wellfleet Group, LLC www.wellfleetstudent.com
Insurance Benefits Claim Processing ID Cards	Wellfleet Group, LLC (877) 657-5030 www.wellfleetstudent.com Email: customerservice@wellfeetinsurance.com
Find Network Provider	Wellfleet Student or Cigna www.cigna.com (877) 657-5030
Find Prescription Drug Provider	Wellfleet RX Pharmacy Network www.wellfleetstudent.com

The following Value-Added Services are not part of the Policy and are not underwritten by Wellfleet Insurance Company. The services are provided by Independent vendors and are included if the student participates in the student health plan.

- Vision discount program through Davis Vision
- Medical travel assistance through Assist America
- 24-hour nurse line
- 24-hour Teladoc Behavioral Health

University of Louisiana at Lafayette
2023-2024 Student Health Plan
for International Students and Scholars
Group No: ST0312SH
Policy No: WI2324LASHIP51

Dear International Students and Scholars:
We are pleased to provide you with this summary of the Student Health Plan for University of Louisiana at Lafayette. This plan is fully compliant with the Affordable Care Act.

Who is Eligible to Enroll?
All registered F-1 non-immigrant graduate, undergraduate, Intensive English Program (IEP) students taking 1 or more credit hours and J-1 exchange visitors are eligible to enroll in this plan. Dependents of eligible students are **NOT** eligible to enroll.

How Do I Enroll?
All registered F-1 non-immigrant graduate, undergraduate, and Intensive English Program (IEP) students are automatically enrolled in this insurance plan at registration, and premium is added to your tuition and fees, unless you waive coverage.

J-1 exchange visitors may enroll on a voluntary basis by enrollment period deadline dates.

How Do I Waive Coverage?
F-1 non-immigrant graduate, undergraduate, and Intensive English Program (IEP) students can waive coverage by providing proof of other comparable medical insurance coverage.

Go to website www.wellfleetstudent.com and complete the online waiver form by the waiver period deadline dates below.

Waiver/Enrollment Period Deadline Dates	
Fall	September 18, 2023
Spring	February 9, 2024
Summer	June 29, 2024

Cost & Periods of Coverage			
	Fall 8/18/23 to 1/8/24	Spring 1/9/24 to 5/28/24	Summer 5/29/24 to 8/17/24
Student	$851	$834	$501

The above rates include an administrative fee. Dependent rates are in addition to student rate.

HEALTH INSURANCE BENEFIT SUMMARY FOR COVERED MEDICAL EXPENSES* UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE (IF APPLICABLE) WILL ALWAYS APPLY.		
BENEFIT	**IN-NETWORK**	**OUT OF NETWORK**
Policy Year Deductible	$0 Individual	$0 individual
Out-of-Pocket Maximum	$1,500 Individual	$6,000 Individual
Coinsurance	100% of NC**	80% of U&C**
Student Health Center	100% of U&C for Covered Medical Services	
Preventive Care	100% of NC (no cost sharing)	80% of U&C
Hospital Room & Board (Inpatient)	100% of NC	80% of U&C
Surgery (Inpatient or Outpatient)	100% of NC	80% of U&C
Physician Office Visits OR Consultant/Specialist	$15 copay per visit then plan pays 100% of NC	80% of U&C
Emergency Services Expense (copay waived if admitted)	$100 copay per visit then plan pays 100% of NC	Paid the same as In-Network, provider subject to U&C
Urgent Care Centers	$25 copay per visit then plan pays 100% of NC	$50 copay per visit then plan pays 80% of U&C
Imaging Services & Laboratory Procedures (Outpatient)	100% of NC	80% of U&C
Outpatient Prescription Drugs (Copay per drug; copay per 30-day supply)	**Generic**: $15 copay **Preferred Brand:** $30 copay **Non-Preferred Brand:** $50 copay **Specialty**: $50 copay then the plan pays 100% of NC	Not Covered
Mental Health & Substance Use Disorder (Outpatient)	100% of NC	80% of U&C
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www.wellfleetstudent.com
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Servicing Agent:
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FlyST0312SH

Where Can I Obtain more Information about the Plan?	
Waive Coverage	Wellfleet Group, LLC www.wellfleetstudent.com
Enroll in the plan as J-1 Visitor or Enroll my F-2/J-2 Dependents	Wellfleet Group, LLC www.wellfleetstudent.com
Insurance Benefits **Claim Processing** **ID Cards**	Wellfleet Group, LLC (877) 657-5030 www.wellfleetstudent.com Email: customerservice@wellfeetinsurance.com
Find Network Provider	Wellfleet Student or Cigna www.cigna.com (877) 657-5030
Find Prescription Drug Provider	Wellfleet RX Pharmacy Network www.wellfleetstudent.com

The following Value-Added Services are not part of the Policy and are not underwritten by Wellfleet Insurance Company. The services are provided by Independent vendors and are included if the student participates in the student health plan.

- Vision discount program through Davis Vision
- Medical travel assistance through Assist America
- 24-hour nurse line
- 24-hour behavioral health hotline/CareConnect

University of Louisiana at Lafayette
2022-2023 Student Health Plan
for International Students and Scholars
Group No: ST0312SH
Policy No: WI2223LASHIP51

Dear International Students and Scholars:
We are pleased to provide you with this summary of the Student Health Plan for University of Louisiana at Lafayette. This plan is fully compliant with the Affordable Care Act.

Who is Eligible to Enroll?
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Student	$856	$834	$502

The above rates include an administrative fee. Dependent rates are in addition to student rate.

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BENEFIT	**IN-NETWORK**	**OUT OF NETWORK**
Policy Year Deductible	$0 Individual	$0 individual
Out-of-Pocket Maximum	$1,500 Individual	$6,000 Individual
Coinsurance	100% of NC**	80% of U&C**
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FlyST0312SH

Where Can I Obtain more Information about the Plan?	
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- Vision discount program through Davis Vision
- Medical travel assistance through Assist America
- 24-hour nurse line
- 24-hour behavioral health hotline/CareConnect

WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

STUDENT HEALTH CERTIFICATE OF COVERAGE

POLICYHOLDER:	UNIVERSITY OF LOUISIANA AT LAFAYETTE (Policyholder)
POLICY NUMBER:	WI2425LASHIP51
POLICY EFFECTIVE DATE:	August 18, 2024
POLICY TERMINATION DATE:	August 17, 2025
STATE OF ISSUE:	Louisiana

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

NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

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

Table of Contents

SCHEDULE OF BENEFITS

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

Out-of-Network Provider: The Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through an Out-of-Network Provider. Benefits are paid at 80% of the Usual and Customary Charge.

Medical Deductible:

In-Network Provider:	Individual:	$0
Out-of-Network Provider:	Individual:	$0

Out-of-Pocket Maximum:

In-Network Provider:	Individual:	$1,500
Out-of-Network Provider:	Individual:	$6,000

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

Coinsurance Amounts:
In-Network Provider: 100% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below.

Out-of-Network Provider: 80% of the Usual and Customary Charge (U&C) for Covered Medical Expenses unless otherwise stated below.

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

When You receive Emergency Services, or 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.

NOTICE: HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTH CARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR COPAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES.

SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT THE WEBSITE ADDRESS OF YOUR HEALTH PLAN OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN.

THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:

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

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK	OUT-OF-NETWORK
INPATIENT SERVICES		
Hospital Care Includes Hospital Room and Board Expenses and Hospital Miscellaneous Expenses. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Certification Required	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses

Preadmission Testing	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Physician's Visits while Confined	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Certification Required	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charg for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge 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, day or visit limits, and any Pre-certification requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.		
Inpatient Mental Health Disorder and Substance Use Disorder Benefit Pre-Certification Required	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Outpatient Mental Health Disorder and Substance Use Disorder Benefit Physician's Office Visits including, but not limited to, Physician visits; individual and group therapy; medication management. All Other Outpatient Services including, but not limited to, Intensive Outpatient Programs (IOP); partial hospitalization; Electronic Convulsive Therapy (ECT); Repetitive Transcranial Magnetic Stimulation (rTMS); Psychiatric and Neuro Psychiatric testing.	 $15 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses 100% of the Negotiated Charge for Covered Medical Expenses	 80% of Usual and Customary Charge for Covered Medical Expenses 80% of Usual and Customary Charge for Covered Medical Expenses
PROFESSIONAL AND OUTPATIENT SERVICES		
Surgical Expenses		
Inpatient and Outpatient Surgery includes: Pre-Certification Required Surgeon Services	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses

Anesthetist Assistant Surgeon		
Outpatient Surgical Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Organ Transplant Surgery travel and lodging expenses a maximum of $2,000 per Policy Year or $250 per day, whichever is less while at the transplant facility. Pre-Certification Required	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Reconstructive Surgery Pre-Certification Required	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Other Professional Services		
Gender Affirming Treatment Benefit Pre-Certification Required	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Home Health Care Expenses Pre-Certification required	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Hospice Care Coverage	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge 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	80% of Usual and Customary Charge for Covered Medical Expenses
Telehealth Services	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Telehealth Services by a contracted Provider (Behavioral Health)	$0 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	
Allergy Testing and Treatment, including injections	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Chiropractic Care Benefit	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Chiropractic Care Benefit Maximum visits per Policy Year	30	30

Tuberculosis screening (TB), Titers, QuantiFERON B tests including shots (other than covered under Preventive Services)	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charg for Covered Medical Expenses
EMERGENCY SERVICES, AMBULANCE AND NON-EMERGENCY SERVICES		
Emergency Services in an emergency department for Emergency Medical Conditions.	$100 Copayment per visit 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 Usual and Customary Charge.
Urgent Care Centers for non-life-threatening conditions	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	100% of the Negotiated Charge for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Non-Emergency Ambulance Expenses ground and/or air (fixed wing) transportation Pre-Certification Required for non-emergency air Ambulance (fixed wing)	100% of the Negotiated Charge for Covered Medical Expenses	Ground Ambulance transportation: 80% of Usual and Customary Charge for Covered Medical Expenses Air Ambulance transportation: Paid the same as In-Network Provider subject to Usual and Customary Charge.
DIAGNOSTIC LABORATORY, TESTING AND IMAGING SERVICES		
Diagnostic Imaging Services Pre-Certification Required	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Certification Required	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Laboratory Procedures (Outpatient)	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
REHABILITATION AND HABILITATION THERAPIES		
Cardiac Rehabilitation	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Pulmonary Rehabilitation	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses

Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Rehabilitation Therapy Maximum Visits for each therapy per Policy Year for Physical Therapy, and Occupational Therapy and Speech Therapy Combined with Habilitation Services Therapy The Maximum Visits do not apply to Rehabilitation Therapy for a Mental Health Disorder or Substance Use Disorder.	30	30
Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Habilitation Services Maximum Visits for each therapy per Policy Year for Physical Therapy, and Occupational Therapy and Speech Therapy Combined with Rehabilitation Therapy The Maximum Visits do not apply to Habilitation Services for a Mental Health Disorder or Substance Use Disorder.	30	30
OTHER SERVICES AND SUPPLIES		
Covered Clinical Trials	Same as any other Covered Sickness	
Diabetic Services and Supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Dialysis Treatment	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Durable Medical Equipment Pre-Certification Required	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Enteral Formulas and Nutritional Supplements	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses

