WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

STUDENT HEALTH CERTIFICATE OF COVERAGE

POLICYHOLDER:	SHAW UNIVERSITY (Policyholder)
POLICY NUMBER:	WI2223NCSHIP197
POLICY EFFECTIVE DATE:	August 1, 2022
POLICY TERMINATION DATE:	July 31, 2023
STATE OF ISSUE:	North Carolina

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

INSURING AGREEMENTS

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

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

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

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

RIGHT TO RETURN POLICY WITHIN 10 DAYS
You have 10 days after you receive this Policy to read and review it. During that 10-day period, if you decide you do not want the Policy, you may return it to us at our Home Office or to the agent who sold it to you. As soon as it is returned, this Policy will be void from the beginning. Premium paid will be returned to you.

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.

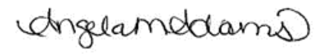
YOUR CERTIFICATE MAY NOT BE IN FORCE WHEN YOU HAVE A CLAIM! PLEASE READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THIS CERTIFICATE. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the Company.

Important Cancellation Information – Please Read The Provision "Termination Dates" Found on Page 19

Non-Participating

One Year Term Insurance This policy maybe renewed by the Policyholder



Andrew M. DiGiorgio, President

Angela Adams, Secretary

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

North Carolina Fiduciary Notice

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR,WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE

TABLE OF CONTENTS

SCHEDULE OF BENEFITS 5
SECTION I - ELIGIBILITY 17
SECTION II - EFFECTIVE AND TERMINATION DATES 17
Effective Dates 17
Special Enrollment - Qualifying Life Event 18
Termination Dates 19
Dependent Child Coverage 19
Newly Born Children 19
Adopted and Foster Children 19
Handicapped Children 20
Extension of Benefits 20
Reinstatement of Reservist After Release From Active Duty 20
Refund of Premium 20
SECTION III - DEFINITIONS 21
SECTION IV - HOW THE PLAN WORKS AND DESCRIPTION OF BENEFITS 30
How the Deductible Works 30
How Your Out-of-Pocket Maximum Works 31
Essential Health Benefits 32
Treatment of Covered Injury and Covered Sickness Benefit 32
Medical Benefit Payments for In-Network and Out-of-Network Providers 32
Preferred Provider Organization 32
Continuity of Care 33
Pre-Certification Process 33
Covered Medical Expenses 34
Preventive Services 34
Inpatient Services 35
Mental Health Disorder and Substance Use Disorder Benefits 36
Professional and Outpatient Services 36
Emergency Services, Ambulance and Non-Emergency Services 38
Diagnostic Laboratory, Testing and Imaging Services 39
Rehabilitation and Habilitation Therapies 40
Other Services and Supplies 40
Pediatric Dental and Vision Benefits 44
Miscellaneous Dental Services 48
Prescription Drugs 49
Mandated Benefits 52
SECTION VI - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT 55
SECTION VI - EXCLUSIONS AND LIMITATIONS 55
SECTION VII - GENERAL PROVISIONS 58
Entire Contract Changes 58
Notice of Claim 58
Claim Forms 58
Proof of Loss 58
Time of Payment 58
Payment of Claims 59
Assignment 59
Physical Examination and Autopsy 59
Legal Actions 59
Conformity with State Statutes 59
SECTION VIII - ADDITIONAL PROVISIONS 59
SECTION IX- APPEALS PROCEDURE 60

SCHEDULE OF BENEFITS

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

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

Medical Deductible

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

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

Out-of-Pocket Maximum:

In-Network Provider	Individual	$2,500
	Family	$5,000
Out-of-Network Provider	Individual	$5,000
	Family	No maximum

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

Coinsurance Amounts:

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

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

When You receive Emergency Services, or certain non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, You are protected from Surprise Billing. In these situations, Your cost sharing responsibility will be calculated as if the total amount that would be charged for the services by an In-Network Provider or facility were equal to the 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.

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

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

Preferred Provider Organization:
To locate an In-Network Provider in Your area, consult Your Provider Directory or call toll free 877-657-5030, TTY 711 or visit Our website at www.wellfleetstudent.com.

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

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

NOTICE: YOUR ACTUAL EXPENSES FOR COVERED SERVICES MAY EXCEED THE STATED COINSURANCE PERCENTAGE OR COPAYMENT AMOUNT BECAUSE THE ACTUAL PROVIDER CHARGES MAY NOT BE USED TO DETERMINE THIS PLAN AND YOUR PAYMENT OBLIGATIONS.

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK	OUT-OF-NETWORK
INPATIENT SERVICES		
Hospital Care Includes Hospital room & board expenses and miscellaneous services and supplies. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined Limited to 1 visit per day of Confinement per provider	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Skilled Nursing Facility Benefit Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Registered Nurse Services for private duty nursing while Confined	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER BENEFITS In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, 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	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Mental Health Disorder and Substance Use Disorder Benefit Pre-Certification Required except for office visits		
Physician's Office Visits including, but not limited to, Physician visits; individual and group therapy; medication management	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
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; Medically Necessary biofeedback	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

PROFESSIONAL AND OUTPATIENT SERVICES		
Surgical Expenses		
Inpatient and Outpatient Surgery includes: Pre-Certification Required Surgeon Services Anesthetist Assistant Surgeon	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Surgical Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Bariatric Surgery Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Organ Transplant Surgery - Transplant surgery and donor search expenses - Travel and lodging expenses while at the transplant facility. - Donor travel and lodging and meal expenses while at the transplant facility Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Reconstructive Surgery Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Other Professional Services		
Gender Transition Benefit Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Pre-Certification required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hospice Care Coverage	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Office Visits		
Physician's Office Visits including Specialists/Consultants	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telemedicine or Telehealth Services	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Allergy Testing and Treatment including injections.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Maximum visits per Policy Year combined with occupational therapy and physical therapy for Rehabilitation and Habilitation	60	60
Tuberculosis screening, Titers, QuantiFERON B tests including shots (other than covered under preventive services)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Services, Ambulance And Non-Emergency Services		
Emergency Services in an emergency department for Emergency Medical Conditions.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Urgent Care Centers for non-life-threatening conditions	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Non-Emergency Ambulance Service ground and/or air, water transportation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diagnostic Laboratory, Testing and Imaging Services		
Diagnostic Imaging Services Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Rehabilitation and Habilitation Therapies		
Cardiac Rehabilitation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maximum Visits per Policy Year for Physical Therapy, Occupational Therapy, and Chiropractic Care Combined	60	60
Maximum Visits per Policy Year for Speech Therapy	60	60
Habilitation Services including, Physical Therapy, and Occupational Therapy, and Speech Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitation Services Maximum Visits per Policy Year for Physical Therapy, Occupational Therapy, and Chiropractic Care Combined	60	60
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.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Durable Medical Equipment Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Enteral Formulas and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hearing Aids Limited to one (1) hearing aid per impaired ear, and replacement hearing aids Once every 36 months	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infertility Treatment Infertility Treatment limited to 3 Treatments per Insured Person per lifetime Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
Prosthetic and Orthotic Devices Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Private Duty Nursing Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Sexual Dysfunction Services	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Sports Accident Expense Benefit - incurred as the result of the play or practice of Intercollegiate or club sports Up to $500 per Accident The maximum dollar benefit limits will only apply to benefits that are not considered essential health benefits.	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	100% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Non-emergency Care While Traveling Outside of the United States	70% of Actual Charge after Deductible for Covered Medical Expenses Subject to $10,000 maximum per Policy Year	
Medical Evacuation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $50,000 maximum per Policy Year. The maximum dollar benefit limits will only apply to benefits that are not considered essential health benefits.	

Repatriation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $25,000 maximum per Policy Year. The maximum dollar benefit limits will only apply to benefits that are not considered essential health benefits.
Pediatric Dental and Vision Care	
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)	See the Pediatric Dental Care Benefit description in the Certificate for further information.
Preventive Dental Care Limited to 2 dental exams every 12 months	100% of Usual and Customary Charge for Covered Medical Expenses
The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care:	
Emergency Dental	70% of Usual and Customary Charge for Covered Medical Expenses
Routine Dental Care	70% of Usual and Customary Charge for Covered Medical Expenses
Endodontic Services	70% of Usual and Customary Charge for Covered Medical Expenses
Prosthodontic Services	70% of Usual and Customary Charge for Covered Medical Expenses
Periodontic Services	70% of Usual and Customary Charge for Covered Medical Expenses
Medically Necessary Orthodontic Care	70% of Usual and Customary Charge for Covered Medical Expenses
Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	

Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19) Limited to 1 visit(s) 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.	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses	
Low Vision Evaluation	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses	
Miscellaneous Dental Services		
Accidental Injury Dental Treatment	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Anesthesia and Hospitalization for Dental Procedures Benefit	Same as any other Covered Sickness	
Treatments of Bones and Joints of the Jaw, Face, or Head Benefit	Same as any other Covered Sickness	
PRESCRIPTION DRUGS		
Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy. Your benefit is limited to a 30 day supply. Coverage for more than a 30 day supply only applies if the smallest package size exceeds a 30 day supply. See "Retail Pharmacy Supply Limits" section for more information.		
TIER 1 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	70% of Actual Charge for Covered Medical Expenses Deductible Waived

