LINDENWOOD
UNIVERSITY

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2022/2023

DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

LINDENWOOD UNIVERSITY

Saint Charles, MO

("the Policyholder")

Policy Number: WI2223MOSHIP200

Group Number: ST2201SH

Effective: 08/01/2022 – 07/31/2023

WELLFLEET STUDENT

UNDERWRITTEN BY:

Wellfleet Insurance Company | Fort Wayne, IN

("the Company")

ADMINISTERED BY:

Wellfleet Group, LLC

Welcome Students…

We are pleased to provide you with this summary of the 2022 – 2023 Student Health Insurance Plan ("Plan"), which is fully compliant with the Affordable Care Act. This is only a brief description of the coverage(s) available under Certificate form MO SHIP Cert (2022). The Certificate will contain reductions, limitations, exclusions, and termination provisions. Full details of coverageare contained in the Certificate. If there are any conflicts between this document and the Certificate, the Certificate shall govern in all cases.

"Benefits at a Glance" includes effective dates and costs of coverage, as well as other helpful information. For additional details about the Plan, please consult the Plan Certificate and other materials at **www.wellfleetstudent.com**. If you have questions about Enrollment into the Plan, please call Dissinger Reed, a Division of HUB International at (813) 491-6385 or email: mam.studentservices@hubinternational.com. For questions about medical benefits or claims, please call Wellfleet Student at (877) 657-5030, TTY 711.

This is not an insurance Policy, and your receipt of this document does not constitute the insurance or delivery of a policy of insurance. Any provisions of the Policy, as described in this Summary, that may be in conflict with the laws of the state where the school is located will be administered to conform with the requirements of that state's laws, including those relating to mandated benefits.

The information contained in this Summary is accurate at the time of publication but may change in accordance with state and federal insurance regulations during the course of the Policy year. The most current version of this document will be posted online at the website listed on the cover. In the case of a discrepancy between two versions of the Summary, the most recent will apply.

Important Contact Information & Resources

Plan Administration

Enrollment, Eligibility, & Waivers

Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115

Benefits, Claim Status, & ID Cards

Wellfleet Group, LLC
PO Box 15369
Springfield, Massachusetts 01115-5369
(877) 657-5030, TTY 711
www.wellfleetstudent.com Monday–Thursday, 8:30 a.m. to 7:00 p.m.Eastern Time

Friday, 8:30 a.m. to 5:00 p.m. Eastern Time

Claims

Cigna OAP
PO Box 188061
Chattanooga, Tennessee 37422-8061
Electronic Payor ID: 62308

PPO Network

Cigna Open Access Plus
www.mycigna.com

Pharmacy Benefits Manager

For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit **www.wellfleetstudent.com**.

Member Pharmacy Help

(877) 640-7940

Student Health Center

BarnesCare / BJC HealthCare

Evans Commons 3rd Floor
(636) 949-4525
Hours of Operation
Monday – Friday 8:00 a.m. to 4:30 p.m.
Closed 12:30-1:00 p.m. daily for lunch

Student Counseling and Resources Center

636-949-4522
scrc@lindenwood.edu
Hours of operation
Monday – Friday 8:00 a.m. to 5:00 p.m.

For further information about your plan please use the QR code below.

What's Inside (Click on section title below to go to section in "Benefits at a Glance.")

General Information

Am I Eligible?

Domestic Undergraduate Students

All domestic undergraduate students taking 9 or more credit hours are eligible for coverage under the Plan. Eligible students are required to have health insurance coverage and will be automatically enrolled in the Student Health Insurance Plan and the premium will be added to the student's tuition fees unless proof of comparable coverage is provided by completing the waiver.

International Students

All international students taking 1 or more credit hours are eligible for coverage under the Policy. Eligible students are required to have health insurance coverage and will be automatically enrolled in the Student Health Insurance Plan and the premium will be added to the student's tuition fees and do not have the option to waive coverage.

Dependents

Dependents are not eligible.

How Do I Waive? (Domestic Undergraduate Students Only)

To Waive:

- Go to www.wellfleetstudent.com.
- Under "Search for your School" feature, type: **Lindenwood University.**
- Once on your school landing page, Click the waiver tab and proceed.
- For all first-time users, You must first "Create a New Account".
- When your account is created, there will be a Waiver button in your account.
- Click on the Waiver button and proceed as directed.
- You must fill in all the required information on the waiver form. If any information is missing, your waiver will not be accepted.
- Click submit and review the information being provided is accurate.
- When your online waiver form is successfully submitted you will receive a confirmation e-mail.