See the Prescription Drug section of this Schedule when purchased at a pharmacy.		
Hearing Aids Limited to 1 hearing aid per ear, per 36 month period	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Fertility Preservation Expense Benefit	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
Prosthetic and Orthotic Devices Pre-Certification Required	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Outpatient Private Duty Nursing Pre-Certification Required	100% of the Negotiated Charg for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Interpreter Services for the Deaf and Hard of Hearing	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Student Health Center/Infirmary Expense Benefit	100% of the Usual and Customary Charge for Covered Medical Expenses	
Sports Accident Expense Benefit - incurred as the result of the play or practice of club sports Pre-Certification Not Required	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Non-emergency Care While Traveling Outside of the United States	80% of Actual Charge for Covered Medical Expenses Subject to $20,000 maximum per Policy Year	
Medical Evacuation Expense (International Students and Domestic Students	100% of Actual Charge for Covered Medical Expenses Subject to $50,000 maximum per Policy Year	
Repatriation Expense (International Students and Domestic Students	100% of Actual Charge for Covered Medical Expenses Subject to $50,000 maximum per Policy Year	
PEDIATRIC AND ADULT DENTAL AND VISION CARE		
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)	See the Dental Care Schedule of Benefits and Pediatric Dental Care Benefits description in the Certificate for further information.	
Type A – Basic Services Preventive Dental Care Limited to 1 dental exam every 6 months The benefit payable amount for the following services is different	100% of Usual and Customary Charge for Covered Medical Expenses	

from the benefit payable amount for Preventive Dental Care: Type B – Intermediate Services Type C – Major Services Type D: • Medically Necessary Orthodontic Services • General Services Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	 90% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses
Adult Dental Care Benefit (age 19 and older) Type A – Basic Services Preventive Dental Care Limited to 2 dental exams every 12 months The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care: Type B – Intermediate Services Type C – Major Services Type D: • Medically Necessary Orthodontic Services • General Services 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 Dental Care Schedule of Benefits and Adult Dental Care Benefit description in the Certificate for further information. 100% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses

Dental Care Schedule of Benefits Type A – Basic Services

Diagnostic and Treatment Services

Periodic oral evaluation - Limited to 1 every 6 months
Limited oral evaluation - problem focused - Limited to 1 every 6 months
Comprehensive oral evaluation - Limited to 1 every 6 months
Comprehensive periodontal evaluation - Limited to 1 every 6 months
Intraoral – complete set of radiographic images including bitewings - 1 every 60 (sixty) months
Intraoral - periapical radiographic image
Intraoral - additional periapical image Intraoral -
occlusal radiographic image
Extraoral – Each Additional Radiographic Image
Bitewing - single image Adult - 1 set every calendar year/Children - 1 set every 6 months Bitewings -
two images - Adult - 1 set every calendar year/Children - 1 set every 6 months Bitewings - four images
- Adult - 1 set every calendar year/Children - 1 set every 6 months
Vertical bitewings – 7 to 8 images – Adult - 1 set every calendar year/Children - 1 set every 6 months Panoramic
radiographic image – 1 image every 60 (sixty) months
Cephalometric radiographic image
2D Oral / Facial Photographic Images-obtained intraorally and extraorally 3D
photographic image
Interpretation of Diagnostic Image Lab
test
Collect & Prep Genetic Sample-1 per lifetime
Genetic Test-Specimen Analysis-1 per lifetime
Diagnostic Models

Preventive Services

Prophylaxis – Adult - Limited to 1 every 6 months Prophylaxis
– Child - Limited to 1 every 6 months
Topical Fluoride – Varnish -1 in 12 months for adults, 2 every 12 months for dependent children based on age limits Topical application of fluoride (excluding prophylaxis) - 2 every 12 months for dependent children based on age limits Sealant - per tooth – unrestored permanent molars - Less than age 19 - 1 sealant per tooth every 36 months Preventative resin restorations in a moderate to high caries risk patient - permanent tooth - 1 sealant per tooth every 36 months
Sealant Repair –Per tooth-Permanent tooth-1 every 36 months
Interim Caries Medicament-Permanent teeth 1 per tooth every 36 months (Molars/Bicuspids excluding Wisdom Teeth) Caries preventive medicament application – per tooth - 1 every 36 months
Space maintainer – fixed – unilateral - Limited to children under age 19 Space
Maintainer- Fixed-bilateral, Maxillary-Limited to children under age 19
Space Maintainer- Fixed-bilateral, mandibular-Limited to children under age 19 Space
maintainer - removable – unilateral - Limited to children under age 19 Space
Maintainer removable-bilateral,maxillary-Limited to children under age 19
Space Maintainer Removable bilateral,mandibular-Limited to children under age 19 Re-
cement or re-bond bilateral space maintainer-maxillary
Re-cement or re-bond bilateral space maintainer-mandibular Re-
cement or re-bond unilateral space maintainer-per quadrant Distal
space maintainer fixed

Additional Procedures Covered as Basic Services

Palliative treatment of dental pain – minor procedure

Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)
Consultation With Medical Professional
Office Visit- after regularly scheduled hours

Type B – Intermediate Services

Minor Restorative Services

Amalgam - one surface, primary or permanent Amalgam - two surfaces, primary or permanent Amalgam - three surfaces, primary or permanent Amalgam - four or more surfaces, primary or permanent Resin–based composite - one surface, anterior
Resin-based composite - two surfaces, anterior
Resin-based composite - three surfaces, anterior
Resin-based composite - four or more surfaces or involving incisal angle (anterior) Resin Crown-1 every 60 months
Porcelain Inlay-1 every 60 months
2 Surface Porcelain Inlay-1 every 60 months
3 or More Surf. Porcelain Onlay-1 every 60 months
Re-cement inlay or re-bond inlay, onlay veneer or partial coverage restoration Re-cement or re-bond indirectly fabricated or prefabricated post and core
Re-cement or re-bond crown
Reattachment of Tooth Fragment
Prefabricated porcelain crown - primary - Limited to 1 every 60 months
Prefabricated stainless steel crown - primary tooth – Under age 15 - Limited to 1 per tooth in 60 months
Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth in 60 months
Protective Restoration
Pin retention - per tooth, in addition to restoration

Endodontic Services

Therapeutic pulpotomy (excluding final restoration) - *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.*
Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development - *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.*
Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - *Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.* Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue treatment. - *Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.*
Pulpal regeneration – initial visit - Limited to 1 per lifetime
Pulpal regeneration – interim medication replacement - Limited to 1 per lifetime
Pulpal regeneration – completion of treatment - Limited to 1 per lifetime

Periodontal Services

Periodontal scaling and root planning-four or more teeth per quadrant – Limited to 1 every 24 months Periodontal scaling and root planning-one to three teeth, per quadrant – Limited to 1 every 24 months
Scaling gingival inflammation - Limited to 1 every 6 months combined with prophylasis and periodontal maintenance Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth Periodontal maintenance – 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy

Prosthodontic Services

Adjust complete denture – maxillary Adjust
complete denture – mandibular Adjust
partial denture – maxillary Adjust partial
denture - mandibular
Repair broken complete denture base-mandibular Repair
broken complete denture base-maxillary
Replace missing or broken teeth - complete denture (each tooth) Repair
resin partial denture base-mandibular
Repair resin partial denture base-maxillary Repair
cast partial framework-mandibular Repair cast
partial framework-maxillary Repair or replace
broken clasp
Replace broken teeth - per tooth Add
tooth to existing partial denture Add
clasp to existing partial denture
Rebase complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
Rebase maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation Rebase mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
Rebase hybrid prosthesis-Replacing the base material connected to the framework-Limited to a 1 in a 36-month period 6 months after the initial installation
Reline complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
Reline complete mandibular denture - Limited to 1 in a 36-month period 6 months after the initial installation
Reline maxillary partial denture - Limited to 1in a 36-month period 6 months after the initial installation Reline mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
Reline maxillary partial denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation Reline mandibular partial denture (laboratory) Rebase/Reline - Limited to 1 in a 36-month period 6 months after the initial installation
Soft liner for complete or partial removable denture-indirect-A discrete procedure provided when the dentist determines placement of the soft liner is clinically indicated-Limited to a 1 in 36-month period 6 months after the initial installation
Tissue conditioning (maxillary) Tissue
conditioning (mandibular) Recement
fixed partial denture
Fixed partial denture repair, by report

Oral Surgery

Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
Removal of impacted tooth - soft tissue Removal
of impacted tooth – partially bony Removal of
impacted tooth - completely bony
Removal of impacted tooth - completely bony with unusual surgical complications
Surgical removal of residual tooth roots (cutting procedure)
Coronectomy - intentional partial tooth removal
Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth

Surgical access of an unerupted tooth
Alveoloplasty in conjunction with extractions - per quadrant
Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
Alveoloplasty not in conjunction with extractions - per quadrant
Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant Removal of exostosis
Incision and drainage of abscess - intraoral soft tissue Suture of recent small wounds up to 5 cm
Collect-Apply Autologous Product-1 every 36 months Bone replacement graft for ridge preservation-per site
Buccal/Labial Frenectomy
Lingual Frenectomy
Excision of pericoronal gingiva

Type C – Major Services

Major Restorative Services

Detailed and extensive oral evaluation - problem focused, by report Inlay - metallic – one surface – An alternate benefit will be provided Inlay - metallic – two surfaces – An alternate benefit will be provided Inlay - metallic – three surfaces – An alternate benefit will be provided Onlay - metallic - two surfaces – Limited to 1 per tooth every 60 months
Onlay - metallic - three surfaces – Limited to 1 per tooth every 60 months
Onlay - metallic - four or more surfaces – Limited to 1 per tooth every 60 months
Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 months
Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 months
Crown - porcelain fused to predominately base metal – Limited to 1 per tooth every 60 months Crown - porcelain fused to noble metal – Limited to 1 per tooth every 60 months
Crown - porcelain fused to titanium and titanium alloys - Limited to 1 per tooth every 60 months
Crown - 3/4 cast high noble metal – Limited to 1 per tooth every 60 months
Crown - 3/4 cast predominately base metal – Limited to 1 per tooth every 60 months Crown - 3/4 porcelain/ceramic – Limited to 1 per tooth every 60 months
Crown - full cast high noble metal– Limited to 1 per tooth every 60 months
Crown - full cast predominately base metal – Limited to 1 per tooth every 60 months Crown - full cast noble metal– Limited to 1 per tooth every 60 months
Crown – titanium– Limited to 1 per tooth every 60 months
Prefabricated porcelain/ceramic crown – permanent tooth - limited to 1 per tooth every 60 months Resin crown - Limited to 1 per tooth every 60 months
Core buildup, including any pins– Limited to 1 per tooth every 60 months Post and core-limited to 1 per tooth every 60 months
Prefabricated post and core, in addition to crown– Limited to 1 per tooth every 60 months
Crown repair, by report
Inlay Repair Onlay
Repair Veneer
Repair
Resin infiltration/smooth surface - Limited to 1 in 36 months

Endodontic Services

Anterior root canal (excluding final restoration)
Bicuspid root canal (excluding final restoration)
Molar root canal (excluding final restoration)

Retreatment of previous root canal therapy-anterior
Retreatment of previous root canal therapy-bicuspid
Retreatment of previous root canal therapy-molar
Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration
Apicoectomy/periradicular surgery - anterior
Apicoectomy/periradicular surgery - bicuspid (first root)
Apicoectomy/periradicular surgery - molar (first root)
Apicoectomy/periradicular surgery (each additional root) Root amputation - per root
Surgical repair of root resorption - anterior
Surgical repair of root resorption – premolar
Surgical repair of root resorption – molar Surg
Exp of Root-Anterior
Surg Exp of Root-Premolar Surg
Exp of Root-Molar
Hemisection (including any root removal) - not including root canal therapy
Intentional removal of coronal tooth structure for preservation of the root and surrounding bone

Periodontal Services

Gingivectomy or gingivoplasty – four or more teeth - Limited to 1 every 36 months
Gingivectomy or gingivoplasty – one to three teeth - Limited to 1 every 36 months
Gingivectomy or gingivoplasty - with restorative procedures, per tooth - Limited to 1 every 36 months
Gingival flap procedure, four or more teeth – Limited to 1 every 36 months
Gingival flap procedure, including root planning - one to three contiguous teeth or tooth bounded spaces per quadrant – Limited to 1 every 36 months
Clinical crown lengthening-hard tissue
Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months
Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months
Bone replacement graft - first site in quadrant - Limited to 1 every 36 months Pedicle soft tissue graft procedure
Autogenous connective tissue graft procedures (including donor site surgery)
Non-Autogenous connective tissue graft - Limited to 1 every 36 months
Free soft tissue graft 1st tooth
Free soft tissue graft-additional teeth
Subepithelial tissue graft/each additional contingous tooth, implant or edentulous tooth position in same graft site
Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material)-each additional contiguos tooth, implant or edentulous tooth position in same graft site-Limited to 1 every 36 months
Full mouth debridement to enable comprehensive evaluation and diagnosis– Limited to 1 per lifetime