More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	70% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Retail pharmacy	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	70% of Actual Charge for Covered Medical Expenses Deductible Waived
TIER 2 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$25 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$25 Copayment then the plan pays 70% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$50 Copayment then the plan pays 70% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Retail pharmacy	$75 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$75 Copayment then the plan pays 70% of Actual Charge for Covered Medical Expenses Deductible Waived
TIER 3 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail Pharmacy	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$50 Copayment then the plan pays 70% of Actual Charge for Covered Medical Expenses Deductible Waived

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

Zero Cost Medications		
Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	100% of Actual Charge for Covered Medical Expenses Deductible Waived
Orally administered anti-cancer prescription drugs (including specialty drugs)		
Benefit	Greater of: Chemotherapy Benefit; or Infusion Therapy Benefit	
Diabetic Supplies (for Prescription supplies purchased at a pharmacy)		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill.	
Mandated Benefits		
Colorectal Cancer Screening Benefit	Same as any other Preventive Service	
Congenital Anomaly Including Cleft Lip/Cleft Palate Benefit	Same as any other Covered Sickness	
Diagnosis and Treatment of Lymphedema	Same as any other Covered Sickness	
Mammography and Cervical Cancer Screening	Same as any other Covered Sickness, unless considered a Preventive Service	
Mastectomy Benefit and Reconstructive Breast Surgery	Same as any other Covered Sickness	
Newborn Hearing Screening Coverage	Same as any other Covered Sickness	
Osteoporosis Coverage/Bone Mass Measurement Benefit	Same as any other Preventive Service	
Ovarian Cancer Surveillance Tests	Same as any other Preventive Service	
Prostate Cancer Benefit	Same as any other Preventive Service	
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 at the Policyholder's School for at least the first 31 days of the period for which he or she is enrolled and/or pursuant to his or her Visa requirements for the period for which coverage is elected.

Except in the case of withdrawal from School due to Sickness or Injury, any student who withdraws from the Policyholder's School during the first 31 days of the period for which he or she is enrolled shall not be covered under the insurance plan. A 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, M-1 and their eligible Dependents (who are not U.S. citizens) are required to have a J-2, F-2, M-2 Visa to be eligible for this insurance plan.

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

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

Who is Eligible

Class	**Description of Class(es)**
1	All registered full-time Domestic and International Students of the Policyholder.

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

Dependents are eligible for coverage under this plan.

Your Dependent may become eligible for coverage under this Certificate only when You become eligible; or within 60 days of a Qualifying Life Event.

SECTION II – EFFECTIVE AND TERMINATION DATES

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

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

the Home Country.

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

Grace Period
A Grace Period of 31 days will be granted for payment of required premiums falling due after the first premium during which grace period the policy shall continue to be in force, unless:
1. We do not intend to renew this Certificate beyond the period for which premium has been accepted; and
2. written notice of Our intention not to renew is delivered to the Policyholder at least 31 days before the Premium is due.

This Certificate will be in force during the Grace Period. If the required premiums are not paid during the Grace Period, insurance will end on the last day of the Grace Period. The Policyholder is liable to Us for any unpaid premium for the time this Certificate was in force.

Reinstatement
The Certificate may be reinstated if it lapsed for nonpayment of premium. You must make the request within 30 days of the termination date. We will reinstate coverage as of the termination date when We accept payment of all amounts due and You give Us reasonable assurances that You can and will fulfill all of Your obligations.

We or an agent may:
- Require that You submit a reinstatement application and
- Issue to You a conditional receipt for the **premium** tendered.

We will reinstate coverage when We approve the reinstatement application. We will notify You in writing if the application is disapproved.

If We do not notify You of an approval or disapproval of the application, then coverage will be reinstated on the 45th day after the date We issued the conditional receipt.

The reinstated coverage shall cover only losses occurring from an:
- Covered sickness that begins more than 10 days after the date of the reinstatement; or
- Accident occurring on or after the date of reinstatement

In all other respects, Your and Our rights and duties survive termination and reinstatement of the coverage. You are subject to any provisions contained within the conditional receipt.

Any Premium accepted in connection with a reinstatement will be applied to a period for which Premium was not previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Special Enrollment – Qualifying Life Event
You, and Your Spouse or Child can also enroll for coverage within 60 days of the loss of coverage in a health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other health plan due to:
1. Involuntary termination of the other health plan;
2. Death of the Spouse;
3. Legal separation, divorce or annulment;
4. A Child no longer qualifies for coverage as a Child under the other health plan.

You, Your Spouse or Child can also enroll 60 days from exhaustion of Your COBRA or continuation coverage or if You gain a Dependent or become a Dependent through marriage, birth, adoption, foster care or placement for adoption.

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

In addition, You, and Your Spouse or Child can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. You or Your Spouse or Child loses eligibility for Medicaid or a state child health plan.
2. You or Your Spouse or Child become eligible for Medicaid or a state child health plan.

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

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

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

Your Dependent's insurance will terminate on the earliest of:

1. The date Your insurance ends; or
2. The date Your Dependent cease to be eligible for the insurance; or
3. The end of the period of coverage for which premium has been paid.

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

Adopted and Foster Children - Dependent Child Coverage also applies to any child adopted or placed for adoption regardless of whether the adoption has become final or placed as a foster child with You.
This includes the necessary care and Treatment of medically diagnosed congenital defects and birth abnormalities from the moment of birth.

We must receive:

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

We will provide coverage for the child placed for adoption or foster care as long as You

1. Have custody of the child;
2. Your coverage under this Certificate remains in effect; and
3. The required premiums are furnished to Us.

As it pertains to this provision:
Child means, in connection with an adoption/foster care or placement for adoption/foster care, an individual who has not attained the age of 18 as of the date of the adoption or placement for adoption.

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

Note: The enrollment period is waived when a parent is required to enroll a child due to an administrative or a court order. If no additional premium is due when adding a newborn, adopted or foster child, a written notice is not required.

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

We will not terminate the coverage of such child due to attainment of that age while the child is and continues to be both:
1. Incapable of self-sustaining employment by reason of developmental disability or physical handicap; and
2. Chiefly dependent upon You for support and maintenance.

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

Extension of Benefits: Coverage under this Certificate ceases on the Termination Date of Your insurance coverage. However, coverage for You will be extended as follows:
1. If You are Hospital Confined for Covered Injury or Covered Sickness on the date Your insurance coverage terminates, We will continue to pay benefits for that Covered Injury or Covered Sickness for up to 90 days from the Termination Date while such Confinement continues.

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

If a Dependent child who is a full time student takes a Medically Necessary leave of absence from school, coverage for that Dependent will continue for a period of 12 months or until the date on which the coverage is scheduled to terminate pursuant to the terms and conditions above, whichever comes first. The period of coverage under this paragraph shall commence on the first day of the medical leave of absence from the school or on the date the Physician determines the Injury or Sickness prevented the Dependent child from attending school, whichever comes first. Documentation or certification of the medical leave of absence from school shall be submitted 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 start date of the medical leave of absence from school.

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

Refund of Premium: Premiums received by Us are fully earned upon receipt. Refund of Premium will be considered only:
1. If a student ceases to be eligible for the insurance and coverage is terminated prior to the next premium due date, a pro rata refund of Premium (less any claims paid) will be made for such person. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.

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. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.
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. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.
4. In the event of the Student's death a pro rata refund will be made minus any claims paid.
5. The Student obtains other health insurance coverage a pro rata refund will be made minus any claims paid.
6. For an Insured International Student departing School to return to his or her Home Country on a permanent basis. We will refund a pro rata refund of Premium (less any claims paid) when written request is received by Us within 60 days of such departure. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.

SECTION III – DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Country of Assignment means the country in which an Eligible International Student, scholar or visiting faculty member is:
1. Temporarily residing; and
2. Actively engaged in education or educational research related activities sponsored by the National Association for Foreign Student Affairs or its Member Organizations.

Covered Clinical Trials means phase I, phase II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that:
1. Involve the treatment of life-threatening medical conditions;
2. Are medically indicated and preferable for that patient compared to available non-investigational treatment alternatives;
3. Have clinical and preclinical data that shows the trial will likely be more effective for that patient than available non-investigational alternatives;
4. Must involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties;
5. Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs; and
6. Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

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 Your Certificate is in force, except with respect to any expenses payable under the Extension of Benefits Provision.

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

Creditable Coverage: Any individual or group Policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes short term limited duration health coverage, continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance Policy or equivalent self-insurance.

- The Federal Medicare programs pursuant to Title XVIII of the Social Security Act.
- The Medicaid program pursuant to Title XIX of the Social Security Act.
- Any other publicly sponsored program, provided in this state or elsewhere, of medical, Hospital and surgical care.
- 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed services (CHAMPUS)).
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health Benefits risk pool.
- A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).
- A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.
- A health Benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. Sec. 2504(e)).
- Any other Creditable Coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

The Insured Person must provide Us proof of prior Creditable Coverage.

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

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

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

Dependent means:

1. An Insured Student’s lawful Spouse;
2. An Insured Student’s dependent biological or adopted child, foster, or stepchild under age 26; and
3. An Insured Student’s unmarried biological or adopted child or foster, stepchild who has reached age 26 and who is:
    a. primarily dependent upon the Insured Student for support and maintenance; and
    b. incapable of self-sustaining employment by reason of intellectual disability, mental illness or disorder or physical handicap.