See the Effective Dates & Costs section for waiver deadline dates.

Effective Dates & Costs

All time periods begin at 12:00 A.M. local time and end at 11:59 P.M. local time at the Policyholder's address.

Coverage Period	Coverage Start Date	Coverage End Date	Waiver Deadline Date
Annual	08/01/2022	07/31/2023	09/02/2022
Spring (new students only)	01/01/2023	07/31/2023	01/20/2023

Plan Costs for Students

	Annual	Spring
Student*	$1,841	$1,069

***The above plan costs include an administrative service fee.**

Plan Benefits

UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE (IF APPLICABLE) WILL ALWAYS APPLY.

Pre-Certification required for Inpatient Services Care, selected Outpatient Services, and Outpatient Surgery. For a complete list of these services, see the Plan Certificate.

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.

Key Plan Benefits

BENEFIT	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Policy Year Deductible	$200	$400
Cost sharing You incur for Covered Medical Expenses that is applied to the Out-of-Network Deductible will not be applied to satisfy the In-Network Deductible. Cost sharing You incur for Covered Medical Expenses that is applied to the In-Network Deductible will not be applied to satisfy the Out-of-Network Provider Deductible.		
Out-of-Pocket Maximum	$7,000	$14,000
Cost sharing You incur for Covered Medical Expenses that is applied to the Out-of-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the In-Network Provider Out-of-Pocket Maximum and cost sharing You incur for Covered Medical expenses that is applied to the In-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the Out-of-Network Provider Out-of-Pocket Maximum.		

Coinsurance	80% of Negotiated Charge (NC)	60% of Usual & Customary (U&C)
Preventive Services	100% of NC Deductible Waived	80% of U&C
Physician Office Visits including specialist and consultant visits ***Check below for additional copayments**	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible waived	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Services	$250 Copayment per visit then the plan pays 100% 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	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Schedule of Benefits

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 STUDENT HEALTH CENTER, IN-NETWORK AND OUT-OF-NETWORK COMBINED.**

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	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Registered Nurse Services for private duty nursing while Confined	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER BENEFITS In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, 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	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Mental Health Disorder and Substance Use Disorder 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	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible waived	60% 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	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% 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	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Anesthetist	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Assistant Surgeon	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Surgical Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Organ Transplant Surgery Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Reconstructive Surgery Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Other Professional Services		
Gender Transition Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Pre-Certification required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hospice Care Coverage	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Office Visits		
Physician's Office Visits including Specialists/Consultants	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible waived	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telemedicine or Telehealth Services	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible waived	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Allergy Testing and Treatment including injections	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit	80% of the Negotiated Charge after Deductible for Covered Medical Expenses Pre-Certification Required after the 5th visit.	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
*Chiropractic Care Benefit Maximum visits per Policy Year	30	30
***Important note:** • The cost-share for a single chiropractic service will not be more than 50% of the Negotiated or Usual and Customary charge (as applicable) for that service.		
Tuberculosis screening, Titers, QuantiFERON B tests including shots (other than covered under preventive services)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Services, Ambulance And Non-Emergency Services		
Emergency Services in an emergency department for Emergency Medical Conditions.	$250 Copayment per visit then the plan pays 100% 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	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Charge.

Non-Emergency Ambulance Service ground and/or air, water transportation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diagnostic Laboratory, Testing and Imaging Services		
Diagnostic Imaging Services Pre-Certification Required	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Certification Required	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation and Habilitation Therapies		
Cardiac Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses Pre-Certification Required after the 5th visit for Physical Therapy and or Occupational Therapy.	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Maximum Visits or each therapy per Policy Year for Physical Therapy, and Occupational Therapy	30	30
Maximum Visits per Policy Year for Speech Therapy	Unlimited	Unlimited
Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy If benefits are also payable under the mandated Early Intervention Services or Autism Benefit for the same service, We will pay only once for the greater of the benefits.	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses Pre-Certification Required after the 5th visit for Physical and/or Occupational Therapy.	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitation Services Maximum Visits for each therapy per Policy Year for Physical Therapy, Occupational Therapy and Speech Therapy	30	30
OTHER SERVICES AND SUPPLIES		
Covered Clinical Trials	Same as any other Covered Sickness	
Diabetic services and supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Durable Medical Equipment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% 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.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hearing Aids and Exams	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
Prosthetic and Orthotic Devices Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Private Duty Nursing Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Sports Accident Expense Benefit - incurred as the result of the play or practice of Intercollegiate sports Up to $20,000 per Accident	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Non-emergency Care While Traveling Outside of the United States	60% of Actual Charge after Deductible for Covered Medical Expenses Subject to $10,000 maximum per Policy Year	
Medical Evacuation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $50,000 maximum per Policy Year	
Repatriation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $25,000 maximum per Policy Year	
Pediatric Dental and Vision Care		
Pediatric Dental Care Benefit Coverage is limited to covered persons through the end of the month in which they turn 19		