Prosthodontic Services

Complete denture - maxillary – Limited to 1 every 60 months
Complete denture - mandibular – Limited to 1 every 60 months
Immediate denture - maxillary – Limited to 1 every 60 months

Immediate denture - mandibular – Limited to 1 every 60 months
Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)– Limited to 1 every 60 months
Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
Immediate maxillary partial denture-resin base (including any conventional clasps, rests and teeth)-Limited to 1 every 60 months
Immediate mandibluar partial denture-resin base (including any conventional clasps, rests and teeth)-Limited to 1 every 60 months
Immediate maxillary partial denture-cast metal framework with resin denture base (including any conventional clasps, rests amd teeth)-Limited to 1 every 60 months
Immediate mandibular partial denture-cast metal framework with resin denture base (including any conventional clasps, rests amd teeth)-Limited to 1 every 60 months
Immediate maxillary partial denture-flexible base (including any clasps, rests and teeth)-Limited to 1 every 60 months
Immediate mandibular partial denture-flexible base (including clasps, rests and teeth)-Limited to 1 every 60 months Removable
Unilateral Partial denture-one piece cast metal (including clasps and teeth), maxillary-Limited to 1 every 60 months
Removable Unilateral partial denture-one piece cast metal (including clasps and teeth), mandibular-Limited to 1 every 60 months
Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant - Limited to 1 every 60 months
Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant - Limited to 1 every 60 months
Add metal substructure to acrylic full denture (per arch)-Limit 1 every 60 months.
Endosteal Implant - 1 every 60 months
Surgical Placement of Interim Implant Body - 1 every 60 months
Eposteal Implant – 1 every 60 months
Transosteal Implant, Including Hardware – 1 every 60 months Connecting
Bar – implant or abutment supported - 1 every 60 months Prefabricated
Abutment – 1 every 60 months
Custom Abutment - 1 every 60 months
Abutment supported porcelain ceramic crown -1 every 60 months
Abutment supported porcelain fused to high noble metal - 1 every 60 months
Abutment supported porcelain fused to predominately base metal crown - 1 every 60 months
Abutment supported porcelain fused to noble metal crown - 1 every 60 months
Abutment supported cast high noble metal crown - 1 every 60 months Abutment
supported cast predominately base metal crown - 1 every 60 months Abutment
supported cast noble metal crown - 1 every 60 months
Implant supported porcelain/ceramic crown - 1 every 60 months
Implant supported porcelain fused to high metal crown - 1 every 60 months Implant
supported metal crown - 1 every 60 months
Abutment supported retainer for porcelain/ceramic fixed partial denture - 1 every 60 months
Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months Abutment
supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months Abutment
supported retainer for porcelain fused to noble metal fixed partial denture - 1 every 60 months
Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months Abutment
supported retainer for predominately base metal fixed partial denture - 1 every 60 months Abutment
supported retainer for cast noble metal fixed partial denture - 1 every 60 months

Implant supported retainer for ceramic fixed partial denture - 1 every 60 months
Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
Implant supported retainer for cast metal fixed partial denture - 1 every 60 months
Implant Maintenance Procedures -1 every 60 months Scaling
and debridement implant-1 every 60 months
Implant supported crown – porcelain fused to predominantly base alloys - 1 every 60 months Implant
supported crown – porcelain fused to noble alloys - 1 every 60 months
Implant supported crown – porcelain fused to titanium and titanium alloys - 1 every 60 months
Implant supported crown – predominantly base alloys - 1 every 60 months
Implant supported crown – noble alloys - 1 every 60 months
Implant supported crown – titanium and titanium alloys - 1 every 60 months Repair
Implant Prosthesis -1 every 60 months
Replacement of Semi-Precision or Precision Attachment -1 every 60 months Repair
Implant Abutment - 1 every 60 months
Remove broken implant retaining screw-1 every 12 months
Abutment supported crown – porcelain fused to titanium and titanium alloy - 1 every 60 months
Implant supported retainer – porcelain fused to predominantly base alloys - 1 every 60 months
Implant supported retainer for FPD – porcelain fused to noble alloys - 1 every 60 months Implant
Removal - 1 every 60 months
Debridement periimplant defect - Limited to 1 every 60 months Debridement
and osseous periimpant defect - Limited to 1 every 60 months Bone graft
periimplant defect
Bone graft implant replacement
Implant/abutment supported removable denture for edentulous arch-maxillary- 1 every 60 months
Implant/abutment supported removable denture for edentulous arch-mandibular- 1every 60 months
Implant/abutment supported removable denture for partially edentulous arch-maxillary- 1 every 60 months
Implant/abutment supported removable denture for partially edentulous arch-mandibular- 1every 60 months
Implant/abutment supported fixed denture for edentulous arch-maxillary- 1 every 60 months Implant/abutment supported fixed denture for edentulous arch-mandibular- 1 every 60 months Implant/abutment supported fixed denture for partially edentulous arch-maxillary- 1 every 60 months Implant/abutment supported fixed denture for partially edentulous arch-mandibular- 1 every 60 months Implant supported retainer – porcelain fused to titanium and titaniumalloys - 1 every 60 months
Implant supported retainer for metal FPD – predominantly base alloys - 1 every 60 months Implant
supported retainer for metal FPD – noble alloys - 1 every 60 months
Implant supported retainer for metal FPD – titanium and titanium alloys - 1 every 60 months Implant
Index - 1 every 60 months
Semi-precision abutment – placement - 1 every 60 months
Semi-precision attachment – placement - 1 every 60 months
Abutment supported retainer – porcelain fused to titanium and titanium alloys - 1 every 60 months Pontic -
cast high noble metal – Limited to 1 every 60 months
Pontic - cast predominately base metal – Limited to 1 every 60 months
Pontic - cast noble metal– Limited to 1 every 60 months
Pontic – titanium – Limited to 1 every 60 months
Pontic - porcelain fused to high noble metal – Limited to 1 every 60 months
Pontic - porcelain fused to predominately base metal – Limited to 1 every 60 months Pontic -
porcelain fused to noble metal – Limited to 1 every 60 months
Pontic – porcelain fused to titanium and titanium alloys - 1 every 60 months Pontic -
porcelain/ceramic – Limited to 1 every 60 months
Inlay/onlay – porcelain/ceramic – Limited to 1 every 60 months Inlay
– metallic – two surfaces – Limited to 1 every 60 months
Inlay – metallic – three or more surfaces - Limited to 1 every 60 months

Onlay – metallic – three surfaces - 1 every 60 months
Onlay – metallic – four or more surfaces -1 every 60 months
Retainer - cast metal for resin bonded fixed prosthesis -1 every 60 months Retainer - porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months Resin retainer- for resin bonded fixed prosthesis - 1 every 60 months
Crown - porcelain/ceramic - 1 every 60 months
Crown - porcelain fused to high noble metal - 1 every 60 months
Crown - porcelain fused to predominately base metal - 1 every 60 months
Crown - porcelain fused to noble metal - 1 every 60 months
Retainer crown – porcelain fused to titanium and titanium alloys - 1 every 60 months Crown - 3/4 cast high noble metal - 1 every 60 months
Crown - 3/4 cast predominately base metal - 1 every 60 months
Crown - 3/4 cast noble metal - 1 every 60 months
Crown - 3/4 porcelain/ceramic - 1 every 60 months
Retainer crown ¾ titanium and titanium alloys - 1 every 60 months Crown - full cast high noble metal - 1 every 60 months
Crown - full cast predominately base metal - 1 every 60 months
Crown - full cast noble metal - 1 every 60 months
Cleaning and inspection of removable complete denture, maxillary-1 every 6 months
Cleaning and inspection of removable complete denture, mandibular-1 every 6 months
Cleaning and inspection of removable partial denture, maxillary-1 every 6 months Cleaning and inspection of removable partial denture, mandibular-1 every 6 months Repair/reline occlusal guard-1 every 24 months for patients 13 and older
Occlusal guard adjustment-1 every 24 months for patients 13 and older
Occlusal guard-hard appliance, full arch - 1 in 12 months for patients 13 and older Occlusal guard-soft appliance, full arch - 1 in 12 months for patients 13 and older Occlusal guard-hard appliance, partial arch - 1 in 12 months for patients 13 and older

Type D – Medically Necessary Orthodontic Services

Orthodontia Services

Limited orthodontic treatment of the primary dentition Limited orthodontic treatment of the transitional dentition Limited orthodontic treatment of the adolescent dentition Limited orthodontic treatment of the adult dentition
Comprehensive orthodontic treatment of the transitional dentition
Comprehensive orthodontic treatment of the adolescent dentition
Comprehensive orthodontic treatment of the adult dentition Removable appliance therapy
Fixed appliance therapy
Pre-orthodontic treatment examination to monitor growth and development Periodic orthodontic treatment visit (as part of contract)
Orthodontic retention (removal of appliances, construction and placement of retainer(s)

Type D – General Services

Anesthesia Services

Deep sedation/general anesthesia-first 15 minutes
Deep sedation/general anesthesia - each 15 minute increment

Intravenous Sedation

Intravenous moderate (conscious) sedation/analgesia-first 15 minutes Intravenous moderate (conscious) sedation/analgesia-each 15 minute increment

Medications Therapeutic drug injection, by report Infiltration of a sustained release therapeutic drug-single or multiple sites **Post Surgical Services** Treatment of complications (post-surgical) unusual circumstances, by report		
Pediatric Vision Care Benefit (to 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.	See the Pediatric Vision Care Benefit description in this Certificate for further information. 100% of Usual and Customary Charge for Covered Medical Expenses	
Adult Vision Care (age 19 and older) Routine Eye Examination once every 24 months 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	
MISCELLANEOUS DENTAL SERVICES		
Accidental Injury Dental Treatment	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Sickness Dental Expense Benefit	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Oral Surgery Benefit	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
PRESCRIPTION DRUGS		
Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy or Student Health Center. We may receive rebates for certain drugs included on Our Formulary. As a result, You may be subject to an excess consumer cost burden, meaning that it may be possible for You to pay a higher portion of the cost for Your prescription		

drug than Our portion of the cost for that same prescription drug. You may be responsible for the payment of local taxes that apply to Your prescription drugs. 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.		
TIER 1 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$15 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 60 day supply filled at a Retail pharmacy	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
TIER 2 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 60 day supply filled at a Retail pharmacy	$90 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
TIER 3 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail Pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered

More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$100 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 60 day supply filled at a Retail pharmacy	$1150 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
Specialty Prescription Drugs		
For each fill up to a 30 day supply.	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
Zero Cost Drugs		
	100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
Orally administered anti-cancer Prescription Drugs (including Specialty Drugs)		
Benefit	If the cost share for the Prescription Drug's Tier is greater than the Chemotherapy Benefit or Infusion Therapy Benefit, the cost share will be calculated as follows: Greater of: • Chemotherapy Benefit; or • Infusion Therapy Benefit	
Diabetic Supplies (for prescription supplies purchased at a pharmacy)		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill except, that the Insured Person's out-of-pocket costs for covered prescription insulin drugs will not exceed $75 per 30-day supply regardless of the amount or type of insulin that is needed to fill the Insured Person's prescription.	
MANDATED BENEFITS		
Attention Deficit/Hyperactivity Disorder Benefit	Same as any other Covered Sickness	
Bone Mass Measurement Benefit	Same as any other Covered Sickness, unless considered a Preventive Service	
Cancer Screening Benefit	Same as any other Preventive Service, except services provided by an Out-of-Network Provider are not subject to the Deductible, if applicable	
Cleft Lip and Cleft Palate Coverage	Same as any other Covered Sickness	
Treatment of Lymphedema Benefit	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 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 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 30 days' prior written notice of termination delivered by Us to the Insured Student.