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

Durable Medical Equipment means a device which:

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

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

Effective Date means the date coverage becomes effective.

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

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

Emergency Medical Condition means the medical condition manifesting itself by acute symptoms of sufficiently severe including, but not limited to severe pain, or by acute symptoms developing from chronic medical conditions that would lead a prudent layperson possessing average knowledge of health and medicine to 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 that are needed to evaluate or Stabilize an Emergency Medical Condition. Coverage also includes Post-Stabilization services after You are Stabilized. Post-Stabilization services include undergoing outpatient Observation Services, or an inpatient or outpatient stay with respect to the visit in which the other Emergency Services are furnished. The Post-Stabilization services will no longer qualify as Emergency Services once You can travel using non-medical or non-emergency transportation and You are in a condition to receive notice of, and to consent to, Out-of-Network Treatment.

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

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

Infertility means the inability after 12 consecutive months of unsuccessful attempts to conceive a child.

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.

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

Home Country means Your country of citizenship. If You have dual citizenship, Your Home Country is the country of the passport You used to enter the United States. Your Home Country is considered the Home Country for any International Dependent of Yours while insured under this Certificate.

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 Rehabilitation facilities if such is specifically required for Treatment of physical disability.

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

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

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

Insured Person means an Insured Student or Dependent of an Insured Student while insured under this Certificate.

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

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

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

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

Medically Necessary or **Medical Necessity** means
Covered services or supplies that are:
- (1) Provided for the diagnosis, treatment, cure, or relief of a health Condition, Illness, Injury, or disease; and, except as allowed under G.S. 58-3-255, not for Experimental, Investigational, or cosmetic purposes.
- (2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health Condition, Illness, Injury, disease, or its symptoms.
- (3) Within generally accepted standards of medical care in the community.
- (4) Not solely for the convenience of the You, Your family, or the Provider.

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

Morbid Obesity means:
1. a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance Tables;
2. a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
3. a BMI of 40 kilograms per meter squared without comorbidity.

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

Nurse means a licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who:
1. Is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
2. Provides medical services which are within the scope of the Nurse's license or certificate who does not ordinarily reside in Your home or is not related to You by blood or marriage.

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

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

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

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

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

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

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

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

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

Qualifying Payment Amount means the median Negotiated Charge for:
1. the same or similar services;
2. furnished in the same or similar facility;
3. by a provider of the same or similar specialty;
4. in the same or similar geographic area.

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

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

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

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

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

Sexual Dysfunction means any group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder, and hypoactive sexual disorder.

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

Spouse means an eligible individual who is legally married to the Insured Student under the laws of the state or jurisdiction in which the marriage was performed.

Stabilize/Stabilization and Post-Stabilization means, with respect to an Emergency Medical Condition, to provide such medical Treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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

Surgeon means a Physician who actually performs surgical procedures.

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

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

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

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

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

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

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

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

Special terms used

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

Service or Supply	Reasonable Amount Rate
Professional services and Inpatient and outpatient charges of hospitals	The lesser of: 1. The billed charge for the services; or 2. An amount determined using current publicly-available data which is usual and customary when compared with the charges made for a) similar services and supplies and b) to persons having similar medical conditions in the geographic area where service is rendered; or 3. An amount based on information provided by a third party vendor, which may reflect 1 or more of the following factors: 1) the complexity or severity of Treatment; 2) level of skill and experience required for the Treatment; or 3) comparable providers' fees and costs to deliver care; or 4. In the case of Emergency Services from an Out-of-Network Provider or facility, and certain non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, the Recognized Amount.

Our reimbursement policies

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

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

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

Our reimbursement policies are based on Our review of:

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

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

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

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

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

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

SECTION IV – HOW THE PLAN WORKS AND DESCRIPTION OF BENEFITS

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

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

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

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

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

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

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

How Your Out-of-Pocket Maximum Works

The In-Network Provider and Out-of-Network Provider Out-of-Pocket Maximums are shown in the Schedule of Benefits. The Out-of-Pocket Maximum provides is the amount of Covered Medical Expenses You have to incur before Covered Medical Expense will be paid at 100% for the reminder 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(s) will not be applied to satisfy the Out-of-Network Provider Out-of-Pocket Maximum and Covered Medical Expenses applied to the Out-of-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the In-Network Provider Out-of-Pocket Maximum.

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

Individual

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

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

that apply towards the limits for the rest of the Policy Year for that covered individual.

Family

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

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

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

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

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

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

The Out-of-Pocket Maximum may not apply to certain Covered Medical Expenses. If the Out-of-Pocket Maximum does not apply to a covered benefit, Your Copayment and Coinsurance for that medical expense will not count toward satisfying the 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 Usual and Customary Charge or the Negotiated Charge for Covered Medical Expenses that are incurred as the result of a Covered Injury or Covered Sickness; and
2. Subject to the Exclusions and Limitations provision.

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

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

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

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

Note, however, that We will pay at the In-Network level for Treatment by an Out-of-Network Provider, and will calculate Your cost sharing amount at the In-Network Provider level, and Your cost share will be applied to Your In-Network Deductible and Out-of-Pocket Maximum if:
1. there is no In-Network Provider in the Preferred Provider service area available to provide a Preventive Service or treat You for a specific Covered Injury or Covered Sickness; or

2. You have an Emergency Medical Condition and receive Emergency Services from an Out-of-Network Provider or facility. The most the Out-of-Network Provider or facility may bill You is the In-Network cost sharing amount (such as Deductibles, Copayments and Coinsurance). You can't be balance billed for these Emergency Services. This includes services You may get after You're in stable condition, unless the Out-of-Network Provider or facility determines that You can travel using non-medical or non-emergency transportation, the Out-of-Network Provider satisfies the consent and notice requirements, and You are in a condition to receive notice of, and to consent to, Out-of-Network Treatment; or

3. You receive non-Emergency Services from an In-Network Hospital or Ambulatory Surgical Center, but certain providers there may be Out-of-Network Providers. In these cases, the most those Out-of-Network Providers may bill You is the In-Network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, Assistant Surgeon, hospitalist, or intensivist services. These Out-of-Network Providers can't balance bill You and may not ask You to give up Your protections not to be balance billed.

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

Continuity of Care

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

Pre-Certification Process

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

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

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

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

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

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

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 We or Our authorized presentative determines that services, supplies, or other items are covered under this health benefit plan, including any determination under NCGS 58-50-61, We shall not subsequently retract its determination after the services, supplies, or other items have been provided, or reduce payments for a service, supply or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about Your health condition that was knowingly made by You or the Your Provider of service, supply or other item.

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

COVERED MEDICAL EXPENSES

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

Preventive Services

The following services shall be covered without regard to any Deductible, Coinsurance or Copayment requirement that would otherwise apply when provided by an In-Network Provider:
1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
4. With respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

5. Outpatient/office contraceptive services are covered, provided that the services are related to the use of FDA approved contraceptives. Examples of covered contraceptive services are: office visits, consultations, examinations and services related to the use of federal legend oral contraception or IUD insertion, diaphragm fitting, tubal ligation, 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 Expense**,** including general nursing care. Benefit may not exceed the daily semi-private room rate unless intensive care unit is required.
    - Intensive Care Unit**,** including 24-hour nursing care.
    - Hospital Miscellaneous Expenses, while Hospital Confined or as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as:
        a. The cost for use of an operating room;
        b. Prescribed medicines (excluding take-home drugs);
        c. Laboratory tests;
        d. Therapeutic services;
        e. X-ray examinations;
        f. Casts and temporary surgical appliances;
        g. Oxygen, oxygen tent; and
        h. Blood and blood plasma. Benefits cover the cost of transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream. Benefits are provided for the cost of storing an insured's own blood only when it is stored and used for previously scheduled procedure .

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

3. **Physician's Visits while Confined** not to exceed 1 visit per day of confinement per provider. 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. Within 7 days after Your discharge from a Hospital Confinement;
   b. Such Confinement must be of at least 3 consecutive days that began while coverage was in force under this Certificate; and
   c. Was for the same or related Sickness or Accident.

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

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

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

MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER BENEFITS

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

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

PROFESSIONAL AND OUTPATIENT SERVICES

SURGICAL EXPENSES

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

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

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

2. **Outpatient Surgical Facility and Miscellaneous** expense benefit. Benefits will be paid for services and supplies, including:
   a. Operating room;
   b. Therapeutic services;
   c. Oxygen, oxygen tent; and
   d. Blood and blood plasma. Benefits cover the cost of transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream. Benefits are provided for the cost of storing an insured's own blood only when it is stored and used for previously scheduled procedure.

3. **Bariatric Surgery** when it is Medically Necessary. This benefit requires prior approval.

4. **Organ Transplant Surgery**
   Recipient Surgery for Medically Necessary, non-Experimental and non-investigative solid organ, bone marrow, stem-cell or tissue transplants. We will provide benefits for the Hospital and medical expenses of when You are the recipient of an Organ Transplant.

   Benefits are also available for reasonable and necessary services related to the search for a donor.

