

WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

STUDENT HEALTH CERTIFICATE OF COVERAGE

POLICYHOLDER: UNIVERSITY OF CALIFORNIA, BERKELEY
(Policyholder)
POLICY NUMBER: WI2223CASHIP40
POLICY EFFECTIVE DATE: August 1, 2022
POLICY TERMINATION DATE: July 31, 2023
STATE OF ISSUE: California

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 or Preventive Service which results in Covered Medical Expenses.

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

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

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

Term of the Certificate

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

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

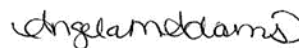
This Certificate is executed for the Company by its President and Secretary.

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

**Non-Participating
Non-Renewable**



President



Secretary

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

Administrator: HealthComp
621 Santa Fe Avenue
Fresno, CA 93721
(833) 302-9785

The following applies to Insured Persons age 65 or older only:

THE POLICYHOLDER HAS THE RIGHT TO RETURN THE POLICY, BY MAIL OR OTHER DELIVERY METHOD, WITHIN 30 DAYS OF ITS RECEIPT, AND TO HAVE THE FULL PREMIUM AND ANY POLICY OR MEMBERSHIP FEE PAID REFUNDED.

Insured Persons who have complaints regarding their ability to access needed health care in a timely manner may complain to Us and to the California Department of Insurance. Our contact information can be found above, and the Consumer Services Division of the Department of Insurance's contact information can be found below.

**California Department of Insurance
300 S. Spring Street
11th Floor
Los Angeles, CA 90013
Inside State Toll-Free: 1-800-927-4357
Outside State: 1-213-897-8921
Fax: 1-213-897-9641
TDD: 1-800-482-4833
www.insurance.ca.gov**

Limitations to Network Provider services can be found in the Preferred Provider Organization provision in Section V - HOW THE PLAN WORKS AND DESCRIPTION OF BENEFITS.

If an Insured Person uses an In-Network Provider, he or she will pay the Coinsurance percentage of the Negotiated Charge shown in the Schedule of Benefits for Covered Medical Expenses. If an Out-of-Network Provider is used, the Insured Person will pay the percentage of the Usual and Customary Charge for Covered Medical Expense shown in the Schedule of Benefits. Note, however, that We will pay at the Negotiated Charge level for Treatment by an Out-of-Network Provider if: there is no In-Network Provider available to treat the Insured Person for Medically Necessary health care services; or the Insured Person has an Emergency Medical Condition and immediate medical Treatment is needed.

COVID19 COVERAGE DISCLOSURE

Benefits will be paid for Medically Necessary in-vitro diagnostic products approved or authorized by the FDA, along with related diagnostic items and services for COVID-19 testing and Treatment, when medically appropriate for the Insured Person.

Testing includes but is not limited to the following in-vitro administered COVID-19 tests:

- Antigen test (on-site rapid screening and in-lab test for active COVID-19 disease)
- PCR (Polymerase Chain Reaction) test (in-lab test for active COVID-19 disease)
- Antibody (serology) test (in-lab test for immune response to late active or past COVID-19 disease)

Benefits will be paid for COVID-19 Treatment administered in a Physician office or via a telehealth visit including Urgent Care Center and emergency room visits.

All Copayments, Deductibles and Coinsurance, including out-of-pocket costs, will be waived for any item, service, or immunization that is intended to prevent or mitigate coronavirus disease (e. g., a chest x-ray, diagnostic test panels for influenza A and B, Physician or facility fees related to reading the x-ray, etc.).

In-vitro diagnostic COVID-19 testing and Treatment or any related service or item is not subject to any pre-certification requirements.

Consistent with the CARES Act and current CMS vaccine guidance, the Insured Person is not responsible for any balance billed for COVID-19 testing or vaccine administration by either an In-Network or Out-of-Network Provider for such Treatment or testing. We will also waive Copayments, Deductibles and Coinsurance for administration of the COVID-19 vaccine.

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SCHEDULE OF BENEFITS

Metal Tier: Platinum
Actuarial Value: 87.87%

Preventive Services:

In-Network Provider: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. We will pay 100% of the Negotiated Charge for Covered Medical Expenses 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. We will pay 50% of the Usual and Customary Charge for Covered Medical Expenses when services are provided through an Out-of-Network Provider.