Type A services: Diagnostic and Preventive care	100% of Usual and Customary Charge
Type B services: Basic Restorative Care	50% of Usual and Customary Charge
Type C services: Major Restorative care	50% of Usual and Customary Charge
Orthodontic services	50% of Usual and Customary Charge

Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.

Type A services: Diagnostic and Preventive care

Visits and images

- Office visit during regular office hours, for oral examination (limited to 2 visits every 12 months)
- Problem-focused examination (limited to 2 visits every 12 months)
- Oral evaluation – child under 3 (limited to 2 visits every 12 months)
- Comprehensive oral evaluation (limited to 2 visits every 12 months)
- Detailed and extensive oral evaluation – problem focused
- Comprehensive periodontal evaluation (limited to 2 visits every 12 months)
- Complete image series, including bitewings (limited to 1 set every 3 years)
- Periapical 1st image
- Intra-oral, occlusal radiographic image
- Bitewing image – one image (limited to 2 sets per 12 months)
- Bitewing images – two images (limited to 2 sets per 12 months)
- Bitewing image – three images (limited to 2 sets per 12 months)
- Bitewing images – four images (limited to 2 sets per 12 months)
- Vertical bitewing images (limited to 2 sets per year)
- Panoramic images (limited to 1 set every 3 years)
- Cephalometric image
- 2D oral/facial photographic images
- Interpretation of diagnostic image
- Diagnostic models
- Prophylaxis (cleaning) - adult (limited to 2 treatments per year)
- Prophylaxis (cleaning) - child (limited to 2 treatments per year)
- Topical fluoride varnish (limited to 2 courses every 12 months)
- Topical application of fluoride (limited to 2 courses every 12 months)
- Sealants, per tooth (limited to one application every 3 years for permanent molars)
- Preventive resin restoration in a moderate to high caries risk patient-permanent tooth (limited to one application every 3 years for permanent molars)
- Sealant repair, per tooth
- Resin infiltration of lesion (1 per tooth every 3 years)
- Emergency palliative treatment per visit

Space maintainers (Includes all adjustments within 6 months after installation)

Fixed (unilateral or bilateral)
Removable (unilateral or bilateral)
Re-cementation of space maintainer
Removal of space maintainer

Type B services: Basic Restorative Care

Visits and images

Consultation (by other than the treating dental provider)
Professional visit after hours (payment will be made on the basis of services rendered or the charge for the after-hours visit, whichever is greater)
Treatment of complications (post-surgical) unusual circumstances, by report

Images, pathology and drugs

Extra-oral first 2D projection radiographic image
Extra-oral posterior dental radiographic image
Therapeutic drug injection, by report

Oral surgery

Extractions
Coronal remnants-deciduous tooth
Erupted tooth or exposed root (elevation and/or forceps removal)
Surgical removal of erupted tooth requiring removal of bone and/or resectioning of tooth
Coronectomy
Surgical removal of residual tooth roots
Surgical removal of impacted teeth – partial bony
Impacted teeth
Removal of tooth (soft tissue)
Surgical removal of impacted teeth

- Removal of tooth (partially bony)
- Removal of tooth (completely bony)
- Removal of tooth (completely bony with unusual surgical complications)

Odontogenic cysts and neoplasms
Other surgical procedures
Closure of oral fistula of maxillary sinus

- Tooth reimplantation

Tooth transplantation
Surgical access of an unerupted tooth
Crown exposure to aid eruption
Incision and drainage of abscess
Alveoplasty, in conjunction with extractions – four or more teeth, per quadrant
Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
Alveoplasty, not in conjunction with extraction - per quadrant
Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
Removal of exostosis
Removal of torus palatinus
Removal of torus mandibularis

Suture of soft tissue injury wound less than 5cm
Bone replacement graft for ridge preservation – per site
Frenectomy
Excision of hyperplastic tissue
Excision of periocoronal gingiva