Who is Eligible

Class	**Description of Class(es)**
1	All registered F-1 non-immigrant graduate, undergraduate, and Intensive English Program (IEP) students of the Policyholder taking one or more credit hours.
2	All J-1 exchange visitors of the Policyholder.

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

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 not eligible for coverage under this plan.

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.

Special Enrollment – Qualifying Life Event
The Insured Student, 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, is 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, can also enroll 60 days from exhaustion of the Insured Student's COBRA or continuation coverage.

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

1. The Insured Student loses eligibility for Medicaid or a state child health plan.
2. The Insured Student becomes 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; 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. On any Premium due date the Policyholder fails to pay the required Premium for the Insured Student except as the result of an inadvertent error and subject to any Grace Period provision.

Dependent Child Coverage Newly Born Children

A newly born child of 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 or until such time as the newborn is well enough to be discharged from a Hospital or neonatal special care unit to its home, whichever period is longer. This includes the necessary care and Treatment of medically diagnosed congenital defects and birth abnormalities and transportation costs by professional Ambulance, including ground or air transport, of the newly born child to the nearest available Hospital or neonatal special care unit for the Treatment of such condition, and complications of premature birth, furnished any newly born child from the moment of birth. Transportation by professional Ambulance of the temporarily medically disabled mother of the ill newly born child when accompanying the ill newly born child to the nearest available Hospital or neonatal special care unit is included in this provision, provided the mother's need for professional ambulance service is certified by her attending Physician. Dependent coverage is not available under this plan. When this 31 day provision has been exhausted, all Dependent coverage ends. No further benefits will be paid.

As used in this provision:
Temporarily medically disabled mother means an Insured Person who has recently given birth and whose Physician has advised that normal travel would be hazardous to her health.

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 have been diagnosed with a Life-threatening Illness, or are Hospital Confined for a Covered Injury or Covered Sickness on the date Your insurance coverage terminates, We will continue to pay benefits for that Covered Injury or Covered Sickness for up to 90 days from the Termination Date while such Confinement continues.

Reinstatement Of Reservist After Release From Active Duty

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

within 60 days of such departure.

SECTION III – DEFINITIONS

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

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

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

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

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.

Autism Spectrum Disorder means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder not otherwise specified.

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 voluntary abortion.)

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

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

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

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

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

Covered Injury/Injury means a bodily injury due to an 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 benefits are payable under this Certificate. The amount of the Deductible, if any, will be shown in the Schedule of Benefits.

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

Durable Medical Equipment means a device which:

1. Is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of Sickness or Injury and is able to withstand repeated use;
2. Is used exclusively by You;
3. Is 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 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: transportation services, including but not limited to Ambulance Services, a medical screening examination that is within the capability of the emergency department, including ancillary services routinely available to the emergency department, and covered inpatient and outpatient services furnished by a Hospital, independent freestanding emergency department, or Physician qualified to furnish those services necessary to screen, evaluate, and Stabilize an Emergency Medical Condition. Coverage also includes Post-Stabilization services after You are Stabilized. Post-Stabilization services include undergoing outpatient Observation Services, or an inpatient or outpatient stay with respect to the visit in which the other Emergency Services are furnished. The Post-Stabilization services will no longer qualify as Emergency Services once You can travel using non-medical or non-emergency transportation and You are in a condition to receive notice of, and to consent to, Out- of-Network Treatment.

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

Formulary means a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary indicates the type of drug 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. Habilitation Services may include such services as Physical Therapy, occupational therapy, and speech therapy.

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.

Home Health Care Agency means an agency that:

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

Home Health Care means the continued care and Treatment if:

1. Your institutionalization would have been required if Home Health Care was not provided; and
2. Your Physician establishes and approves in writing the plan of treatment covering the Home Health Care service; and
3. Home Health Care is provided by:
    a. a Hospital that has a valid operating certificate and is certified to provide Home Health Care services; or
    b. a public or private health service or agency that is licensed as a Home Health 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 and other healthcare providers who have contracted with Us to provide specific medical care at negotiated prices.

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

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

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

International Student means an international student:

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

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

Life-threatening Illness means a severe, serious, or acute condition for which death is probable.

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

Medically Necessary or **Medical Necessity** means health care services 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 means a condition or disorder that substantially limits the life activities of an Insured Person with the disorder. Mental Health Disorders must be listed as a Mental Health Disorder in the most recent version of the International Classification of Disease Manual (ICD) published by the World Health Organization.

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

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

1. Is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and

2. Provides medical services which are within the scope of the Nurse's license or certificate who does not ordinarily reside in Your home or is not related to You by blood or marriage.

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

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

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

Out-of-Pocket Maximum means the most You will 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 and within 5 working days of a scheduled surgery where an operating room has been reserved before the tests are done.

Qualifying Life Event means an event that qualifies a student to apply for coverage for him/herself due to a Qualifying Life Event under this Certificate.

Qualifying Payment Amount means the median Negotiated Charge for:

1. The same or similar services;
2. Furnished in the same or similar facility;
3. By a provider of the same or similar specialty;
4. In the same or similar geographic area.

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.

Remote Patient Monitoring Services means the delivery of healthcare services using telecommunications technology to enhance the delivery of health care, including but not limited to all of the following:

- Monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, and other condition-specific data, such as blood glucose;
- Medication adherence monitoring (the monitoring of a patient's conformance with the healthcare provider's medication plan regarding timing, dosing, and frequency of medication-taking through electronic transmission of data in a remote patient monitoring services program); and
- Interactive video conferencing with or without digital image upload.

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.

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.

Student Health Center/Student Infirmary means an on-campus facility or a designated facility by the Policyholder that provides:

1. Medical care and Treatment to sick or injured students; and
2. Nursing services.

A Student Health Center/Student Infirmary does not include:

1. Medical, diagnostic and Treatment facilities with major surgical facilities on its premises or available on a pre-arranged basis; or
2. Inpatient care

Substance Use Disorder means any condition or disorder that substantially limits the life activities of an Insured Person with the disorder. Substance Use Disorders must be listed as a Substance Use Disorder in the most recent version of the International Classification of Disease Manual (ICD) published by the World Health Organization.

Surgeon means a Physician who actually performs surgical procedures.

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

Telehealth means healthcare services (including behavioral health services) provided by a healthcare provider, to a person through the use of electronic communications, information technology, asynchronous store-and-forward transfer technology, or synchronous interaction between a provider at a distant site and a patient at an originating site, including but not limited to assessment of, diagnosis of, consultation with, treatment of, and Remote Patient Monitoring Services, and transfer of medical data.

Telehealth does not include:

- Electronic mail messages and text messages that are not compliant with applicable requirements of HIPAA; or
- Facsimile transmissions.

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 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 entirestate.
- "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, while insured under this Certificate.

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

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

SECTION IV – HOW THE PLAN WORKS AND DESCRIPTION OF BENEFITS

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

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

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

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.

Individual
Once the amount of the Copayments, Coinsurance, and Deductibles the Insured Student 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.

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

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

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

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

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

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

2. You have an Emergency Medical Condition and receive Emergency Services from an Out-of-Network Provider or facility. The most the Out-of-Network Provider or facility may bill You is the In-Network cost sharing amount (such as Deductibles, Copayments and Coinsurance). You can't be balance billed for these Emergency Services. This includes services You may get after You're in 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 or if You have a Life-threatening Illness. The transitional period must extend through the provision of postpartum care directly related to the pregnancy.

Continuation of Treatment by an In-Network Provider is not required when:

1. In-Network Provider termination is due to suspension, revocation, or applicable restriction of their license to practice, or for another documented reason related to quality of care;
2. You choose to change Providers;
3. You move out of the geographic service area;
4. You require only routine monitoring for a chronic condition, but it is not in an acute phase of Your condition.

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.

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

1. All Inpatient admissions, including length of stay, to a Hospital, Skilled Nursing Facility, a facility established primarily for the Treatment of a Substance Use Disorder, or a residential Treatment facility;
2. All Inpatient maternity care after the initial 48/96 hours;
3. Home Health Care;
4. Durable Medical Equipment over $500 per item;
5. Surgery;
6. Transplant Services;
7. Diagnostic testing/radiology;
8. Chemotherapy/radiation;
9. Infusions/injectables;
10. Botox Injections;
11. Orthognathic Surgery;
12. Genetic Testing, except for BRCA;
13. Orthotics/prosthetics;
14. Non-emergency air Ambulance (fixed wing) expenses.

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. Your

Physician will be notified of Our decision as follows:

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

Our agent will make this determination within 72 hours for an urgent request and 4 business days for non-urgent requests following receipt of all necessary information for review. Notice of an Adverse Benefit Determination made by Our agent will be in writing and will include:

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

Failure by Our agent to make a determination within the time periods prescribed 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).
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
4. With respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
5. Outpatient/office contraceptive services are covered, provided that the services are related to the use of FDA approved contraceptives. Examples of covered contraceptive services are: office visits, consultations, examinations and services related to the use of federal legend oral contraception or IUD insertion, diaphragm fitting, vasectomy or contraceptive injections. Please note that prescription and nonprescription contraceptive drugs and devices (such as oral contraceptives, IUDs, diaphragms, and contraceptive injections) are covered under the Prescription Drug Benefit. See Prescription Drugs for information on those services and devices.

Important Notes:

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

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

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

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

Inpatient Services

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

- Room and Board Expenses**,** including general nursing care. 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.

2. **Preadmission Testing** for routine tests performed as a preliminary to Your being admitted to a Hospital. These tests must be performed within 5 working days prior to admission. This benefit is limited to routine tests such as complete blood count, urinalysis, and chest x-rays. Unless otherwise payable under this Certificate, We will pay for major diagnostic procedures under the Hospital Miscellaneous 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. **Physical Therapy while Confined** when prescribed by the attending Physician.

Mental Health Disorder and Substance Use Disorder Benefits

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

Coverage includes the diagnosis and Treatment of Autism Spectrum Disorders in Insured Persons less than twenty-one (21) years of age.

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

Professional and Outpatient Services

SURGICAL EXPENSES

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

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

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

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

2. **Outpatient Surgical Facility and Miscellaneous** 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.

3. **Organ Transplant Surgery**

Recipient Surgery for Medically Necessary, non-Experimental and non-Investigative solid organ, bone marrow, stem-cell or tissue transplants.

a. Solid organ transplants include transplants of the: liver; heart; lung; kidney; pancreas; small bowel; and other solid organ transplant procedures, which We determine have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These solid organ transplants will be considered on a case by case basis.
b. Tissue transplant procedures (autologous and allogeneic) include: blood transfusions; autologous parathyroid transplants; corneal transplants; bone and cartilage grafting; skin grafting; autologous islet cell transplants; and other tissue transplant procedures which We determine have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These tissue transplants will be considered on a case by case basis.
c. Bone marrow transplants include: allogeneic, autologous, and syngeneic bone marrow transplants, including tandem transplants, mini transplants (transplant lite) and donor lymphocyte infusions are covered.

We will provide benefits for the Hospital and other Covered Medical Expenses when You are the recipient of an Organ Transplant. Related services or supplies include administration of high-dose chemotherapy to support transplant procedures. Benefits include coverage for immunosuppressive drugs prescribed for transplant procedure(s).

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

The following exclusions apply to this benefit: Any costs of donating an organ or tissue for transplant when an Insured Person is a donor; the transplant of any non-human organ or tissue; or bone marrow transplants and stem cell rescue (autologous and allogeneic) are not covered, except as provided in this Certificate. If any organ, tissue or bone marrow is sold rather than donated to an Insured Person, the purchase price of such organ, tissue or bone marrow is not covered.

Donor's Surgery for Medically Necessary transplant services required by the Insured Person who serves as an organ donor only if the recipient is also an Insured Person. We will not cover the transplant services of a non- Insured Person acting as a donor for an Insured Person if the non-Insured Person's expenses will be covered under another health plan or program.

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

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

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

4. **Reconstructive Surgery** covers mastectomies and all stages of breast reconstruction following mastectomies. Mastectomies and the breast reconstruction procedures to be performed shall be selected by the Insured Person in consultation with their attending Physician. This benefit also covers cosmetic surgery specifically and solely for: Reconstruction due to bodily Injury, infection or other disease of the involved part.