Medical Deductible per Policy Year (other than Pediatric Dental Care):

Combined In-Network Provider and Out-of-Network Provider	Individual:	\$450
	Family:	\$1,350

The Medical Deductible is waived if Covered Medical Expenses are incurred at the Student Health Center.

Pediatric Dental Care Deductible per Policy Year:

Combined In-Network Provider and Out-of-Network Provider	Individual:	\$60
	Family:	\$180

The Pediatric Dental Care Deductible does apply toward the Medical Deductible.

Out-of-Pocket Maximum per Policy Year*:

For other than Pediatric Dental Care:

In-Network Provider:	Individual	\$3,200
	Family	\$6,400

Out-of-Network Provider:	Individual	\$6,500
	Family	\$13,000

Student Health Center:	Applied to In-Network Provider Out of Pocket Maximum	
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For Pediatric Dental Care:

Combined In-Network Provider and Out-of-Network Provider	Individual:	\$1,000
	Family:	\$2,000

*The combined Out of Pocket Maximums for all Covered Medical Expenses You incur will never exceed the maximum amount permitted by law.

Coinsurance Amounts You Will Pay:

In-Network Provider: 10% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below.

Out-of-Network Provider: 50% of the Usual and Customary Charge (U&C) for Covered Medical Expenses unless otherwise stated below.

Student Health Center: Unless otherwise stated below, paid as In-Network Provider.

Except Prescription Drugs, Covered Medical Expenses incurred for the Treatment of cervical pre-cancer, diagnosed cervical cancer, primary cardiovascular hypertension, or diabetes mellitus are not subject to the Medical Deductible, Coinsurance, or Copayments when services are provided through an In-Network Provider. This does not apply to an underlying condition causing hypertension. All other policy provisions will apply.

Referral Penalty:

Unless an exception to the Student Health Center Referral applies, if an Insured Student does not obtain a Referral from the Student Health Center then, We will not pay for Covered Medical Expenses under this Certificate.

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 Out-of-Network air Ambulance Services, or certain non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center without Your consent, 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 the lesser of the Actual Amount billed by the provider or facility 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.

Preferred Provider Organization Service Area:

Our Services Area consists of counties inside and outside the State of California.

Preferred Provider Organization:

To locate an In-Network Provider in Your area, consult Your Provider Directory or call toll free (833) 302-9785 or visit Our website at <http://berkeley.wellfleetinsurance.com/providers>.

If You incurred Covered Medical Expenses from an Out-of-Network Provider because You 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), Your cost sharing will 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 DEDUCTIBLE WILL ALWAYS APPLY.**
5. **UNLESS OTHERWISE SPECIFIED BELOW ANY DAY OR VISIT LIMITS WILL BE APPLIED TO IN-NETWORK AND OUT-OF-NETWORK COMBINED.**

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING	OUT-OF-NETWORK PROVIDER INSURED'S RESPONSIBILITY FOR COST SHARING
Inpatient Benefits		
Hospital Care Includes hospital room & board expenses and miscellaneous services and supplies.	\$250 Copayment per admission then You pay 10% of the Negotiated Charge after Deductible for Covered Medical Expenses	\$500 Copayment per admission then You pay 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses

<p>Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care.</p> <p>Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p>		
Preadmission Testing	10% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined	10% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
<p>Inpatient Surgery:</p> <p>Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p> <p>Surgeon Services</p> <p>Anesthetist</p> <p>Assistant Surgeon</p>	<p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
Physical Therapy while Confined (inpatient)	10% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
<p>Skilled Nursing Facility Benefit</p> <p>Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p>	\$250 Copayment per admission then You pay 10% of the Negotiated Charge after Deductible for Covered Medical Expenses	\$500 Copayment per admission then You pay 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
<p>Skilled Nursing Facility Benefit Maximum days per benefit period</p> <p>This limitation does not apply to Mental Health Disorder or Substance Use Disorder Benefits</p>	100	100

Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required Refer to the Pre-Certification Process provision for details.	\$250 Copayment per admission then You pay 10% of the Negotiated Charge after Deductible for Covered Medical Expenses	\$500 Copayment per admission then You pay 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Autologous Blood Banking (self-donated blood collection, testing, processing & storage for planned surgery)	10% of the Negotiated Charge after Deductible for Covered Medical Expenses	10% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Outpatient Benefits