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

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

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

5. **Reconstructive Surgery** covers all stages of reconstruction of the breast on which the mastectomy has been performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and Treatment of physical complications for all stages of mastectomy, including lymphedemas. This benefit also covers cosmetic surgery specifically and solely for: Reconstruction due to bodily Injury, infection or other disease of the involved part; or for a congenital anomaly of a Dependent child which resulted in a functional impairment.

OTHER PROFESSIONAL SERVICES

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

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

3. **Hospice Care Coverage** when, as the result of a Covered Injury or Covered Sickness, You require Hospice Care, We will pay the expenses incurred for such care. You must have been diagnosed with a terminal illness by a licensed Physician. Their medical prognosis must be death within 6 months. You must have elected to receive palliative rather than curative care. Any required documentation will be no greater than that required for the same services under Medicare.

OFFICE VISITS

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

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

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

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

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

EMERGENCY SERVICES, AMBULANCE AND NON-EMERGENCY SERVICES

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

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

notice requirements, and You are in a condition to receive notice of, and to consent to, Out-of-Network Treatment.

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

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

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

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

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

4. **Non-Emergency Ambulance Service** for Medically Necessary transportation by a licensed Ambulance, whether by ground or air Ambulance (as appropriate), when the Medically Necessary transportation is:

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

   Transportation from a facility to Your home is not covered.

DIAGNOSTIC LABORATORY, TESTING AND IMAGING SERVICES

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

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

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

4. **Chemotherapy and Radiation Therapy** for chemotherapy, oral chemotherapy drugs, and radiation therapy to treat or control a serious illness, as shown in the Schedule of Benefits.

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

REHABILITATION AND HABILITATION THERAPIES

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

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

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

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

4. **Habilitation Services** when prescribed by the attending Physician, limited to 1 visit per day.

OTHER SERVICES AND SUPPLIES

1. **Covered Clinical Trials** includes coverage for participation in phase I, phase II, phase III, and phase IV Covered Clinical Trials by an Insured who meets protocol requirements of the trials and when informed consent is provided. Only Covered Medical Expenses for the costs of health care services which are a Medical Necessity and associated a with participation in a Covered Clinical Trial, including those related health care services typically provided absent a clinical trial, the diagnosis and treatment of complications, and Medically Necessary monitoring will be paid and only to the extent that such costs have not been or are not funded by national agencies, commercial manufacturers, distributors, or other research sponsors of participants in clinical trials.

   No benefits will be provided for non-FDA approved drugs provided or made available to an Insured Person who received the drug during a Covered Clinical Trial after the clinical trial has been discontinued.

   The following clinical trial costs are not covered:
   1. Costs of services that are not health care services;
   2. Cost of services provided solely to satisfy data collection and analysis needs;
   3. Costs of services related to investigation drugs and devices; and
   4. Costs of services that are not provided for the direct clinical management of the Insured patient.

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

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

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

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

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

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

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

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

4. **Durable Medical Equipment** for the rental or purchase of Durable Medical Equipment, including, but not limited to, Hospital beds, wheel chairs, walkers, braces that stabilize an injured body part and braces to treat curvature of the spine. This also includes orthotic devices for positional plagiocephaly which is limited to one device per lifetime. 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 when prescribed by a Physician**.** Covered expenses include:
   - Initial hearing aids and replacement hearing aids not more frequently than every 36 months.
   - A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the Insured Person.
   - Services, including the initial hearing aid evaluation, fitting, and adjustments, and supplies, including ear molds. Benefits are limited as shown in the Schedule of Benefits.

7. **Infertility Treatment** We Cover services for the diagnosis and Treatment (surgical and medical) of infertility for all Insured Persons except for Dependent children. Benefits are limited to three medical ovulation induction cycles per lifetime per Insured Person. Such Coverage is available as follows:
   1. **Basic Infertility Services.** Basic infertility services will be provided to an Insured Person who is an appropriate candidate for infertility Treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, and the American Society for Reproductive Medicine.

      Basic infertility services include:
      - Initial evaluation;
      - Semen analysis;
      - Laboratory evaluation;
      - Evaluation of ovulatory function;
      - Postcoital test;
      - Endometrial biopsy;
      - Pelvic ultra sound;
      - Hysterosalpingogram;
      - Sonohysterogram;
      - Testis biopsy;
      - Blood tests; and
      - Medically appropriate Treatment of ovulatory dysfunction.

   Additional tests may be Covered if the tests are determined to be Medically Necessary.

   All services must be provided by Physicians who are qualified to provide such services in accordance with the guidelines established and adopted by 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, 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.

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

9. **Prosthetic and Orthotic Devices** to replace all or part of a body organ, or replace all or part of the function of a permanently inoperative, absent, or malfunctioning body part when Medically Necessary and prescribed by a Physician. Therapeutic contact lenses may be covered when used as a corneal bandage for a medical condition. Benefits include a one-time replacement of eyeglass or contact lenses due to a prescription change after cataract surgery.

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. **Sexual Dysfunction Services** for certain services related to the diagnosis, Treatment and correction of any underlying causes of Sexual Dysfunction. We will not cover Sexual Dysfunction that is unrelated to organic disease.

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

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

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

    If:
    a. You are unable to continue Your academic program as the result of a Covered Injury or Covered Sickness;
    b. 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 under the Certificate for You; and
f. Transportation must be by the most direct and economical route.

15. **Repatriation Expense**

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

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

PEDIATRIC DENTAL AND VISION BENEFITS

1. **Pediatric Dental Care Benefit** for the following dental care services for Insured Persons (to the end of the month in which the Insured Person turns age 19):

a. Preventive Services, including:
(1) Prophylaxis - Limited to 2 during the calendar year;
(2) Topical Fluoride – Varnish and topical application of fluoride. Limited to 2 during the calendar year for Dependent children under age 19;
(3) Sealant - per tooth - unrestored permanent molars for dependent children under age 19 - any combination of a sealant or a preventive resin restoration is allowed 1 time per tooth every 24 months;
(4) Preventive resin restorations in a moderate to high caries risk patient - permanent tooth - any combination of a sealant or a preventive resin restoration is allowed 1 time per tooth every 24 months;
(5) Space maintainer - fixed or removable - unilateral or bilateral. Limited to children under age 19; and
(6) Recementation of space maintainer. Limited to children under age 19.

b. Diagnostic and Treatment Services, including:
(1) Periodic oral evaluation. Limited to 2 during the calendar year;
(2) Limited oral evaluation - problem focused. Limited to 2 during the calendar year;
(3) Oral evaluation for a patient under three years of age and counseling with primary caregiver. Limited to 2 during the calendar year;
(4) Comprehensive oral evaluation. Limited to 2 during the calendar year;
(5) Detailed and extensive oral evaluation. Limited to 2 during the calendar year;
(6) Comprehensive periodontal evaluation. Limited to 2 during the calendar year;
(7) Intraoral - complete set of radiographic images including bitewings limited to 1 every 60 Months;
(8) Intraoral - periapical films and occlusal radiographic image;
(9) Extraoral - radiographic images;
(10) Bitewing - Children - 1 set every six months;
(11) Vertical bitewings - 7 to 8 radiographic images - children - 1 set every six months;
(12) Panoramic radiographic image - once every 60 months;
(13) Caries susceptibility tests; and
(14) Accession of brush biopsy.

c. Minor restorative services, including:
(1) Amalgam;
(2) Resin-based composite – anterior (up to three surfaces);
(3) Resin-based composite – four or more surfaces or involving incisal angle (anterior);
(4) Recement inlay;
(5) Recement crown;
(6) Prefabricated porcelain/ceramic crown – primary tooth – under age 15 – limited to 1 per tooth in 60 months;

(7) Prefabricated stainless steel crown - primary tooth – under age 15 – limited to 1 per tooth in 60 months;
(8) Prefabricated stainless steel crown – permanent tooth – under age 15 – limited to 1 per tooth in 60 Months;
(9) Protective Restoration; and
(10) Pin retention – per tooth, in addition to restoration.

d. Major restorative services, including:
(1) Detailed and extensive oral evaluation – problem focused, by report;
(2) Onlay - metallic - Limited to 1 per tooth every 60 months;
(3) Crown - Limited to 1 per tooth every 60 months;
(4) Core buildup, including any pins - Limited to 1 per tooth every 60 months;
(5) Prefabricated post and core, in addition to crown - Limited to 1 per tooth every 60 months;
(6) Crown repair, by report – Limited to 1 per 12 months;
(7) Inlay Repair or Onlay Repair - Limited to 1 per 12 months;
(8) Veneer Repair – Limited to 1 per 12 months; and
(9) Resin infiltration/smooth surface.

e. Endodontic services, including:
(1) Pulp cap – direct or indirect (excluding final restoration);
(2) Therapeutic pulpotomy (excluding final restoration);
(3) Pulpal debridement, primary and permanent teeth;
(4) Partial pulpotomy for apexogenesis – permanent teeth with incomplete root development;
(5) Pulpal therapy (resorbable filling) – anterior or posterior, primary tooth (excluding final restoration);
(6) Anterior root canal, bicuspid root canal, or molar root canal, (excluding final restoration);
(7) Retreatment of previous root canal therapy – anterior, bicuspid, or molar;
(8) Apexification/recalcification – initial visit, interim medication replacement, or final visit (apical closure/calcific repair of perforations, root resorption, etc.);
(9) Pulpal regeneration (completion of regenerative Treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration;
(10) Pulpal regeneration initial visit, interim visit, completion of treatment;
(11) Apicoectomy/periradicular surgery;
(12) Retrograde filling – per root;
(13) Root amputation – per root; and
(14) Hemisection (including any root removal) – not including root canal therapy.