As used in this benefit:
Breast reconstruction means both of the following:

a. All stages of reconstruction of the breast on which a unilateral mastectomy has been performed and on the other breast to produce a symmetrical appearance, including but not limited to contralateral prophylactic mastectomies, liposuction performed for transfer to a reconstructed breast or to repair a donor site deformity, tattooing the areola of the breast, surgical adjustments of the non-mastectomized breast, unforeseen medical complications which may require additional reconstruction in the future, and prostheses and physical complications, including but not limited to lymphedemas.
b. All stages of reconstruction of both breasts if a bilateral mastectomy has been performed, including but not limited to liposuction performed for transfer to a reconstructed breast or to repair a donor site deformity, tattooing the areola of the breast, unforeseen medical complications which may require additional reconstruction in the future, and prostheses and physical complications, including but not limited to lymphedemas.

Covered Medical Expenses include breast reconstruction performed on an Insured Person who underwent a mastectomy because of breast cancer that was covered under another health insurance plan.

OTHER PROFESSIONAL SERVICES

1. **Gender Affirming Treatment Benefit** for Medically Necessary expenses incurred for services and supplies provided in connection with gender affirming Treatment when You have been diagnosed with gender identity disorder or gender dysphoria. Covered Medical Expenses include the following:
   a. Counseling by qualified mental health professional;
   b. Hormone therapy, including monitoring of such therapy;
   c. Gender affirming surgery and procedures.

2. **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.

3. **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.

Coverage includes Physician-administered drugs Your Physician ordered and administers to You during a Physician's Visit when all criteria for Medical Necessity are met. Your Physician is not required to obtain Physician- administered drugs from a participating network pharmacy.

2. **Telehealth Services** for health care delivery, diagnosis, consultation, or Treatment provided to You by a Physician or a contracted provider subject to the plan cost share shown on the Schedule of Benefits.

3. **Allergy Testing and Treatment, including injections.** This includes tests that You need such as PRIST, RAST, and scratch tests. Also, includes Treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications and asthma not responding to usual Treatments. This also includes the administration of allergy therapy, injections, allergy serum, and supplies used for allergy therapy.

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

5. **Tuberculosis (TB) screening**, **Titers, QuantiFERON B tests including shots** (other than covered under Preventive Services) when required by the School for high risk Insured Persons.

Emergency Services, Ambulance and Non-Emergency Services

1. **Emergency Services** only in connection with care for an Emergency Medical Condition as defined. Benefits will be paid for the use of a Hospital emergency department or independent freestanding emergency department, a medical screening examination that is within the capability of the emergency department, including ancillary services routinely available to the emergency department, pre-stabilization services and supplies after You are moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered

after You are Stabilized as part of Observation Services or an inpatient or outpatient stay with respect to the visit in which the other Emergency Services are furnished. Refer to the Emergency Ambulance Service provision for transportation coverage.

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

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

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

2. **Urgent Care Centers (non-life-threatening conditions)** for services provided at an Urgent Care Center, as shown in the Schedule of Benefits. In the case of a life-threatening condition, You should go to the nearest emergency room.

3. **Emergency Ambulance Service,** with respect to an Emergency Medical Condition, for ground transportation to a Hospital by a licensed Ambulance. Transportation from a facility to Your home is not covered.

Your plan also covers transportation to a Hospital by professional air 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 Medically Necessary transportation by a licensed Ambulance, whether by ground or air Ambulance (fixed wing) (as appropriate), when the transportation is:

- From an Out-of-Network Hospital to an In-Network Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective acute care Hospital/facility; or
- From an acute care Hospital/facility to a sub-acute setting.

Transportation from a facility to Your home is not covered.

Diagnostic Laboratory, Testing and Imaging Services

1. **Diagnostic Imaging Services** for diagnostic X-ray services when prescribed by a Physician.

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

3. **Laboratory Procedures (Outpatient)** for laboratory procedures when prescribed by a Physician. Laboratory procedures include genetic or molecular testing as follows:

a. Genetic or molecular testing for cancer including but not limited to:
   - Tumor mutation testing,
   - Next generation sequencing,
   - Hereditary germline mutation testing,
   - Pharmacogenomic testing,
   - Whole exome and genome sequencing, and
   - Biomarker Testing.

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.

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

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

Rehabilitation and Habilitation Therapies

1. **Cardiac Rehabilitation.** Benefits are available for Outpatient cardiac Rehabilitation programs. Covered Medical Expenses are: exercise and education under the direct supervision of skilled program personnel in the intensive Rehabilitation phase of the program.

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

2. **Pulmonary Rehabilitation.** Benefits are available for pulmonary Rehabilitation services as part of an inpatient Hospital stay if it is part of a treatment plan ordered by a Physician. A course of outpatient pulmonary Rehabilitation may also be eligible for coverage if it is performed at a Hospital, Skilled Nursing Facility, or Physician's office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by a Physician.

3. **Rehabilitation Therapy** when prescribed by the attending Physician, limited to 1 visit per day. Coverage for Physical Therapy or occupational therapy provided via Telehealth will be considered on the same basis as in person Physical Therapy.

4. **Habilitation Services** when prescribed by the attending Physician, limited to 1 visit per day. Coverage for Physical Therapy or occupational therapy provided via Telehealth will be considered on the same basis as in person Physical Therapy.

Other Services and Supplies

1. **Covered Clinical Trials** coverage for expenses incurred as a result of a Treatment being provided in accordance with a clinical trial for cancer, except any applicable Copayment, Deductible, or Coinsurance amounts. Costs of investigational Treatments and costs of associated protocol-related patient care shall be covered if all of the following criteria are met:
   a. The Treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer.
   b. The Treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase

IV clinical trial for cancer.

c. The Treatment is being provided in accordance with a clinical trial approved by one of the following entities:
   (1) One of the United States NIH.
   (2) A cooperative group funded by one of the NIH.
   (3) The FDA in the form of an investigational new drug application.
   (4) The United States Department of Veteran Affairs. (5) The United States Department of Defense.
   (5) A federally funded general clinical research center.
   (6) The Coalition of National Cancer Cooperative Groups.
d. The proposed protocol has been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks.
e. The facility and personnel providing the protocol provided the Treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.
f. There is no clearly superior, non-investigational approach.
g. The available clinical or preclinical data provide a reasonable expectation that the Treatment will be at least as efficacious as the non-investigational alternative.
h. The Insured Person has signed an institutional review board approved consent form.

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

Benefits 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

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

Training

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

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

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

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

3. **Dialysis Treatment** of an acute or chronic kidney ailment, provided in an Outpatient facility of a Hospital, a free-standing renal Dialysis facility or in 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, walkers, braces that stabilize an injured body part and braces to treat curvature of the spine. We will pay the lesser of either the rental or purchase charges, but not both. Such equipment must be prescribed by a Physician and a copy of the written prescription must accompany the claim. Durable Medical Equipment must:
   a. Be primarily and customarily used to serve a medical, rehabilitative purpose;
   b. Be able to withstand repeated use; and
   c. Generally, not be useful to a person in the absence of Injury or Sickness.

5. **Enteral Formulas and Nutritional Supplements** Covered Medical Expenses prescribed by a Physician used to treat malabsorption of food caused by:
   - Crohn's Disease
   - Ulcerative colitis
   - Gastroesophageal reflux
   - Gastrointestinal motility;
   - Chronic intestinal pseudo-obstruction
   - Phenylketonuria
   - Eosinophilic gastrointestinal disorders
   - Inherited diseases of amino acids and organic acids
   - Multiple severe food allergies
   - Branded-chain ketonuria,
   - Galactosemia
   - Homocystinuria

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

6. **Hearing Aids** for Insured Persons if hearing aids are fitted and dispensed by a licensed audiologist or licensed hearing aid specialist following medical clearance by a Physician and an audiological evaluation that is medically appropriate**.** Benefits are limited as shown in the Schedule of Benefits.

As used in this benefit:
Hearing Aid means a non-disposable device that is of a design and circuitry to optimize audibility and listening skills.

7. **Fertility Preservation Expense Benefit** for standard fertility preservation services and the costs associated with storage of oocytes and sperm incurred while You are an Insured Person under this Certificate.

We will provide coverage for standard fertility preservation procedures when Medical Necessary to preserve fertility due to a need for medical Treatment that may directly or indirectly cause iatrogenic infertility. This includes coverage for an Insured Person who has been diagnosed with cancer for which necessary cancer Treatment may directly or indirectly cause iatrogenic fertility.

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 potential side effect of impaired fertility as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

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 normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the caesarean section delivery is the result of Complications of Pregnancy. If the delivery is the result of Complications of Pregnancy, the Hospital stay will be covered the same as for any other Covered Sickness. Services of a licensed Nurse midwife are covered when rendered in a Hospital or licensed outpatient facility rendering maternity services.

Home Births are also covered when services are rendered by a licensed Nurse midwife.

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

c. **Inpatient Physician charges or Surgeon charges** will be covered the same as for any other Covered Sickness for both mother and newborn child.

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

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

Covered Medical Expenses also include inpatient and outpatient coverage for up to two months for Medically Necessary pasteurized donor human milk upon prescription of an infant's pediatrician or licensed pediatric provider stating that the infant is medically or physically unable to receive maternal human milk or participate in breastfeeding, or the infant's mother is medically or physically unable to produce maternal human milk in sufficient quantities.

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

f. **Maternity Support Services**, including postpartum bereavement support, provided by a doula to a pregnant and birthing Insured Person before, during, and after childbirth up to a maximum of $1,500.

As used in this benefit:
Doula means an individual who has been trained to provide physical, emotional, and educational support, but not medical or midwifery care, to pregnant and birthing women and their families before, during, and after childbirth.

9. **Prosthetic Devices and Services and Orthotic Devices** when Medically Necessary and prescribed by a Physician.

a. Prosthetic Devices or prosthesis means:
   - an artificial limb designed to maximize function, stability, and safety of the Insured Person;
   - an artificial medical device that is not surgically implanted and that is used to replace a missing limb;
   - a device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of a Covered Injury or Covered Sickness.

The term does not include artificial eyes, ears, noses, dental appliances, ostomy products, or devices such as eyelashes or wigs.

Prosthetic Services means the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing of a prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities to restore function, cosmesis, or both. It shall also include any Medically Necessary clinical care.

b. Orthotic Devices includes mechanical supportive devices ordered by Your Physician for the Treatment of weak or muscle deficient feet.

10. **Outpatient Private Duty Nursing** services for non-hospitalized care performed by a R.N. or L.P.N for a Covered Injury or Covered Sickness if the condition requires skilled nursing care and visiting nursing care is not adequate. Services must be:

- Rendered in the home;
- Prescribed by the attending Physician as being Medically Necessary; and
- Performed by a certified Home Health Care Agency.

11. **Interpreter Services for the Deaf and Hard of Hearing** when performed by a qualified interpreter/transliterator, other than an Immediate Family Member, when such services are used by the Insured Person in connection with medical Treatment or diagnostic consultations performed by a Physician, provided the services are required because of a hearing impairment of the Insured Person or a failure of the Insured Person to understand or otherwise communicate in spoken language.

12. **Student Health Center/Infirmary Expense Benefit** if an Insured Person incurs Covered Medical Expenses as the result of Treatment at a Student Health Center/Infirmary, We will pay the Covered Medical Expenses incurred. Benefits will not exceed the amount shown in the Schedule of Benefits.

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

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

15. **Medical Evacuation Expense**(International Students and Domestic Students

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 31 days 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.

16. **Repatriation Expense**(International Students and Domestic Students

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 and Adult Dental and Vision Benefits

1. **Pediatric Dental Care Benefit** for dental care services for Insured Persons (to the end of the month in which the Insured Person turns age 19). Please refer to the Schedule of Benefits section of this Certificate for cost sharing requirements.

2. **Adult Dental Care Benefit** for dental care services for Insured Persons age 19 and older. Please refer to the Schedule of Benefits section of this Certificate for cost sharing requirements.