Periodontics

Periodontal scaling and root planing, per quadrant – 4 or more teeth (limited to 4 separate quadrants every 2 years)
Root planning and scaling – 1 to 3 teeth per quadrant (limited to once per quadrant every 2 years)
Periodontal maintenance procedures following active therapy (limited to 4 in 12 months combined with prophylaxis after completion of active periodontal therapy)
Collection and application of autologous blood concentrate product (limited to 1 in 36 months)
Occlusal adjustment – limited
Occlusal adjustment - complete

Endodontics

Pulp capping – direct
Pulp capping - indirect
Pulpotomy (theraputec)
Partial pulpotomy of apexogensis
Pulpal therapy – anterior primary tooth
Pulpal therapy – posterior primary tooth
Pulpal regeneration
Retrograde filling

Restorative dentistry

Does not include inlays, crowns (other than prefabricated stainless steel or resin) and bridges.
Multiple restorations in 1 surface are considered as a single restoration.

Amalgam restorations – 1 surface –
Amalgam restorations – 2 surface
Amalgam restorations – 3 surface
Amalgam restorations – 4 or more surface
Resin-based composite restorations – 1 surface anterior
Resin-based composite restorations – 2 surfaces anterior
Resin-based composite restorations – 3 surfaces anterior
Resin-based composite restorations – 4 or more surfaces or involving incisal angle (anterior)
Resin-based composite crown, anterior
Resin-based composite – 1 surface posterior
Resin-based composite – 2 surfaces posterior
Resin-based composite – 3 surfaces posterior
Resin-based composite – 4 or more surfaces posterior
Pins
Pin retention—per tooth, in addition to amalgam or resin restoration
Crowns (when tooth cannot be restored with a filling material)
Prefabricated stainless steel – primary teeth
Prefabricated stainless steel – permanent teeth

Prefabricated resin crown (excluding temporary crowns)
Protective resin
Interim therapeutic restoration – primary teeth
Prefabricated porcelain/ceramic crown – primary teeth
Re-cementation
Inlay
Fabricated-prefabricated post and core
Crown
Implant/abutment supported crown
Implant/abutment supported fixed partial denture
Fixed partial denture retainers

Prosthodontics

- Dentures and partials (Adjustments made within 6 months after installation, by the same dentist who installed it, are inclusive to the denture)
    - Adjustment to complete denture – upper (Adjustments made within 6 months after installation, by the same dentist who installed it, are inclusive to the denture)
    - Adjustment to complete denture – lower (Adjustments made within 6 months after installation, by the same dentist who installed it, are inclusive to the denture)
    - Adjustment to partial denture – upper (Adjustments made within 6 months after installation, by the same dentist who installed it, are inclusive to the denture)
    - Adjustment to partial denture – lower (Adjustments made within 6 months after installation, by the same dentist who installed it, are inclusive to the denture)
- Repairs
    - Broken complete denture base
    - Replace missing or broken tooth – complete denture
    - Resin denture base (partial denture)
    - Repair cast framework (partial denture)
    - Broken clasp, per tooth (partial denture)
    - Replace broken tooth – per tooth (partial denture)
    - Add tooth to existing partial denture
    - Add clasp to existing partial denture – per tooth
    - Replace all teeth and acrylic on cast metal framework – upper partial denture
    - Replace all teeth and acrylic on cast metal framework – lower partial denture

Special tissue conditioning, per denture – upper
Special tissue conditioning, per denture – lower
Rebase, complete upper denture
Rebase, complete lower denture Rebase upper partial denture Rebase lower partial denture
Reline complete upper denture (chairside)

- Reline complete lower denture (chairside)
- Reline upper partial denture (chairside)
- Reline lower partial denture (chairside)
- Reline complete upper denture (laboratory)
- Reline complete lower denture (laboratory)
- Reline upper partial denture (laboratory)

- Reline lower partial denture (laboratory)
- Fixed partial denture repair necessitated by material failure

General anesthesia and intravenous sedation
- Evaluation – general anesthesia/deep sedation
- General anesthesia/deep sedation – each 15 minute increments
- General anesthesia/deep sedation – each 15 minute increment