f. Periodontal services, including:
(1) Periodontal scaling and root planning - four or more teeth per quadrant. Limited to 1 every 24 Months;
(2) Periodontal scaling and root planning - one to three teeth per quadrant. Limited to 1 every 24 Months;
(3) Periodontal maintenance - 4 in 12 months after the completion of active periodontal therapy;
(4) Collect - Apply Autologous Product. Limited to 1 in 36 months;
(5) Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces, per quadrant. Limited to 1 every 36 months;
(6) Gingivectomy or gingivoplasty – one to three teeth, per quadrant;
(7) Gingivectomy or gingivoplasty - with restorative procedures, per tooth;
(8) Gingival flap procedure, including root planning, four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months;
(9) Gingival flap procedure, including root planning, one to three teeth per quadrant. Limited to 1 every 36 months;
(10) Clinical crown lengthening – hard tissue;
(11) Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant. Limited to 1 every 36 months;
(12) Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant. Limited to 1 every 36 months;
(13) Surgical revision procedure, per tooth;
(14) Pedicle soft tissue graft procedure;

(15) Subepithelial connective tissue graft procedures (including donor site surgery);
(16) Soft tissue allograft. Limited to 1 every 36 months;
(17) Combined connective tissue and double pedicle graft, per tooth. Limited to 1 every 36 months;
(18) Free soft tissue graft procedure;
(19) Full mouth debridement to enable comprehensive evaluation and diagnosis. Limited to 1 per lifetime; and
(20) Localized delivery of antimicrobial agents.

g. Prosthodontic services, including:
(1) Adjust complete or partial denture – maxillary or mandibular;
(2) Repair broken complete denture base;
(3) Replace missing or broken teeth – complete denture (each tooth);
(4) Repair resin denture base or framework;
(5) Repair or replace broken clasp;
(6) Replace broken teeth – per tooth;
(7) Add tooth or clasp to existing partial denture;
(8) Replace all teeth and acrylic on cast metal framework. Limited to 2 in a 24-month period, 6 months after the initial installation;
(9) Rebase complete or partial denture. Limited to 1 in a 36-month period, 6 months after the initial installation;
(10) Reline complete maxillary denture or maxillary partial denture. Limited to 1 in a 36-month period, 6 months after the initial installation;
(11) Reline complete mandibular denture or mandibular partial denture. Limited to 1 in a 36-month period, 6 months after the initial installation;
(12) Tissue conditioning (maxillary or mandibular);
(13) Recement fixed partial denture;
(14) Fixed partial denture repair, by report;
(15) Complete or immediate denture. Limited to 1 every 60 months;
(16) Maxillary or Mandibular partial denture - resin base (including any conventional clasps, rests and teeth). Limited to 1 every 60 months;
(17) Maxillary or Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth). Limited to 1 every 60 months;
(18) Removable unilateral partial denture-one piece cast metal (including clasps and teeth). Limited to 1 every 60 months;
(19) Endosteal Implant – surgical placement. Limited to 1 every 60 months;
(20) Surgical Placement of Interim Implant Body. Limited to 1 every 60 months
(21) Mini Implant. Limited to 1 every 60 months;
(22) Eposteal Implant. Limited to 1 every 60 months;
(23) Transosteal Implant, including hardware. Limited to 1 every 60 months;
(24) Implant/Abutment supported removable denture for complete edentulous arch or for partial edentulous arch;
(25) Connecting Bar – implant or abutment supported. Limited to 1 every 60 months;
(26) Prefabricated Abutment - includes modification and placement. Limited to 1 every 60 months;
(27) Custom fabricated abutment - includes modification and placement. Limited to 1 every 60 months;
(28) Abutment supported crown. Limited to 1 every 60 months;
(29) Implant supported crown. Limited to 1 every 60 months;
(30) Abutment supported retainer for FPD. Limited to 1 every 60 months;
(31) Implant supported retainer for FPD. Limited to 1 every 60 months;
(32) Implant/abutment supported fixed denture for completely or partially edentulous arch. Limited to 1 every 60 Months;
(33) Implant Maintenance Procedures. Limited to 1 every 60 months;
(34) Repair Implant Prosthesis. Limited to 1 every 60 months
(35) Replacement of Semi-Precision or Precision Attachment. Limited to 1 every 60 months;
(36) Recement Implant/abutment supported crown or fixed partial denture. Limited to 1 every 60 months;
(37) Abutment supported crown - titanium. Limited to 1 every 60 months;

(38) Repair Implant Abutment. Limited to 1 every 60 months;
(39) Implant Removal. Limited to 1 every 60 months;
(40) Debridement of a preimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure;
(41) Debridement and osseous contouring of a preimplant defect; include surface cleaning of exposed implant surfaces and flap entry and closure;
(42) Bone graft for repair of preimplant defect – not including flap entry and closure or, when indicated, placement of a barrier membrane or biologi materials to aid in osseous regeneration;
(43) Bone graft at time of implant placement;
(44) Implant Index. Limited to 1 every 60 months;
(45) Abutment supported retainer crown for FPD - titanium. Limited to 1 every 60 months;
(46) Pontic - limited to 1 every 60 months;
(47) Inlay or Onlay - metallic;
(48) Retainer - for resin bonded fixed prosthesis. Limited to 1 every 60 months;
(49) Inlay or Onlay - cast predominantly base metal. Limited to 1 every 60 months;
(50) Crown - limited to 1 every 60 months;
(51) Occlusal guard, by report - 1 in 12 months for patients 13 and older; and
(52) Unspecified Adjunctive procedure, by report.

h. Oral surgery, including:
(1) Extraction coronal remnants, deciduous tooth;
(2) Extraction, erupted tooth or exposed root (elevation and/or forceps removal);
(3) Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth;
(4) Removal of impacted tooth – soft tissue, partially bony, or completely bony;
(5) Removal of impacted tooth – completely bony with unusual surgical complications;
(6) Surgical removal of residual tooth roots (cutting procedure);
(7) Coronectomy - intentional partial tooth removal;
(8) Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth;
(9) Surgical access of an unerupted tooth;
(10) Alveoloplasty in conjunction or not in conjunction with extractions;
(11) Removal of exostosis;
(12) Incision and drainage of abscess – intraoral soft tissue;
(13) Suture of recent small wounds up to 5 cm;
(14) Excision of pericoronal gingiv; and
(15) Unspecified oral surgery procedure, by report.

i. Medically Necessary orthodontics, including
(1) Limited orthodontic Treatment of the primary, transition, or adolescent dentition;
(2) Interceptive orthodontic Treatment of the primary or transitional dentition;
(3) Comprehensive orthodontic Treatment of the transitional, adolescent dentition;
(4) Removable appliance therapy;
(5) Fixed appliance therapy;
(6) Pre-orthodontic Treatment visit;
(7) Periodic orthodontic Treatment visit (as part of contract); and
(8) Orthodontic retention (removal of appliances, construction and placement of retainer(s)).

j. Additional procedures covered as basic services. This includes palliative Treatment of dental pain – minor procedure, consultation (diagnostic service provided by dentist or physician other than requesting dentist or Physician), and office visit after regularly scheduled hours.

2. **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 examination per Policy Year; and
   b. 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year.
   c. Vision exams for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover one vision exam. This includes dilation if professionally indicated, in any twelve (12) month period, unless more frequent exams are Medically Necessary as evidenced by appropriate documents. The vision exam may include, but is not limited to:
      (1) Case history;
      (2) External exam of the eye or internal exam of the eye;
      (3) Opthalmoscopic exam;
      (4) Determination of refractive status;
      (5) Binocular distance;
      (6) Tonometry tests for glaucoma;
      (7) Gross visual fields and color vision testing; and
      (8) Summary findings and recommendation for corrective lenses.
   d. Prescription lenses or contact lenses once in any twelve (12) month period, unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by the appropriate documents. Prescription lenses may be constructed of either glass or plastic. We also cover standard frames adequate to hold lenses once in any twelve (12) month period, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by the appropriate documents.
   e. Low vision services, including one comprehensive low vision evaluation and prescribed optical devices such as high-power spectacles, magnifiers and telescopes.

MISCELLANEOUS DENTAL SERVICES

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

2. **Anesthesia and Hospitalization for Dental Procedures Benefit** for payment of anesthesia and Hospital or facility charges for services performed in a Hospital or Ambulatory Surgical Facility in connection with dental procedures for the following Insured Persons:
   a. Children below 9 years of age;
   b. Persons with serious mental or physical conditions; and
   c. Persons with significant behavioral problems, where the Physician treating them certifies that, because of their age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures.

   This benefit does not cover the cost of the dental procedure.

3. **Treatments of Bones and Joints of the Jaw, Face, or Head Benefit** for expenses incurred for diagnostic, therapeutic, or surgical procedures involving bones or joints of the human skeletal structure as long as the procedure is Medically Necessary to treat a condition which prevents normal functioning of the particular bone or joint involved and the condition is caused by congenital deformity, disease, or traumatic injury. Benefits are payable in the same basis as coverage of procedures involving other bones and joints of the human skeletal structure.