3. **Pediatric Vision Care Benefit** for Insured Persons (to the end of the month in which the Insured Person turns age (19)

We will provide benefits for:

a. 1 vision examinations per Policy Year, including dilation, if professionally indicated; and
b. 1 pairs of prescribed lenses and frames including glass or plastic lenses, all lens powers (single, bifocal, trifocal, lenticular), fashion and gradient tinting, ultraviolet protective coating, oversized and glass-grey #3 prescription sunglass lenses; or
c. Prescription contact lenses (in lieu of eyeglasses) per Policy Year.

Covered Medical Expenses also include:

a. Aphakic prescription lenses prescribed after cataract surgery has been performed;
b. Low vision services including comprehensive low vision evaluations and prescribed optical devices, such as high-power spectacles, magnifiers, and telescopes;
c. Medically Necessary contact lenses for the Treatment of Insured Persons affected by the following conditions:
    - Keratoconus
    - Pathological myopia
    - Aphakia

- Anisometropia
- Aniseikonia
- Aniridia
- Corneal disorders
- Post-traumatic disorders
- Irregular astigmatism

4. Adult Vision Care for Insured Persons age 19 and older. We will provide benefits for a routine eye examination once every 24 months.

Miscellaneous Dental Services

1. **Accidental Injury Dental Treatment (non-surgical)** as the result of Injury to Sound, Natural Teeth. Routine dental care and Treatment are not payable under this benefit. Damage to teeth due to chewing or biting is not deemed an accidental Injury and is not covered.

2. **Sickness Dental Expense Benefit** when, by reason of Sickness, You require Treatment for impacted wisdom teeth or dental abscesses, We will pay the Covered Medical Expenses incurred for the Treatment.

3. **Treatment for Temporomandibular Joint (TMJ) Disorders** for Treatment provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

4. **Oral Surgery Benefits** are provided for the following services or procedures:
   a. Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth;
   b. Surgery and dental appliances required to correct accidental injuries of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth, and of Sound Natural Teeth. (For the purposes of this section, Sound Natural Teeth includes those which are capped, crowned or attached by way of a crown or cap to a bridge. Sound Natural Teeth may have fillings or a root canal.);
   c. Excision of exostoses or tori of the jaws and hard palate;
   d. Incision and drainage of abscess and Treatment of cellulitis;
   e. Incision of accessory sinuses, salivary glands, and salivary ducts;
   f. Anesthesia for the above services or procedure when rendered by an oral surgeon;
   g. Anesthesia for the above services or procedure when rendered by a dentist who holds all required permits or training to administer such anesthesia;
   h. Anesthesia when rendered in a Hospital setting and for associated Hospital charges when an Insured Person's mental or physical condition requires dental Treatment to be rendered in a Hospital setting. Anesthesia benefits are not available for Treatment rendered for Temporomandibular Joint (TMJ) Disorders;
   i. Benefits are available for dental services not otherwise covered by this plan, when specifically required for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth.

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. These prescription requirements help Your prescriber and pharmacists check that Your outpatient Prescription Drug is clinically appropriate using evidence-based criteria.

If Your covered Prescription Drug is removed from the Formulary, We will continue to cover that covered Prescription Drug at the current benefit level until Your coverage under this Certificate terminates. If We add prior authorization requirements on Formulary medications that are taken by You, We will notify You 60 days in advance of the change. You have the right to appeal those changes for Medical Necessity reasons during that 60-day notification period.

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 all of the following conditions have been met:
    1. The drug is approved by the FDA;
    2. The drug is prescribed for the Treatment of a life-threatening condition, including cancer, HIV or AIDS;
    3. The drug has been recognized for Treatment of that condition by a nationally recognized drug database or two separate articles in major peer reviewed medical journals/clinical practice guidelines (cancer indications will only require evidence from ONE article or clinical practice guideline).

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

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

a. Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted; or
b. Disease or conditions with a potentially fatal outcome and where the end point of clinical intervention is survival.

b. **Dispense as Written (DAW)** – If a prescriber prescribes a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available and specifies: "Dispense as Written" (DAW), You will pay the cost sharing for the Brand-Name Prescription Drug. If a prescriber does not specify DAW and 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..

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

d. **Specialty Prescription Drugs** are limited to no more than a 30 day supply. However, if the Specialty Prescription Drug dispensed is the smallest package size available and exceeds a 30 day supply, You are responsible for the cost sharing defined for the day supply as shown in the Schedule of Benefits.

Specialty Drugs – are Prescription Drugs which:

1. Are used in the management of chronic, orphan, or rare diseases;
2. Require specialized storage, distribution, and/or handling;
3. Have frequent dosing adjustments and clinical monitoring to decrease potential for drug toxicity and improve clinical outcomes;
4. Involve additional patient education, adherence, and/or support;
5. May include generic or biosimilar products; and/or
6. May have limited or exclusive drug distribution restrictions.

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

e. **Self-Administered Prescription Drugs** – Certain self-administered Prescription Drugs are only covered under the Prescription Drug benefit and are excluded from the medical 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.wellfleetstudent.com.

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

g. **Step Therapy** – When medications for the Treatment of any medical condition are restricted for use by a step therapy or fail-first protocol, the prescribing practitioner shall have access to a clear and convenient process to request an override of the restriction from Us. An override of that restriction will be granted by Us upon completion of the review if all necessary information to perform the override review has been provided, under the following documented circumstances:
    1. The prescribing practitioner can demonstrate, based on sound clinical evidence, that the preferred Treatment required under step therapy or fail-first protocol has been ineffective in the Treatment of Your disease or medical condition; or
    2. Based on sound clinical evidence or medical and scientific evidence:
        a. The prescribing practitioner can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the Insured Person and known characteristics of the drug regimen; or
        b. The prescribing practitioner can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to You.

We will make a non-urgent step therapy exception determination within 72 hours of receiving all the clinical information from the prescribing practitioner. We will make an urgent step therapy exception determination within 24 hours of receiving all the clinical information from the prescribing practitioner. If We fail to comply with the timelines provided above, the override request shall be considered approved.

We will not use step therapy or fail first protocols as the basis to restrict any prescription benefit for the Treatment of stage-four advanced, metastatic cancer or associated conditions if at least one of the following criteria is met:

1. The prescribed drug or drug regimen has the United States Food and Drug Administration approved indication.
2. The prescribed drug or drug regimen has the National Comprehensive Cancer Network Drugs and Biologics Compendium indication.
3. The prescribed drug or drug regimen is supported by peer-reviewed, evidenced-based medical literature.

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** –You may access the most up to date tier status on Our website at www.wellfleetstudent.com or by calling the number on Your ID card.

j. **Compounded Prescription Drugs** will be covered only when they contain at least 1 ingredient that is a covered legend Prescription Drug, do not contain bulk chemicals, and are obtained from a pharmacy that is approved for compounding. Compounded Prescription Drugs may require Your Provider to obtain Preauthorization. Compounded Prescription Drugs will be covered as the tier associated with the highest tier ingredient.

k. **Formulary Exception Process** – If a Prescription Drug is not on Our Formulary, You, Your Authorized Representative or Your prescribing Physician may request a Formulary exception for clinically appropriate Prescription Drug in writing, electronically or telephonically. If coverage is denied under Our standard or expedited Formulary exception process, the Insured Person is entitled to an external appeal as outlined in the External Appeal section of this Certificate. Refer to the Formulary posted on Our website at www.wellfleetstudent.com 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.

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

l. **Tobacco cessation prescription and over-the-counter drugs** – Tobacco cessation Prescription Drugs and OTC drugs will be covered up to a six (6) month period if a Physician recommends and certifies that the smoking cessation benefits may help You to quit smoking.. 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, refer to the Formulary posted on Our website www.wellfleetstudent.com 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 Formulary posted on Our website at www.wellfleetstudent.com.

n. **Preventive contraceptives -** 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. You can access the list of contraceptive prescription drugs by referring to the Formulary posted on Our website at www.wellfleetstudent.com 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.

o. **Orally administered anti-cancer drugs, including chemotherapy drugs** - Covered Medical Expenses include any drug prescribed for the Treatment of cancer if it is recognized for Treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication.

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

You can identify covered diabetic supplies by referring to the Formulary posted on Our website at www.wellfleetstudent.com 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. **Treatment of Metastatic or Unreasonable Tumors –** Covered Medical Expenses include FDA-approved drugs used for the Treatment of metastatic or unresectable tumors or other advanced cancers, even if the drug is not approved by the FDA for this Treatment. Coverage shall be included for a minimum initial Treatment period of not less than 3 months. After Coverage shall continue after the initial Treatment period if Your treating Physician certifies the drug is Medically Necessary based on documented improvement in Your condition.

Mandated Benefits for Louisiana

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. **Attention Deficit Disorder Benefit** for the diagnosis and Treatment for attention deficit/hyperactivity disorder when rendered or prescribed by a Physician or other appropriately licensed health care provider and received in any Physician's or other appropriate health care provider's office, any licensed Hospital, or in any other licensed public or private facility, including but not limited to clinics and mobile screening units. Benefits will be paid as shown on the Schedule of Benefits.

2. **Bone Mass Measurement Benefit** for a Qualified Individual for scientifically proven bone mass measurement for the diagnosis and Treatment of osteoporosis.

As used in this benefit:

Qualified Individual means an estrogen-deficient woman at clinical risk of osteoporosis who is considering Treatment; an individual receiving long-term steroid therapy; or an individual being monitored to assess the response to or efficacy of approved osteoporosis drug therapies.

3. **Cancer Screening Benefits** for the following:
    - Annual Pap test for cervical cancer.
    - Annual preventive cancer screening following a full unilateral or bilateral mastectomy.
    - Minimum mammography examination (including diagnostic imaging and ultrasound designed to evaluate an abnormality) when prescribed by a health care provider and performed no less frequently than the following:
        - One baseline mammogram for any woman who is 35 through 39 years of age;
        - Annual mammogram for any woman who if 40 and older;
        - For women with a hereditary susceptibility from pathogenic mutation carrier status or prior chest wall radiation, an annual MRI starting at age 25 and annual mammography starting at age 30.
        - Annual mammography and access to supplemental imaging starting at age 35 upon recommendation by her Physician.
    - The cost of genetic testing of the BRCA1 and BRCA2 genes to detect an increased risk of breast and ovarian cancer when recommended by a health care provider in accordance with the USPSTF recommendations for testing.
    - Routine colorectal cancer screening for adults age 45 to 75.
    - Prostate specific antigen (PSA) testes for men age 45 to 75 years and as Medically Necessary and appropriate for men over the age of 40 years.

As used in this benefit:
Minimum Mammography Examination means mammographic examinations, including but not limited to Digital Breast Tomosynthesis and Diagnostic Imaging, performed no less frequently than the following schedule provides:

a. For women with a hereditary susceptibility from pathogenic mutation carrier status or prior chest wall radiation, an annual MRI starting at age 25 and annual mammography (DBT preferred modality) starting at age 30.
b. Annual mammography (DBT preferred modality) and access to supplemental imaging (MRI preferred modality) starting at age 35 upon recommendation by her Physician if the woman has a predicted lifetime risk greater than 20% by any validated model published in peer reviewed medical literature.
c. Annual mammography (DBT preferred modality) for any woman who is 40 years of age or older.
    - Consideration given to supplemental imaging (breast ultrasound initial preferred modality, followed by MRI if inconclusive), if recommended by her Physician, for women with increased breast density (C and D density).
    - Access to annual supplemental imaging (MRI preferred modality), if recommended by her Physician, for women with a prior history of breast cancer below the age of 50 or with a prior history of breast cancer at any age and dense breast (C and D density).

Diagnostic Imaging means a diagnostic mammogram or breast ultrasound screening for breast cancer designed to evaluate an abnormality in the breast that is any of the following:

- Seen or suspected from a screening examination for breast cancer;
- Detected by another means of examination; or
- Suspected based on the Insured Person's
    - Medical history; or
    - Family medical history.

Digital Breast Tomosynthesis (DBT) 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.