Type C services: Major Restorative Care

Periodontics

Gingivectomy or gingivoplasty, per quadrant (limited to 1 per quadrant every 3 years)
Gingivectomy or gingivoplasty, 1 to 3 teeth per quadrant (limited to 1 per quadrant every 3 years)
Gingivectomy or gingivoplasty, to allow access for restorative procedure, per tooth (limited to 1 per quadrant every 3 years)
Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)
Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
Clinical crown lengthening
Osseous surgery, four or more contiguous teeth (limited to 1 per quadrant every 3 years)
Osseous surgery, including flap and closure, 1 to 3 contiguous teeth per quadrant (limited to 1 per site every 3 years)
Bone replacement graft – first site in quadrant (limited to 1 every 3 years)
Pedical soft tissue graft procedure
Autogenous subepithelial connective tissue graft procedures
Non-autogenous connective soft tissue allograft
Free soft tissue graft procedure 1st tooth, implant, or edentulous tooth position in graft
Free soft tissue graft procedure each additional contiguous tooth, implant or edentulous tooth position in same graft site
Autogenous connective tissue graft procedure – each additional contiguous tooth, implant or edentulous tooth position in same graft site
Non-autogenous connective tissue graft procedure – each additional contiguous tooth, implant or edentulous tooth position in same graft site
Full mouth debridement (limited to 1 treatment per lifetime)

Endodontics

Root canal therapy including medically necessary images:
- Anterior
- Bicuspid
- Molar

Retreatment of previous root canal therapy including medically necessary images:
- Anterior
- Bicuspid
- Molar
- Root amputation
- Hemisection (including any root removal)

Apexification/recalcification-initial visit
Apexification/recalcification- interim medication replacement
Apexification/recalcification- final visit
Pulpal regeneration-initial visit
Interium medications replacement
Completion of treatment
Apicoectomy-anterior
Apicoectomy-bicuspid
Apiciectomy-molar
Apiciectomy-each additional tooth

Restorative
Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. (limited to 1 per tooth every 5 years)

- Inlays/Onlays (limited to: 1 tooth every 5 years)
- Inlay-metallic-1 surface (limited to: 1 tooth every 5 years)
- Inlay-metallic-2 surface (limited to: 1 tooth every 5 years)
- Inlay-metallic-3 or more surface (limited to: 1 tooth every 5 years)
- Onlay-metallic-2 surface (limited to: 1 tooth every 5 years)
- Onlay-metallic-3 surface (limited to: 1 tooth every 5 years)
- Onlay-metallic-4 or more surface (limited to: 1 tooth every 5 years)
- Inlay-porcelain/ceramic-1 surface (limited to: 1 tooth every 5 years)
- Inlay-porcelain/ceramic-2 surface (limited to: 1 tooth every 5 years)
- Inlay-porcelain/ceramic-3 or more surface (limited to: 1 tooth every 5 years)
- Onlay-porcelain/ceramic-2 surface (limited to: 1 tooth every 5 years)
- Onlay-porcelain/ceramic-3 surface (limited to: 1 tooth every 5 years)
- Onlay-porcelain/ceramic-in addition to inlay (limited to: 1 tooth every 5 years)
- Inlay-composite/resin-1 surface (limited to: 1 tooth every 5 years)
- Inlay-composite/resin-2 surface (limited to: 1 tooth every 5 years)
- Inlay-composite/resin-3 surface (limited to: 1 tooth every 5 years)
- Onlay-composite/resin-2 surface (limited to: 1 tooth every 5 years)
- Onlay-composite/resin-3 surface (limited to: 1 tooth every 5 years)
- Onlay-composite/resin-4 or more surface (limited to: 1 tooth every 5 years)
- Crowns (limited to: 1 tooth every 5 years)
- Resin (limited to: 1 tooth every 5 years)
- Resin with noble metal (limited to: 1 tooth every 5 years)
- Resin with base metal (limited to: 1 tooth every 5 years)
- Resin with noble metal metal (limited to: 1 tooth every 5 years)
- Porcelain/ceramic substrate (limited to: 1 tooth every 5 years)
- Porcelain with high noble metal (limited to: 1 tooth every 5 years)
- Porcelain with base metal (limited to: 1 tooth every 5 years)
- Porcelain with noble metal (limited to: 1 tooth every 5 years)

- 3/4 cast high noble metal (limited to: 1 tooth every 5 years)
- 3/4 cast predominatly base metal (limited to: 1 tooth every 5 years)
- 3/4 cast noble metal (limited to: 1 tooth every 5 years)
- 3/4 porcelain/ceramic (limited to: 1 tooth every 5 years)
- Full cast high noble metal (limited to: 1 tooth every 5 years)
- Full cast base metal (limited to: 1 tooth every 5 years)
- Full cast noble metal (limited to: 1 tooth every 5 years)
- Titanium (limited to: 1 tooth every 5 years)

Core build-up –
Post and core
Each additional post
Prefabricated post and core
Each additional prefabricated post
Labial veneer - (resin) - chairside
Labial veneer- (resin laminate) - laboratory
Labial veneer- (porcelain) – laboratory
Repairs