   Authorized therapeutic procedures for the Treatment of conditions of the jaw (temporomandibular joint) shall include splinting and use of intraoral prosthetic appliances to reposition the bones.

   This benefit does not cover orthodontic braces, crowns, bridges, dentures, Treatment for periodontal disease, dental root form implants, or root canals.

PRESCRIPTION DRUGS

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

   a. **Off-Label Drug Treatments** – When prescription drugs are provided as a benefit of the issued Certificate, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
      1. The drug is approved by the FDA;
      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 (ex. a. The American Medical Association Drug Evaluations; b. The American Hospital Formulary Service Drug Information; c. The United States Pharmacopoeia Dispensing Information, volume 1, "Drug Information for Health Care Professionals"; d. The National Comprehensive Cancer Network Drugs & Biologics Compendium; e) The Thomson Micromedex DrugDex; or g) The Elsevier Gold Standard's Clinical Pharmacology.) or 2 articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal (cancer indications will only require evidence from ONE article or clinical practice guideline).

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

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

   b. **Dispense as Written (DAW)** – If a prescriber prescribes a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available and specifies: "Dispense as Written" (DAW), You will pay the cost sharing for the Brand-Name Prescription Drug. If a prescriber does not specify DAW and the Member requests a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available, the Member will be responsible for the cost difference between the Brand-Name Prescription Drug and the Generic Prescription Drug equivalent, and the cost sharing that applies to Brand-Name Prescription Drugs. This DAW penalty does not apply to Your Out-of-Pocket Maximum or Deductible.

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

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

Specialty Drugs – are Prescription Drugs which:
1. Are only approved to treat limited patient populations, indications, or conditions; or
2. Are normally injected, infused, or require close monitoring by a Physician or clinically trained individual; or
3. Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

Specialty prescription drugs are identified in the Formulary posted on Our website at www.wellfleetstudent.com.

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

f. **Retail Pharmacy Supply Limits** – We will pay for no more than a 30 day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for 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. You cannot refill a prescription until 30 days of the supply has been used, except under certain circumstances during a state of emergency or disaster.

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

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

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

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

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

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

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

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

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

n. **Preventive contraceptives -** Your Outpatient Prescription Drug plan covers certain Prescription drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a Physician and the prescription is submitted to the pharmacist for processing. Your outpatient prescription drug plan also covers related services and supplies needed to administer covered devices. At least 1 form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive prescription drugs by referring to the Formulary posted on Our website at www.wellfleetstudent.com 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

You can access the list of 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. See Your Diabetic services and supplies (including equipment and training) section for coverage of blood glucose monitors and external insulin pumps.

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

Mandated Benefits for North Carolina

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

1. **Colorectal Cancer Screening Benefit** for colorectal cancer exams and lab tests for cancer, in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control for colorectal cancer screening, for any non-symptomatic Insured Person who is:
   a. At least 45 years of age; or
   b. Less than 45 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of the American Cancer Society or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

2. **Congenital Anomaly Including Cleft Lip/Palate Benefit** for expenses incurred for congenital defects or anomalies specifically including, but not limited to, all necessary Treatment and care for Dependent Children born with cleft lip or cleft palate.

3. **Diagnosis and Treatment of Lymphedema** for expenses incurred for Medically Necessary for the diagnosis, evaluation, and Treatment of lymphedema. Benefits include equipment, supplies, complex decongestive therapy, Gradient Compression Garments, and self-management training and education, if the Treatment is determined to be Medically Necessary and is provided by a licensed occupational or physical therapist or licensed Nurse that has experience providing this Treatment, or other licensed health care professional whose Treatment of lymphedema is within the professional's scope of practice.

   As used in this Benefit:
   Gradient Compression Garments require a prescription, are custom-fit for You, and do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products.

4. **Mammography and Cervical Cancer Screening** for expenses incurred for Examinations and Laboratory Tests for the Screening for the Early Detection of Cervical Cancer and for Low-dose Screening Mammography. Coverage for Low- dose Screening Mammography shall be provided as follows: 1. One or more mammograms a year, as recommended by a Physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true; the woman has a personal history of breast cancer; the woman has a personal history of biopsy-proven benign breast disease; the woman's mother, sister, or daughter has or has had breast cancer; or the woman has not given birth prior to the age of 30; 2. One baseline mammogram for any woman 35 through 39 years of age, inclusive; 3. A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a Physician; and 4. A mammogram every year for any woman 50 years of age or older.

   Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation standards established by the North Carolina Medical Care Commission.

   Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. Coverage shall include the exam, the lab fee, and the Physician's interpretation of the lab results. Reimbursements for lab fees shall be made only if the lab meets accreditation standards adopted by the North Carolina Medical Care Commission.

   As used in this Benefit:
   Examinations and Laboratory Tests for the Screening for the Early Detection of Cervical Cancer means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the FDA.

   Low-dose Screening Mammography means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography. This includes a Physician's interpretation of the results of the procedure.
   Coverage for Low-dose Screening Mammography shall be provided as follows:
   a. One or more mammograms a year, as recommended by a Physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:
      1) The woman has a personal history of breast cancer;
      2) The woman has a personal history of biopsy-proven benign breast disease;
      3) The woman's mother, sister, or daughter has or has had breast cancer; or
      4) The woman has not given birth prior to the age of 30;
   b. One baseline mammogram for any woman 35 through 39 years of age, inclusive;
   c. A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a Physician; and
   d. A mammogram every year for any woman 50 years of age or older.

5. **Mastectomy Benefit and Reconstructive Breast Surgery** for expenses incurred for a mastectomy performed while an inpatient, including coverage for post-mastectomy inpatient care. The decision to discharge You following mastectomy must be made by the attending Physician in consultation with You. This shall further ensure that the length of post-mastectomy Hospital stay is based on the unique characteristics of each Insured Person taking into consideration the health and medical history of the Insured Person.

   We will also pay the expenses incurred for Reconstructive Breast Surgery following a mastectomy. The coverage shall include coverage for all stages and revisions of Reconstructive Breast Surgery performed on a non-diseased breast to establish symmetry if reconstructive surgery on a diseased breast is performed. This also includes coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating Physician.

As used in this Benefit:
Reconstructive Breast Surgery means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. Reconstructive breast surgery also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the non-diseased breast.

6. **Newborn Hearing Screening Coverage** for expenses incurred for newborn hearing screening ordered by the attending Physician pursuant to the newborn screening program.

7. **Osteoporosis Coverage/Bone Mass Measurement Benefit** for expenses incurred for You who are a Qualified Individual for scientifically proven and approved Bone Mass Measurement for the diagnosis and evaluation of osteoporosis or low bone mass. We will only pay for a Bone Mass Measurement every 23 months, unless a Physician determines that a more frequent measurement is Medically Necessary. Conditions under which more frequent Bone Mass Measurement coverage may be Medically Necessary include, but are not limited to:
   a. Monitoring beneficiaries on long-term glucocorticoid therapy of more than three months; or
   b. Allowing for a central Bone Mass Measurement to determine the effectiveness of adding an additional Treatment regimen for a qualified individual who is proven to have low bone mass so long as the Bone Mass Measurement is performed 12 to 18 months from the start date of the additional regimen.

   As used in this benefit:
   Bone Mass Measurement means a scientifically proven radiologic, radioisotopic, or other procedure performed on a qualified individual to identify bone mass or detect bone loss for the purpose of initiating or modifying Treatment.

   Qualified Individual means any one or more of the following:
   a. An individual who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass;
   b. An individual with radiographic osteopenia anywhere in the skeleton;
   c. An individual who is receiving long-term glucocorticoid (steroid) therapy;
   d. An individual with primary hyperparathyroidism;
   e. An individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies;
   f. An individual who has a history of low-trauma fractures; and
   g. An individual with other conditions or on medical therapies known to cause osteoporosis or low bone mass.

8. **Ovarian Cancer Surveillance Tests** for expenses incurred for Surveillance Tests for female Insured Persons age 25 and older At Risk for Ovarian Cancer.

   As used in this benefit:
   At Risk for Ovarian Cancer means either:
   a. Having a family history with at least one first-degree relative with ovarian cancer and a second relative, either first degree or second degree, with breast, ovarian, or nonpolyposis colorectal cancer; or
   b. Testing positive for a hereditary ovarian cancer syndrome.

   Surveillance Tests means annual screening using transvaginal ultrasound and rectovaginal pelvic exam.

9. **Prostate Cancer Benefit** for expenses incurred for Prostate-Specific Antigen (PSA) tests or Equivalent Tests for the Presence of Prostate Cancer when recommended by a Physician.

   As used in this benefit:
   Prostate-Specific Antigen (PSA) tests or Equivalent Tests for the Presence of Prostate Cancer means serological tests for determining the presence of prostate cytoplasmic protein (PSA) and the generation of antibodies to it, as a novel marker for prostatic disease.