4. **Cleft Lip and Cleft Palate Coverage** is provided for expenses incurred for the Treatment of cleft lip and cleft palate. Such coverage shall also include benefits for secondary conditions and Treatment attributable to that primary medical condition. Benefits include, but are not limited to:
   a. Oral and facial surgery, surgical management, and follow-up care.
   b. Prosthetic Treatment such as obturators, speech appliances, and feeding appliances.
   c. Orthodontic Treatment and management.
   d. Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic Treatment or prosthetic management or therapy.
   e. Speech-language evaluation and therapy.
   f. Audiological assessments and amplification devices.
   g. Otolaryngology Treatment and management.
   h. Psychological assessment and counseling.
   i. Genetic assessment and counseling for Insured Person and parents.

5. **Treatment of Lymphedema Benefit** for the Treatment of lymphedema, rendered or prescribed by a Physician or received in any Hospital or in any other public or private facility authorized to provide lymphedema Treatment. This includes multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

SECTION V - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

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

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

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

SECTION VI - EXCLUSIONS AND LIMITATIONS

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

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

General Exclusions

- **International Students Only -** Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible.
- Treatment, service or supply which is not Medically Necessary for the diagnosis, care or Treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended or approved by the Student Health Center or by Your attending Physician or dentist.
- Medical services rendered by a provider employed for or contracted with the Policyholder, including team

Physicians or trainers, except as specifically provided in the Schedule of Benefits or as part of the Student Health Center benefits provided by this plan.

- Professional services rendered by an Immediate Family Member or anyone who lives with You.
- Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services covered by Student Health Fees.
- Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
- Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which You are required to pay.
- Services that are duplicated when provided by both a certified Nurse midwife and a Physician.
- Expenses payable under any prior policy which was in force for the person making the claim.
- Loss resulting from war or any act of war, whether declared or not, or Loss sustained while in the armed forces of any country or international authority.
- Injury sustained as the result of Your operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle Accident takes place.
- Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
- Expenses incurred after:
    - The date insurance terminates as to an Insured Person, except as specified in the extension of benefits provision; and
    - The end of the Policy Year specified in the Policy.
- Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
- Custodial Care service and supplies.
- Charges for hot or cold packs for personal use.
- Services of private duty Nurse except as provided in the Certificate.
- Expenses that are not recommended and approved by a Physician.
- Experimental or Investigative drugs, devices, Treatments or procedures unless otherwise covered under Covered Clinical Trials. See the Other Benefits section for more information.
- Routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal or artificial organs or tissues.
- Loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
- Non-chemical addictions.
- Outpatient non-physical, occupational, speech therapies (art, dance, etc.).
- Modifications made to dwellings.
- General fitness, exercise programs.
- Hypnosis.
- Rolfing.
- Biofeedback.
- Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
- Sleep Disorders, except for a sleep study performed in the Insured Person's home or performed in a sleep laboratory that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM), the diagnosis, and Treatment of obstructive sleep apnea.
- Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary because of Injury, infection or disease.

Activities Related

- Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.

- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate for which benefits are paid under another Sports Accident policy issued to the Policyholder; or for which coverage is provided by the National Collegiate Athletic Association (NCAA), National Association of Intercollegiate Athletic (NAIA) or any other sports association.
- Racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles).

Weight Management/Reduction

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

Family Planning

- Infertility Treatment (male or female)-this includes but is not limited to:
  - Procreative counseling;
  - Premarital examinations;
  - Genetic counseling and genetic testing;
  - Impotence, organic or otherwise;
  - Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
  - In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
  - Costs for an ovum donor or donor sperm;
  - Ovulation induction and monitoring;
  - Artificial insemination;
  - Hysteroscopy;
  - Laparoscopy;
  - Laparotomy;
  - Ovulation predictor kits;
  - Reversal of tubal ligations;
  - Reversal of vasectomies;
  - Costs for and relating to surrogate motherhood (maternity services are covered for Insured Persons acting as surrogate mothers);
  - Cloning; or
  - Medical and surgical procedures that are Experimental or Investigative, unless Our denial is overturned by an External Appeal Agent.
- Abortion services, except when Medically Necessary to save the life of the Insured Person.

Vision

- Expenses for radial keratotomy.
- Adult Vision unless specifically provided in the Certificate.
- Charges for office visit exam for the fitting of prescription contact lenses, duplicate spare eyeglasses, lenses or frames, non-prescription lenses or contact lenses that are for cosmetic purposes.

Dental

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

Hearing

- Charges for hearing exams, hearing screening, and the fitting or repair or replacement of hearing aids or cochlear implants except as specifically provided in the Certificate.

Cosmetic

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

Prescription Drugs

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

Third Party Refund:

When:

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

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

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

Coordination Of Benefits

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

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

DEFINITIONS

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

Each Certificate for coverage under a. or b. is a separate Plan. If a Plan has 2 parts and COB rules apply only to one of the two, 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 one 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 service or expense, including Deductibles, Coinsurance and Copayments, that is covered in full or 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 one of the Plans provides coverage for private hospital room expenses.
b. If a person is covered by two 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 two 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 one 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 two 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.
(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.

B. 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.

C. 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.

C. Effect on the Benefits of This Plan
   1. 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 or claim determination period are not more than 100 percent of total Allowable expenses. The difference between the benefit payments that this Plan would have paid had it been the Primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Insured and used by this Plan to pay any Allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted,

This Plan will:

   a. determine its obligation to pay or provide benefits under its contract;
   b. determine whether a benefit reserve has been recorded for the Insured; and
   c. determine whether there are any unpaid Allowable Expenses during that claims determination period.
   2. If there is a benefit reserve, the Secondary Plan will use the Insureds benefit reserve to pay up to 100 percent of total Allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

COORDINATION OF BENEFITS - IMPORTANT NOTICE

This is a summary of only a few of the provisions of the health plan to help You understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in this Certificate, which determines Your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When You are covered by more than one health plan, state law permits Your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when You have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than Your covered health care expenses.

Coordination of Benefits (COB) is complicated and covers a wide variety of circumstances. This is only an outline of some of the most common ones. Read this Certificate or contact Your state insurance department.

Primary or Secondary?
You will be asked to identify all the plans that cover members of Your family. We need this information to determine whether We are the “primary” or “secondary” benefit payer. The Primary Plan always pays first when You have a claim.

Any Plan that does not contain the state’s COB rules will always be primary.

When This Plan is Primary
If You or a family member (if covered under this Certificate) are covered under another Plan in addition to this one, We will be primary for:

- Your own health care expenses;
- Your spouse’s expenses;
- Your dependent child’s expenses;
- The claim is for the health care expenses of Your child who is a dependent under This Plan and You are married and Your birthday is earlier in the year than Your spouse’s or You are living with another individual, regardless of whether or not You have ever been married to that individual, and Your birthday is earlier than that other individual’s birthday. This is known as the “birthday rule;” or
- You are separated, or divorced, and We have been informed of a court decree that makes Your responsible for the dependent child’s health care expenses; or
- There is no court decree, but You have custody of the dependent child.

Other Situations
We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary
When We are the Primary Plan, We will pay the benefits in accordance with the terms of Your contract, just as if You had no other health care coverage under any other Plan.

How We Pay Claims When We Are Secondary
We will be secondary whenever the rules do not require us to be primary.

When We are the Secondary Plan, We do not pay until after the Primary Plan has paid its benefits. We will then pay part, or all, of the Allowable expenses left unpaid, as explained below. An Allowable expense is a health care service or expense covered by one of the Plans, including Copays, Coinsurance and Deductibles.

- If there is a difference between the amount the Plans allow, We will base Our payment on the higher amount. However, if the Primary Plan has a contract with the provider, Our combined payments will not be more than the contract calls for. Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) usually have contracts with their providers.
- We will determine Our payment by subtracting the amount the Primary Plan paid from the amount We would have paid if We had been primary.
- We will use any savings to pay the balance of any unpaid Allowable expenses covered by either Plan.
- If the Primary Plan covers similar kinds of health care expenses, but allows expenses that We do not cover, We will pay for those items as long as there is a balance in Your benefit reserve, as explained below.
- We will not pay an amount the Primary Plan did not cover because You did not follow its rules and procedures. For example, if Your Plan has reduced its benefit because You did not obtain pre-certification, as required by that Plan, We will not pay the amount of the reduction, because it is not an Allowable expense.
- Benefit Reserve
- When We are secondary, We often will pay less than We would have paid if We had been primary. Each time We "save" by paying less, We will put that savings into a benefit reserve. Each dependent covered by this Plan has a

separate benefit reserve. We use the benefit reserve to pay Allowable expenses that are covered only partially by both Plans. To obtain a reimbursement, You must show Us what the Primary Plan has paid so We can calculate the savings.

- To make sure You receive the full benefit or coordination, You should submit all claims to each Plan. Savings can build up in Your reserve for one year. At the end of the year any balance is erased, and a fresh benefit reserve begins for each person the next year as soon as there are savings on their claims.

Questions about Coordination of Benefits?
Contact the State of Louisiana's Insurance Department

Notice to Insured Persons
If You are covered by more than one Plan, claims should be filed with each Plan. Additionally, You may request a paper or electronic version of the "Explanation for Secondary Plans on the Purpose and Use of the Benefit Reserve and How Secondary Plans Calculate Claims" notice. To request a copy of this notice, please contact Us.

This notice is also available on the Louisiana Department of Insurance's website.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, Our Agent or We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. Our Agent or We will not have to pay that amount again. The term payment made includes providing benefits in the form of services, in which case payment made means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

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

SECTION VII - GENERAL PROVISIONS

Entire Contract Changes
The Policy, this Certificate, including the application, endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in 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.

Reinstatement
If default is made in the payment of any agreed Premium for the Policy, the subsequent acceptance of the defaulted

Premium by Us or by any producer authorized by Us to accept such Premium, shall reinstate the Policy; however, the reinstated policy shall cover only loss resulting from accidental injury thereafter sustained or loss due to sickness beginning more than 10 days after the date of such acceptance.

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

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

Uniform Claim Forms
All claims shall be processed in conformity with the uniform claim form issued by the Department of Insurance pursuant to R.S. 22:1824.

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

Time of Payment
Indemnities payable under this Certificate will be paid immediately upon receipt of due proof of such Loss.

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

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

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

As used in the provision:
Beneficiary means a person designated by the Insured Person, or by the terms of this Certificate, who is or may become entitled to a benefit under this Certificate.

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 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.

Time Limit on Certain Defenses
After three years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application of such Policy shall be used to void the Policy or deny a claim for loss incurred or disability, as defined in the Policy, commencing after the expiration of such three-year period.

Conformity with State Statutes
Any provision of this Certificate which, on its Effective Date, is in conflict with the statutes of the state in which this Certificate was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statutes.

SECTION VIII - ADDITIONAL PROVISIONS

1. We do not assume any responsibility for the validity of assignment.

2. You will have free choice of a legally qualified Physician with the understanding that the Physician-patient relationship will be maintained. No authorization or referral requirement will apply to obstetrical or gynecological care provided by In-Network Providers.

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.

9. We will not be liable for any loss to which a contributing cause was Your commission of or attempt to commit a felony or to which a contributing cause was Your being engaged in an illegal occupation.

SECTION IX – APPEALS PROCEDURE

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

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

For purposes of this Section, the following definitions apply:
Adverse Benefit Determination means:

- A determination by Us or Our designee Utilization review organization that, based upon the information provided, a request for a benefit under the Policy upon application of any utilization review technique does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be Experimental or Investigative and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;
- The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by Us or Our designee Utilization review organization of Your eligibility under the Policy;
- Any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit; or
- A rescission of coverage.

Authorized Representative means:

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

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

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

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

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

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

Prospective review means utilization review conducted prior to an admission or the provision of a health care

service or a course of treatment in accordance with Our requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

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

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

1.
    a. Could seriously jeopardize Your life or health or Your ability to regain maximum function; or
    b. In the opinion of a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the health care service or Treatment that is the subject of the request.
2.
    a. Except as provided in (b) of this paragraph, in determining whether a request is to be treated as an Urgent Care request, an individual acting on Our behalf shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
    b. Any request that a Physician with knowledge of Your medical condition determines is an Urgent Care Request shall be treated as an urgent care request.