- Crown repair
- Inlay repair
- Onlay repair
- Veneer repair

Prosthodontics
Dentures and partial dentures
- Replacement of existing bridges or dentures (limited to 1 every 5 years)

- Complete upper denture (limited to 1 every 5 years)
- Complete lower denture (limited to 1 every 5 years)
- Immediate upper denture (limited to 1 every 5 years)
- Immediate lower denture (limited to 1 every 5 years
- Partial upper, resin base (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
- Partial lower, resin base (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
- Partial upper, cast metal base with resin saddles (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
- Partial lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
- Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
- Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
- Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) Includes limited follow-up care only; does not include future rebasing (limited to 1 every 5 years)
- Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)

- Interium partial denture, upper (limited to 1 every 5 years)
- Interium partial denture, lower (limited to 1 every 5 years)
- Removable partial denture (unilateral) (limited to 1 every 5 years)

Implant Services

- Surgical placement of implant: endosteal (1 every 5 years)
- Surgical placement of interium implant body (1 every 5 years)
- Surgical placement of eposteal implant (1 every 5 years)
- Transosteal implant, including hardware (1 every 5 years)
- Connecting bar – implant or abutment supported (1 every 5 years)
- Prefabricated abutment (1 every 5 years)
- Custom fabricated abutment (1 every 5 years)
- Abutment supported porcelain/ceramic crown (1 every 5 years)
- Abutment supported porcelain fused to high noble metal (1 every 5 years)
- Abutment supported porcelain fused to predominately base metal crown (1 every 5 years)
- Abutment supported porcelain fused to noble metal crown (1 every 5 years)
- Abutment supported cast high noble metal crown (1 every 5 years)
- Abutment supported cast predominately base metal crown (1 every 5 years)
- Abutment supported cast noble metal crown (1 every 5 years)
- Implant supported porcelain/ceramic crown (1 every 5 years)
- Implant supported porcelain fused to high noble metal (titanium) (1 every 5 years)
- Implant supported metal crown (titanium) (1 every 5 years)
- Abutment supported retainer for porcelain/ceramic fixed partial denture (1 every 5 years)
- Abutment supported retainer for porcelain fused to high noble metal fixed partial denture (1 every 5 years)
- Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture (1 every 5 years)
- Abutment supported retainer for porcelain fused to noble metal fixed partial denture (1 every 5 years)
- Abutment supported retainer for cast high noble metal fixed partial denture (1 every 5 years)
- Abutment supported retainer for predominately base metal fixed partial denture (1 every 5 years)
- Abutment supported retainer for cast noble metal fixed partial denture (1 every 5 years)
- Implant supported retainer for ceramic fixed partial denture (1 every 5 years)
- Implant supported retainer for porcelain fused to high noble metal fixed partial denture (1 every 5 years)
- Implant supported retainer for cast metal fixed partial denture (1 every 5 years)
- Implant maintenance procedures (1 every 5 years)
- Repair implant prosthesis (1 every 5 years)
- Replacement of semi-precious or precision attachment (1 every 5 years)
- Abutment supported crown titanium (1 every 5 years)
- Repair implant abutment (1 every 5 years)
- Implant removal, by report (1 every 5 years)
- Debridement of a peri-implant defect or defects surrounding a single implant (1 every 5 years)
- Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant (1 every 5 years)
- Bone graft for repair of peri-implant defect (1 every 5 years)
- Bone graft at time of implant placement (1 every 5 years)
- Implant/abutment supported removable denture, upper (1 every 5 years)

- Implant/abutment supported removable denture, lower (1 every 5 years)
- Implant/abutment supported removable denture for partially edentulous arch, upper (1 every 5 years)
- Implant/abutment supported removable denture for partially edentulous arch, lower (1 every 5 years)
- Implant/abutment supported fixed denture for completely edentulous arch – upper (1 every 5 years)
- Implant/abutment supported fixed denture for completely edentulous arch – lower (1 every 5 years)
- Implant/abutment supported fixed denture for partially edentulous arch – upper (1 every 5 years)
- Implant/abutment supported fixed denture for partially edentulous arch – lower (1 every 5 years)
- Implant index (1 every 5 years)