SECTION V - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

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

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

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

SECTION VI - EXCLUSIONS AND LIMITATIONS

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

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

General Exclusions

- **International Students Only -** Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible.
- Treatment, service or supply which is not Medically Necessary for the diagnosis, care or Treatment of the sickness or injury involved. This applies even if they are prescribed, recommended or approved by Your attending Physician or dentist.
- Medical services rendered by a provider employed for or contracted with the Policyholder, including team Physicians or trainers, except as specifically provided in the Schedule of Benefits.
- Professional services rendered by an Immediate Family Member or anyone who lives with You.
- Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance, except tax supported institutions 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.
- Services or supplies for the Treatment of an occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or Workers' Compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
- Expenses covered under any public assistance program or government plan, except Medicaid.
- Expenses incurred after:
  - The date insurance terminates as to an Insured Person, except as specified in the extension of benefits provision; and
  - The end of the Policy Year specified in the Policy.

- Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
- You are:
  - committing or attempting to commit a felony,
  - engaged in an illegal occupation, or
  - participating in a riot.
- Custodial Care service and supplies.
- Charges for hot or cold packs for personal use.
- Services of private duty Nurse when provided by a close relative or a member of your household.
- 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 or covered under clinical trials (routine patient costs). See the Other Benefits section for more information.
- Routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal or artificial organs or tissues.
- 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.
- Non-physical, occupational, speech therapies (art, dance, etc.).
- Modifications made to dwellings.
- General fitness, exercise programs.
- Hypnosis.
- Rolfing.
- Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
- Sleep Disorders, except for the diagnosis and Treatment of obstructive sleep apnea.
- Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary because of Injury, infection or disease.

Activities Related:

- Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate or club sports 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 in excess of $500.00 per Intercollegiate or club sports Accident.
- Racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles) or other hazardous sport or hobby.

Weight Management/Reduction

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

Family Planning:

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

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 except as covered under the Pediatric Vision benefit, duplicate spare eyeglasses, lenses or frames, non-prescription lenses or contact lenses that are for cosmetic purposes.

Dental

- Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
- Extraction of impacted wisdom teeth or dental abscesses.

Hearing

- Charges for hearing screening, or cochlear implants.

Cosmetic

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

Prescription Drugs

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

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

SECTION VII - GENERAL PROVISIONS

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

All statements made by the policyholder or by an Insured Person are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 2 years from the Insured Person’s Effective Date of coverage, no misstatements will cause such coverage to be void or cause the denial of a claim for loss incurred or disability commencing after the expiration of such two-year period.

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

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

Proof of Loss: Written proof of Loss must be furnished to Us or to Our authorized agent within 180 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 within 30 calendar days upon receipt of due written proof of such Loss. Within 30 days of receipt of the claim, the We may request additional information in order to process all or part of the claim. If the requested additional information is not received within 90 days after the request is made, the We may deny the claim and send notice of the denial. Payment of claims not made in accordance with these provisions will be bear interest at the annual percentage rate of eighteen percent (18%) beginning on the date following the day on which the claim should have been paid.

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

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

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

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

Physical Examination 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.

Incontestability
The validity of the Certificate will not be contested after it has been in forced for 2 years from the Certificate Effective Date, except for non-payment of Premium. We reserve the right to contest coverage at any time based upon the Insured Person's ineligibility for coverage under the Certificate or upon other provisions of the Certificate.

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.

Certificate of Creditable Coverage: A certificate of Creditable coverage will be provided to the Insured at the time coverage ceases under this Certificate and upon request on behalf of the Insured made no later than 24 months after the date coverage ended. The certification will be a written certification of the period of Creditable coverage of the Insured under this Certificate and any waiting period and affiliation period, if applicable, imposed with respect to the Insured for any coverage under this Certificate.

SECTION VIII - ADDITIONAL PROVISIONS

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

2. You will have free choice of a legally qualified Physician with the understanding that the Physician-patient relationship will be maintained.

3. Our acknowledgment of the receipt of notice given under this Certificate, or the furnishing of forms for filing proofs of loss or acceptance of such proof, or the investigation of any claim hereunder will not operate as a waiver of any of Our rights in defense of any claim arising under this Certificate.

4. This Certificate is not in lieu of and does not affect any requirement of coverage by Workers' Compensation Insurance.

5. All new persons in the groups or classes eligible to and applying for this insurance will be added in the respective groups or classes in which they are eligible.

6. The insurance of any Insured Person will not be prejudiced by the failure on the part of the Policyholder to transmit reports, pay premium or comply with any of the provisions of this Certificate when such failure is due to inadvertent error or clerical mistake.

7. All books and records of the Policyholder containing information pertinent to this insurance will be open to examination by Us during the Certificate term and within one year after the termination of this Certificate.

8. Benefits are payable under this Certificate only for those expenses incurred while You are covered. No benefits are payable for expenses incurred after the date Your insurance terminates, except as may be provided under an Extension of Benefits.

SECTION IX – APPEALS PROCEDURE

If You have a claim that is denied by Us, You have the right to appeal it. Your Authorized Representative may act on Your behalf in pursuing a benefit claim or appeal of an Adverse 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 External Review provisions appearing in this section.

Internal Appeals, Grievance, and External Review Procedures
The following levels of review are available to Insured Persons or providers who have a complaint, Grievance, or receive an Adverse Determination.

For purposes of this Section, the following definitions apply:

Adverse Determination means review and decision by Us or Our designee utilization review organization that a requested service or payment for service is denied, reduced, or terminated. The decision will be based on Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness. Denials of coverage based on a decision that a service or requested health care or treatment is Experimental also are Adverse Determinations. These denials will comply with procedures for reviewing coverage denials based on a decision that a recommended or requested health care service or Treatment is Experimental.

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.

Grievance means a written complaint submitted by an You or Your Authorized Representative. Grievances may be submitted about any of the following**:**

1. Our decisions, policies, or actions related to availability, delivery, or quality of health care services. A written complaint from You about a decision because this Certificate contains an exclusion for the health care service in question is not a Grievance if the exclusion of the specific service is clearly stated in this Certificate.
2. Claims payment or handling; or reimbursement for services.
3. The contractual relationship between You and Us.
4. The outcome of an appeal of a Non-certification under this section.

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.

Non-certification means a decision by Our designated utilization review organization or Us that a service or Treatment does not meet Our requirements and has been denied based on the information provided. Such services include:

1. An admission;
2. Availability of care;
3. Continued stay, or
4. Other health care service has been reviewed and, based upon the information provided, does not meet Our requirements for:
   a. Medical Necessity;
   b. Appropriateness;
   c. Health care setting;
   d. Level of care or effectiveness; or
   e. Whether the prudent layperson standard for coverage of Emergency Services is met.

A Non-certification is not a decision based only on the fact that this Certificate does not provide benefits for the service or treatment in question, if the exclusion of the service or Treatment is clearly stated in the certificate of coverage. A Non-certification includes any situation in which We or Our designated utilization review organization make a decision about an Insured Person's condition to determine whether a requested Treatment is Experimental, Investigational, or cosmetic, and the extent of coverage under this Certificate is affected by that decision.

Prospective (Pre-Certification) 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 review, and Retrospective review. In addition, certain Pre-Service or Concurrent review Claims may involve Urgent Care. If the Company makes an Adverse 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 if additional information is needed:	If additional information is needed, You must provide within:
Prospective (Pre-certification) review	15 days from receipt of claim (whether adverse or not)	One extension of 15 days (additional information must be requested within 15 days from receipt of claim)	45 days of date of extension notice (We must notify You of determination within 3 business days of receipt of Your information)
Prospective (Pre-certification) review 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 determination prior to the end or reduction of prescribed Treatment	N/A	N/A

Concurrent: To deny Your request to extend Treatment	15 days from receipt of Your request to extend Treatment	N/A	N/A
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)
Retrospective review	30 days from receipt of claim	None	90 days of the date of request for additional information

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.

Step 2:

INTERNAL APPEAL – FORMAL REVIEW

How to Appeal a Claim Decision – Formal Review

The Formal Review process includes only one level of Internal Appeal. This Formal Review is provided free of charge.

Internal Appeal Formal Review:

1. If You do not agree with Our decision and wish to appeal, You or Your provider of service acting on Your behalf may submit an Internal Appeal for Formal Review within 180 days after receipt of the Adverse Determination or denial of a benefit (or oral notice if an Urgent Care request) referenced in Step 1. If the claim involves Urgent Care, Your appeal may be made orally.
2. You or Your provider of service must submit the material in writing in clear terms. Failure to do so may result in a denial of certification. We may request additional information, in clear terms, that is necessary to certify the service in question.
3. Within 3 business days after We receive the request for a Formal Review, We must provide You with the name, address and telephone number of the Formal Review coordinator and information on how to submit written material.
4. The Formal Review will enable You to review Your file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the review.
5. You may or may not attend this review but is not required to do so.
6. We will issue a written decision, in clear terms, to You and, if applicable, Your provider of services within 30 days of the receipt of the Formal Review request. The person reviewing the Internal Appeal will not be the same person who initially handled the matter that is the subject of the Internal Appeal. If the issue is a clinical one, a Physician with appropriate expertise will evaluate the matter. The written decision issued in a Formal Review will contain:
    a. The professional qualifications and licensure of the person or persons reviewing the Internal Appeal;
    b. The name, address, and phone number of the review coordinator;
    c. A statement of the reviewer's understanding of the Internal Appeal;
    d. The following information to identify the claim, including:
        1) The date of the service;
        2) The health care provider;
        3) The claim amount (if applicable); and
        4) Upon request, a statement describing the availability of the diagnosis code and the Treatment code and their meanings.
    e. A statement of Your right to contact the Health Insurance SMART NC for assistance:

       NC Department of Insurance
       Health Insurance Smart NC
       1201 Mail Service Center
       Raleigh, NC 27699-1201
       Phone: 855-408-1212

    f. The reviewer's decision in clear terms and the contractual or medical basis in sufficient detail for You to respond;
    g. A reference to the evidence or documents used as the basis for the decision.
7. For Formal Reviews concerning the quality of clinical care delivered by a provider of service, We will acknowledge the Formal Review request within 10 business days. The acknowledgement will advise You that:
    a. We will refer the Formal Review request to its quality assurance committee for review and consideration or any appropriate action against the provider of service; and
    b. State law does not allow for a Grievance review for Grievances concerning quality of care.
8. For Formal Reviews concerning prospective and concurrent determinations, We will communicate Our decision through written or electronic means to You or Your provider of services acting on Your behalf within three business days after Our receipt of all necessary information.