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

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

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

Step 1:

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

Type of Claim	**You will be notified by Us that a claim is denied as soon as possible but no later than:**	**Extension period allowed for circumstances beyond Our control:**	**If additional information is needed, You must provide within:**
Pre-Service Claim	15 days from receipt of	One extension of 15 days	45 days of date of

	claim (whether adverse or not)		extension notice
Pre-Service Claim involving Urgent Care	72 hours from receipt of claim (whether adverse or not) (24 hours after receipt of claim if additional information is needed from You)	None	48 hours (We must notify You of determination within 48 hours of receipt of Your information)
Concurrent: To end or reduce Treatment prematurely (other than by policy amendment or termination) Pending the outcome of an appeal, benefits for an ongoing course of Treatment will not be reduced or terminated.	Notification to end or reduce Treatment will allow sufficient time in advance to allow You to appeal and obtain a determination on the adverse benefit determination prior to the end or reduction of prescribed Treatment	N/A	N/A
Concurrent: To deny Your request to extend Treatment	30 days from receipt of claim for Pre-Service Claim; or 60 days from receipt of claim for Post-Service Claim	One extension of 15 days	45 days of the date of extension notice
Concurrent: Involving Urgent Care	72 hours from receipt of claim (whether adverse or not) (24 hours after receipt of claim if additional information is needed from You; or 24 hours after receipt of claim provided that any such claim is made at least 24 hours prior to the end or reduction of prescribed Treatment)	None	48 hours (We must notify You of determination within 48 hours of receipt of Your information)
Post-Service Claim	30 days from receipt of claim	One extension of 15 days	45 days of the date of extension notice

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

1. The reason(s) for the denial and the Policy provisions on which the denial is based.
2. A description of any additional information necessary for You to perfect Your claim, why the information is necessary, and Your time limit for submitting the information.
3. A description of the Policy's appeal procedures and the time limits applicable to such procedures, including a statement of Your right to bring a civil action following a final denial of Your appeal.
4. A statement indicating whether an internal rule, guideline or protocol was relied upon in making the denial and a statement that a copy of that rule, guideline or protocol will be made available upon request free of charge.
5. If the denial is based on a Medical Necessity, Experimental Treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request; and
6. If the claim was an Urgent Care request, a description of the expedited appeals process. The notice may be provided to You orally within 72 hours; however, a written or electronic notification will be sent to You no later than 3 days after the oral notification. If the claim was/is an Urgent Care request, You may initiate an internal appeal and an external review simultaneously.
7. Information sufficient to identify the claim (including the date of service, the health care provider, and the claim amount (if applicable).
8. An explanation of how to request diagnosis and treatment codes (and their corresponding meanings).
9. The contact information for all relevant review agency contacts and the office of health insurance consumer assistance to assist You with Your claims, appeals and external review.
10. Notification that culturally and linguistically appropriate services are available.

INTERNAL APPEAL

<u>Step 2</u>:

If You do not agree with Our decision and wish to appeal, You must file a written appeal with Us at the address below within 180 days after receipt of the Adverse Benefit Determination notification (or oral notice if an Urgent Care request) referenced in Step 1. If the claim involves Urgent Care, Your appeal may be made orally.

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

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

Type of Claim	**You must file Your appeal within:**	**You will be notified of Our determination as soon as possible but no later than:**
Pre-Service Claim	180 days after receipt of Adverse Benefit Determination	30 days of receipt of appeal
Pre-Service Claim involving Urgent Care	180 days after receipt of Adverse Benefit Determination	72 hours of receipt of appeal
Concurrent: To end or reduce Treatment	180 days after receipt of Adverse Benefit Determination Pending the outcome of the	15 days of receipt of appeal

prematurely	appeal, benefits for an ongoing course of Treatment will not be reduced or terminated.	
Concurrent: To deny Your request to extend Treatment	180 days after receipt of Adverse Benefit Determination for Pre-Service or Post-Service Claim	15 days of receipt of appeal for Pre-Service Claim; or 30 days of receipt of appeal for Post- Service Claim
Concurrent: Involving Urgent Care	180 days after receipt of Adverse Benefit Determination	72 hours of receipt of appeal
Post-Service Claim	180 days after receipt of Adverse Benefit Determination	60 days of receipt of appeal

Step 3:

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

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

You may also seek an external review for a rescission of coverage.

STANDARD EXTERNAL REVIEW

Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination, You may file a request for an external review with Us.

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

Within 5 business days of receiving Your request for an external review, We will complete a preliminary review of the request to determine whether:

1. You were covered under the Policy at the time the health care service was requested; or,
2. In the case of a Retrospective review, You were covered under the Policy at the time the expense was incurred;
3. The health care service is the subject of an Adverse Benefit Determination or final denial;
4. You have exhausted the Internal Appeal process where required;
5. You have provided all the information and forms required to process an external review.

You will be required to authorize the release of any of Your medical records that may be required to be reviewed for the purpose of reaching a decision of the external review.

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

- Contact Your state's Department of Insurance to request an investigation of a claim determination or appeal;
- File a complaint or appeal with Your state's Department of Insurance;
- File a request for an External Review;

- Pursue arbitration, litigation or other type of administrative proceedings.

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

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

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

If initially eligible for an external review, We will notify the Commissioner by submitting a request for assignment of an IRO through the Department of Insurance's website. Upon notification, the Commissioner will assign an IRO to conduct the external review. Within one business day, the Commissioner will send written notice to You of the request's eligibility and acceptance for external review and the identity and contact information of the assigned IRO. The Commissioner will include in the notice provided to You a statement that You may submit in writing to the assigned IRO, within 5 business days following the date of receipt of the notice, additional information that the IRO will consider when conducting the external review. The IRO will be authorized but not required to accept and consider additional information submitted after 5 business days. The IRO will make a determination and provide You and Us with notice of its determination within 45 days of receiving the review request.

If initially not eligible for an external review, We will notify the Commissioner, and the notice shall state with specificity the information or materials needed to make the request complete. If You have not provided all the information and forms required to process an external review, We will include in the notice a copy of the form, and copies of any materials submitted by You that could reasonably be interpreted as pertaining to the same subject matter or purpose of the form.

If We fail to provide the documents and information within 5 business days after receipt of the notice, the assigned IRO may terminate the external review process and make a decision to reverse the Adverse Benefit Determination or the final Adverse Benefit Determination.

EXPEDITED EXTERNAL REVIEW

If, due to Your medical condition, the time frame for completion of the standard external review process would seriously jeopardize Your life or health or Your ability to regain maximum function, You may request an expedited external review, the preliminary review will be completed immediately. If determined to be initially eligible, We will notify the Commissioner by submitting a request for assignment of an IRO through the Department of Insurance's website. Upon receipt of the notice that the request meets the reviewability requirements, the Commissioner shall immediately assign an IRO to conduct the expedited external review. The Commissioner will immediately notify Us and You of the name and contact information of the assigned IRO. The IRO will complete the review as expeditiously as Your medical condition requires, but in no event more than 72 hours after receiving the request. If the notice is provided to You orally, a written or electronic notification will be sent to You no later than 48 hours after the oral notification.

IMPORTANT INFORMATION

- Each level of appeal will be independent from the previous level (i.e., the same person(s) involved in a prior level of appeal will not be involved in the appeal).
- The claims reviewer will review relevant information that You submit even if it is new information. In addition, You have the right to request documents or other records relevant to Your claim.
- If a claim involves medical judgement, then the claims reviewer will consult with an independent health care professional that has expertise in the specific area involving medical judgment.
- You may review the claim file and present evidence and testimony at each state of the appeals process.
- You may request, free of charge, any new or additional evidence considered, relied upon, or generated by Us in connection with Your claim.
- If a decision is made based on new or additional rationale, You will be provided with the rationale and be given a reasonable opportunity to respond before a final decision is made.
- If You wish to submit relevant documentation to be considered in reviewing Your claim for appeal, it must be submitted with Your claim and/or appeal.
- You should exhaust these appeals procedures before filing a complaint or appeal with Your state's Department of Insurance.
- You should raise all issues that You wish to appeal during Our Internal Appeal process and during the External Review.

CONTACT INFORMATION

If You have any questions or concerns, You can contact Us at: Wellfleet
Insurance Company
Attention: Appeals Unit Wellfleet
Group, LLC
P.O. Box 15369
Springfield, MA 01115-5369

Louisiana Department of Insurance
P.O. Box 94214
Baton Rouge, LA 70804-9214
(225) 342-5900
(800)259-5300

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.

هيبنتن: اذإ تنكن تدحتن **ةيبرعلا (Arabic)**، نإف تامدخ ةدعاسملا ةيوغللا ةينانجملا ةحاتمك. 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 امشد نابز رگا :هجوت **(Farsi)** دشاب یم امشد رایتخا رد نارگیار روط هب ینابز دادما تامدخ ،تسا. 657-5030 تمسا بیگرید.

कृपा ध्या द: यद आप **हंद (Hindi)** भाषी ह तो आपके लए भाषा सहायता सेवाएंन:शुल् उपलब् ह। कृपा 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)** បសវាកម្មភាសាជំនួយឥតគិតថ្លៃមានសម្រាប់អ្នក។ 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 yániłti'go, saad bee áka'anída'awo'ígíí, t'áá jiík'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:લ્ક 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 ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ(877) 657-5030

ਪੰਜਾਬੀ (Punjabi) ਧਆਿਨ ਿ 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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (877) 657-5030

Summary of the Louisiana Life and Health Insurance Guaranty Association Law and Notice Concerning Coverage Limitations and Exclusions

Residents of Louisiana who purchase life insurance, annuities, or health insurance should know that the insurance companies licensed in this state to write these types of insurance are required by law to be members of the Louisiana Life and Health Insurance Guaranty Association (LLHIGA). The purpose of LLHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, LLHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through LLHIGA is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Disclaimer

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. *COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.* Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA
P.O. Box 3337
Baton Rouge, Louisiana 70821

Department of Insurance
P.O. Box 94214
Baton Rouge, Louisiana 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the Law), and is set forth at R.S. 22:2081 *et seq*. The following is a brief summary of this Law's coverages, exclusions and limits. This summary does not cover all provisions of the Law; nor does it in any way change any person's rights or obligations under the Law or the rights or obligations of LLHIGA.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a covered life, health or annuity policy, or contract issued by an insurer (including a health maintenance organization) authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well even if they live in another state unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the Law are applicable.

(over)

EXCLUSIONS FROM COVERAGE

A person who holds a covered life, health or annuity policy, plan or contract is not protected by LLHIGA if:

(1) He is eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);
(2) The insurer was not authorized to do business in this state;
(3) His policy was issued by a profit or nonprofit hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined in R.S. 22:952(A)(3), or any entity similar to any of these.

LLHIGA also does not provide coverage for:

(1) Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
(2) Any policy of reinsurance (unless an assumption certificate was issued);
(3) Interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;
(4) Dividends, premium refunds, or similar fees or allowances described under the Law;
(5) Credits given in connection with the administration of a policy by a group contract holder;
(6) Employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured;
(7) Unallocated annuity contracts (which give rights to group contract holders, not individuals), except unallocated annuity contracts and defined contribution government plans qualified under section 403(b) of the United States *Internal Revenue Code* (26 U.S.C. §403(b));
(8) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the Law;
(9) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part A Coverage", "Medicare Part B Coverage", "Medicare Part C coverage", "Medicare Part D coverage" or "Medicaid" and any regulations issued pursuant to those parts;
(10) Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNTS OF COVERAGE

The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount that LLHIGA is obligated to pay out. The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following:

(1) LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.
(2) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $300,000 in life insurance death benefits, but not more than

$100,000 in net cash surrender and net cash withdrawal values for life insurance.

(3) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $500,000 in health insurance benefits, and LLHIGA will pay a maximum of $250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than $500,000 in the aggregate with respect to any one individual.