Pontics – Fixed partial denture

- Cast high noble metal (1 every 5 years)
- Cast base metal (1 every 5 years)
- Cast noble metal (1 every 5 years)
- Titanium (1 every 5 years)
- Porcelain fused to high noble metal (1 every 5 years)
- Porcelain fused to base metal (1 every 5 years)
- Porcelain fused to noble metal (1 every 5 years)
- Porcelain/ceramic (1 every 5 years)
- Resin with high noble metal (1 every 5 years)
- Resin with predominantly base metal (1 every 5 years)
- Resin with noble metal (1 every 5 years)
- Inlays/Onlays – Fixed partial denture
- Retainer cast metal for resin bonded fixed prosthesis
- Retainer porcelain/ceramic for resin bonded fixed prosthesis

Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)

Crowns – Fixed partial dentures o Retainer crown - porcelain/ceramic (limited to 1 every 5 years)

- Retainer crown - porcelain fused to high noble metal (limited to 1 every 5 years)
- Retainer crown - porcelain fused to predominantly base metal (limited to 1 every 5 years)
- Retainer crown - porcelain fused to noble metal (limited to 1 every 5 years)
- Retainer crown - 3/4 cast high noble metal (limited to 1 every 5 years)
- Retainer crown - 3/4 cast predominantly base metal (limited to 1 every 5 years)
- Retainer crown - 3/4 cast noble metal (limited to 1 every 5 years)
- Retainer crown - 3/4 porcelain/ceramic (limited to 1 every 5 years)
- Retainer crown - full cast high noble metal (limited to 1 every 5 years)
- Retainer crown - full cast predominantly base metal (limited to 1 every 5 years)
- Retainer crown - full cast noble metal (limited to 1 every 5 years)

Stress breakers

Pediatric partial denture (limited to 1 every 5 years)

Removable appliance therapy

Fixed or cemented appliance therapy

Cleaning and inspection of removable complete denture, upper

Cleaning and inspection of removable complete partial denture, lower

Cleaning and inspection of removable complete partial denture, upper

Cleaning and inspection of removable complete denture, lower

Occlusal guard, patients age 13 older Occlusal guard adjustment (Not eligible within first 6 months after placement of appliance **Orthodontic services** Medically necessary orthodontic treatment (includes removal of appliances, construction of retainer) • Limited orthodontic treatment of the primary dentition • Limited orthodontic treatment of the transitional dentition • Limited orthodontic treatment of the adolescent dentition • Interceptive orthodontic treatment of the primary dentition • Interceptive orthodontic treatment of the transitional dentition • Comprehensive orthodontic treatment of the transitional dentition • Comprehensive orthodontic treatment of the adolescent dentition • Comprehensive treatment of adult dentition • Pre-orthodontic treatment examination to monitor growth and development • Periodic orthodontic treatment visit (as part of contract) • Orthodontic retention (removal of appliances, construction and placement of retainer(s) • Repair of orthodontic appliance • Rebonding or recementing; and/or repair, as required of fixed retainers • Repair of fixed retainers		
Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19) Limited to 1 visit including dilation, refraction and glaucoma testing 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.	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses	
Miscellaneous Dental Services		
Accidental Injury Dental Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Sickness Dental Expense Benefit	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Oral Surgery and Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dental Anesthesia Benefit	Same as any other Covered Sickness, subject to the limitations described in the Benefit	
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.	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$20 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived

More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$40 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Retail pharmacy	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$60 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
TIER 2 (Including 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.	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$40 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$80 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$80 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived

More than a 60 day supply filled at a Retail pharmacy	$120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$120 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
TIER 3 (Including 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.	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$60 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$120 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Retail pharmacy	$180 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$180 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
Specialty Prescription Drugs		
Specialty Prescription Drugs For each fill up to a 30 day supply.	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	$60 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses

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.	Deductible Waived	Deductible Waived
More than a 30 day supply but less than a 61 day supply	$120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$120 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply	$180 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$180 Copayment then the plan pays 100% 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		
Autism Spectrum Disorder and Developmental or Physical Disability Benefit	Same as any other Covered Sickness	
Cancer Screenings	Same as any other Preventive Service	

Leukocyte Antigen Testing Benefit	Same as any other Covered Sickness, up to $75 subject to the limitations described in the Benefit
Low-Dose Mammography Screening	Same as any other Preventive Service
Diagnosis and Treatment of Eating Disorders	Same as any other Covered Sickness
Accidental Death and Dismemberment	
Principal Sum	$10,000
Loss must occur within 365 days of the date of a covered Accident.	
Only one benefit will be payable under this provision, that providing the largest benefit, when more than one (1) loss occurs as the result of any one (1) Accident. This benefit is payable in addition to any other benefits payable under this Certificate.	