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:
Prospective (Pre-certification) review	180 days after receipt of Adverse Benefit Determination	30 days of receipt of appeal
Prospective (Pre-certification) review involving Urgent Care	180 days after receipt of Adverse Benefit Determination	72 hours of receipt of appeal
Concurrent: To end or reduce Treatment prematurely	180 days after receipt of Adverse Benefit Determination Pending the outcome of the appeal, benefits for an ongoing course of Treatment will not be reduced or terminated.	15 days of receipt of appeal
Concurrent: To deny Your request to extend Treatment	180 days after receipt of Adverse Benefit Determination for Pre-Service or Retrospective review	15 days of receipt of appeal for Prospective (Pre-certification) review; or 30 days of receipt of appeal for Retrospective review
Concurrent: Involving Urgent Care	180 days after receipt of Adverse Benefit Determination	72 hours of receipt of appeal
Retrospective review	180 days after receipt of Adverse Benefit Determination	30 days of receipt of appeal

Step 3:

EXTERNAL REVIEW

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

How to Appeal a Claim Decision – External Review:
North Carolina law provides for review of Non-certification decisions by an external, Independent Review Organization (IRO). This independent review is only available for Non-certifications. The North Carolina Department of Insurance (NCDOI) administers this service at no charge to You. The NCDOI arranges for an IRO to review the case once the NCDOI establishes that an Your request is complete and eligible for review. You or Your Authorized Representative may request an external review. We will notify You in writing of Your right to request an external review each time You receive:

1. a Non-certification decision; or
2. an appeal decision upholding a Non-certification decision.

The NCDOI will determine whether Your request is eligible for external review based on:

1. Your request is about a Medical Necessity that resulted in a Non-certification decision;
2. You had coverage with Us in effect when the Non-certification decision was issued;
3. the service for which the Non-certification was issued appears to be a covered service under Your insurance; and
4. You have exhausted Our internal review process described below.

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

For a standard external review, You will have exhausted the internal review process if You have:

a. completed Our appeal and Grievance review and received a written Grievance decision from Us, or
b. filed a Grievance and except to the extent You requested or agreed to a delay, have not received Our written decision within 30 days of the date that a Grievance was filed with Us, or
c. received notification that We have agreed to waive the requirement to exhaust the internal appeal and/or Grievance process, if applicable.

If Your request for a standard external review is related to a retrospective Non-certification (a Non-certification which occurs after You have received the services in question), You will not be eligible to request a standard review until You have completed Our internal review process and received a written final determination from Us. A retrospective review includes emergency claims to determine whether the prudent layperson standard in G.S. 58-3-190 has been met.

If You wish to request a standard external review, You or Your Authorized Representative must make this request to NCDOI within 120 days of receiving Our written notice of final determination that the services in question are not approved. The NCDOI will require that You provide the NCDOI with written, signed permission for the release of any of the Your medical records that need to be reviewed to reach a decision on the external review.

Within 10 business days of receipt of Your request for a standard external review, the NCDOI will notify You and Your provider of whether the request is complete and accepted. If the NCDOI notifies You that the request is incomplete, You must provide all requested additional information to the NCDOI within 150 days of the date of Our written notice of final determination. If the NCDOI accepts Your request, the acceptance notice will include:

1. the name and contact information for the IRO assigned to Your case;
2. a copy of the information about Your case that We have provided to the NCDOI;
3. notice that We will provide You or Your Authorized Representative with a copy of the documents and information considered in making the denial decision. We will also send a copy to the IRO; and
4. notification that You may submit additional written information and supporting documents relevant to the initial Non-certification to the assigned IRO within 7 days after receipt of the notice of acceptance.

If You choose to provide any additional information to the IRO, You must also provide that same information to Us at the same time using the same means of communication (e.g., information faxed to the IRO should be faxed to Us). When faxing to Us, send it to 1-413-733-4612. If You choose to mail it, send it to:

Wellfleet Insurance Company
5814 Reed Road, Fort Wayne, IN 46835
C/O Administrator: Wellfleet Group, LLC
P.O, Box 15369
Springfield, MA 01115-5369
1-877-657-5030
www.wellfleetinsurance.com

Please note that You may provide the additional information to the NCDOI within the 7-day deadline rather than sending it directly to the IRO and Us. The NCDOI will forward this information to the IRO and Us within two business days of receiving Your additional information.

The IRO will send You written notice of its decision within 45 days of the date the NCDOI received a Your standard external review request. If the IRO's decision is to reverse the Non-certification, We will, reverse the Non-certification decision within 3 business days of receiving notice of the IRO's decision. We will then provide coverage for the requested service or supply. If You are no longer covered under this Certificate at the time We receive notice of the IRO's decision to reverse the Non-certification, We will only provide coverage for those services or supplies You actually received or would have received prior to disenrollment if the service had not been Non-certified when first requested.

An expedited external review of a Non-certification decision may be available if You or Your condition where the time required to complete either an expedited internal appeal or Grievance review or a standard external review could be expected to seriously risk Your life or health or would risk Your ability to regain maximum function. If You meet this requirement, You may make a written request to the NCDOI for an expedited review.

You must:
a. receive a Non-certification decision from Us AND file a request with Us for an expedited appeal; or
b. receive an appeal decision upholding a Non-certification decision.

You may also make a request for an expedited external review if You receive an adverse Formal appeal decision concerning a Non-certification of an admission, availability of care, continued stay or emergency care, but has not been discharged from the inpatient facility.

The NCDOI, with a medical professional, will review Your request and decide whether it qualifies for expedited review. You or Your provider will be notified within 2 days if Your request is accepted for expedited external review. If Your request is not accepted for expedited review, the NCDOI may:
1. accept the case for standard external review if Our internal review process was already completed; or
2. require that We finish Our internal review process before You make another request for an external review with the NCDOI. An expedited external review is not available for retrospective Non-certifications.

The IRO will communicate its decision to You within 3 days of the date the NCDOI receives Your request for an expedited external review. If the IRO's decision is to reverse the Non-certification, We will, within one day of receiving notice of the IRO's decision, reverse the Non-certification decision for the requested service or supply. If You are no longer covered by Our Certificate at the time We receive notice of the IRO's decision to reverse the Non-certification, We will only provide coverage for those services or supplies You actually received or would have received prior to disenrollment if the service had not been Non-certified when first requested.

The IRO's external review decision is binding on You and Us, except to the extent You may have other remedies available under applicable federal or state law. You may not file a subsequent request for an external review involving the same Non-certification decision for which You already received an external review decision.

For further information about External Review or to request an external review, contact the NCDOI at:

By Mail:
NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center, Raleigh, NC 27699-1201

In Person:
Albemarle Building
325 N. Salisbury St
Raleigh, NC 27603
855-408-1212 (toll free)

You may also obtain information from Health Insurance SMART NC that will assist him or her with internal claims and appeals and external review processes. You should contact:

North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
855-408-1212 (Toll Free)

CONTACT INFORMATION

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

State of North Carolina
Office of the Commissioner of Insurance
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201
855-408-1212 (Toll Free)

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.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ (877) 657-5030.

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。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. با (877) 657-5030 تماس بگیرید.

कृपा ध्या दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएंनि:शुल्क उपलब्ध हैं। कृपा पर काल करें (877) 657-5030

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

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

សូមទូរស័ព្ទមកលេខ (877) 657-5030 ។

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

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

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

ગુજરાતી (Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 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) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ (877) 657-5030

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

NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA
LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies and Health Maintenance Organizations (HMOs) licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer or HMO becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted *in the box* below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
4441 Six Forks RD STE 106-153
Raleigh NC 27609-5729
https://www.nclifega.org/

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the back of this page* 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 anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer or HMO. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- They are 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);
- The insurer was not authorized to do business in this state;
- Their policy was issued by 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, or by an insurance exchange.
- They acquired rights to receive payments through a structured settlement factoring transaction

The association also does not provide coverage for:

- 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;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contractholder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
- A policy or contract commonly known as Medicare Part C, Medicare Part D, Medicaid or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
(2) Except as provided in (3) (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
(3) The guaranty association will pay a maximum of $500,000 with respect to a health benefit plan.
(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.
(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.