EXCLUSIONS AND LIMITATIONS

Exclusion Disclaimer: Any exclusion in conflict with the Patient Protection and Affordable Care Act or any state-imposed requirements will be administered to comply with the requirements of the federal or state guideline, whichever is more favorable to You.
The Certificate does not cover loss nor provide benefits for any of the following, except as otherwise provided by the benefits of the Certificate and as shown in the Schedule of Benefits.

General Exclusions

- **International Students Only -** Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible.
- Treatment, service or supply which is not Medically Necessary for the diagnosis, care or Treatment of the sickness or injury involved. This applies even if they are prescribed, recommended or approved by Your attending Physician or dentist.
- Medical services rendered by a provider employed for or contracted with the Policyholder, including team Physicians or trainers, except as specifically provided in the Schedule of Benefits.
- Professional services rendered by an Immediate Family Member or anyone who lives with You.
- Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services covered by Student Health Fees.
- Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
- Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which You are required to pay.
- Services that are duplicated when provided by both a certified Nurse midwife and a Physician.
- Expenses payable under any prior policy which was in force for the person making the claim.
- Loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority.
- Injury sustained as the result of Your operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle Accident takes place.
- Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
- Expenses incurred after:
    - The date insurance terminates as to an Insured Person, except as specified in the extension of benefits provision; and

  - The end of the Policy Year specified in the Policy.
- Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
- 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 except as provided in the Certificate.
- Expenses that are not recommended and approved by a Physician.
- Experimental or Investigative drugs, devices, Treatments or procedures unless otherwise covered under Covered Clinical Trials 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.
- Biofeedback.
- Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
- Sleep Disorders, except for the diagnosis and Treatment of obstructive sleep apnea.
- Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary because of Injury, infection or disease.

Activities Related:

- Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any 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 $20,000.00 per Intercollegiate 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. Surgery for removal of excess skin or fat.

Family Planning:

- Infertility Treatment (male or female)-this includes but is not limited to:
  - Procreative counseling;
  - Premarital examinations;
  - Genetic counseling and genetic testing;
  - Impotence, organic or otherwise;
  - Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
  - In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
  - Costs for an ovum donor or donor sperm;
  - 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, 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.

Cosmetic

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

Prescription Drugs

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

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

VALUE ADDED SERVICES

The following are not affiliated with Wellfleet Insurance Company and the services are not part of the Plan Underwritten by Wellfleet Insurance Company. These value-added options are provided by Wellfleet Student.

VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:
www.wellfleetstudent.com

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

Wellfleet Student provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Wellfleet Student at (877) 657-5030, TTY 711.

If you are traveling and need assistance in North America, call the Assistance Center toll-free at: (877) 305-1966 or if you are in a foreign country, call collect at: (715) 295-9311.

When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

How to Access Services

If you require medical assistance or you need assistance with a non-medical situation, such as lost luggage, lost documents or other travel issues, follow these steps:

- Inside the U.S. and Canada:Dial toll-free **(877) 305-1966**
- Outside the U.S. and Canada:
  - **a)** Request an international operator.
  - **b)** Request the operator to place a collect call to the U.S. at **+1 (715) 295-9311**.

Please provide the following information when you call:

- Policy number or school name
- Nature of your call and/or emergency
- Current location
- Contact phone number and email address
- Secondary point of contact
- Date of birth

24 Hour Nurseline

Students who enroll and maintain medical coverage in this insurance plan have access to the 24 Hour Nurseline. This 24-Hour Nurseline program provides:

- Phone-based, reliable health information in response to health concerns and questions; and
- Assistance in decisions on the appropriate level of care for an injury or sickness.

Appropriate care may include:

- self-care at home
- a call to a physician
- or a visit to the emergency room.

Calls are answered 24 hours a day, 365 days a year by experienced registered nurses who have been specifically trained to handle telephone health inquiries.

This program is not a substitute for doctor visits or emergency response systems. The Nurseline does not answer health plan benefit questions. Health benefit questions should be referred to the Plan Administrator. The 24 Hour Nurseline toll free number will be on the ID card.
(800) 634-7629

CareConnect
Integrated Behavioral Health from Wellfleet Student

24/7 Behavioral Telehealth and Nurseline Access

CareConnect is an integrated behavioral health program offering students easy access to licensed behavioral health clinicians 24/7/365 via telephone (888) 857-5462.

Connect to a registered nurse within seconds, helping students manage their health on their terms through easy access.

Behavioral Health Care

Claims are handled as an in-network visit to ensure students face no disruption with their mental health and substance abuse care using a wide-open Mental Health network.