<p>Outpatient Surgery:</p> <p>Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p> <p style="padding-left: 40px;">Surgeon Services</p> <p style="padding-left: 40px;">Anesthetist</p> <p style="padding-left: 40px;">Assistant Surgeon</p>	<p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Outpatient Surgery Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma</p> <p>Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p>	<p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Physician's Office or Home Visits</p> <p>For Mental Health Disorder and Substance Use Disorder benefits see below under Mental Health Disorder and Substance Use Disorder Benefits</p>	<p>\$15 Copayment per visit then You pay 0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>

<p>Specialist/Consultant Physician Services</p> <p>For Mental Health Disorder and Substance Use Disorder benefits see below under Mental Health Disorder and Substance Use Disorder Benefits</p>	<p>\$25 Copayment per visit then You pay 0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Telemedicine or Telehealth Services</p>	<p>\$15 Copayment per visit then You pay 0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Retail Health Clinics</p>	<p>\$15 Copayment per visit then You pay 0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Cardiac Rehabilitation</p> <p>Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p>	<p>\$15 Copayment per visit then You pay 0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Pulmonary Rehabilitation</p> <p>Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p>	<p>\$15 Copayment per visit then You pay 0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Rehabilitation Therapy including, Physical Therapy, Occupational Therapy and Speech Therapy</p> <p>Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p>	<p>\$15 Copayment per visit then You pay 0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Habilitation Services including, Physical Therapy, Occupational Therapy and Speech Therapy</p> <p>Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p>	<p>\$15 Copayment per visit then You pay 0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>

Emergency Services and Supplies in an emergency department for Emergency Medical Conditions	\$250 Copayment per visit then You pay 0% of the Negotiated Charge for Covered Medical Expenses Deductible Waived Copayment waived if admitted	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Urgent Care Centers for non-life-threatening conditions (includes ancillary services received during an Urgent Care visit)	\$50 Copayment per visit then You pay 0% of the Negotiated Charge for Covered Medical Expenses Deductible Waived If Treatment rendered at Urgent Care Center at Student Health Center, Your Copayment is \$35 per visit then You pay 10% of Negotiated Charge for any ancillary services rendered during the visit Deductible Waived	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diagnostic Imaging Services (Outpatient) Pre-Certification Required Refer to the Pre-Certification Process provision for details.	10% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans (Outpatient) Pre-Certification Required Refer to the Pre-Certification Process provision for details.	10% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	10% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required Refer to the Pre-Certification Process provision for details.	10% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required Refer to the Pre-Certification Process provision for details.	10% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses

<p>Home Health Care Expenses</p> <p>Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p>	<p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Home Health Care Expenses Maximum visits per Policy Year</p> <p>This limit applies separately to Rehabilitation Services and Habilitation Services.</p> <p>A visit of 4 hours or less by a home health aide shall be considered as one Home Health Care visit.</p>	<p>100</p>	<p>100</p>
<p>Hospice Care Coverage (Inpatient or Outpatient services)</p>	<p>0% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>0% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Prescription Drugs Retail Pharmacy</p> <p>No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy or Student Health Center.</p> <p>If a pharmacy's retail price for a prescription drug is less than the applicable Copayment or Coinsurance amount, You will not be required to pay more than the retail price for the prescription drug.</p>		
<p>TIER 1 (Including Enteral Formulas)</p> <p>For each fill up to a 30-day supply filled at a Retail pharmacy</p> <p>Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible.</p> <p>Refer to Proof of Loss provision contained in the General Provisions.</p> <p>See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.</p>	<p>\$20 Copayment then You pay 0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p> <p>If prescriptions are obtained at Student Health Center pharmacy, You pay 0% of the Actual Charge for Covered Medical Expenses</p>	<p>\$20 Copayment then You pay 50% of Covered Medical Expenses up to a maximum of \$250 Copayment per prescription plus all charges in excess of the Prescription Drug Maximum Negotiated Charge</p> <p>Deductible Waived</p>

<p>TIER 2 (Including Enteral Formulas)</p> <p>For each fill up to a 30 day supply filled at a Retail pharmacy</p> <p>Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible.</p> <p>Refer to Proof of Loss provision contained in the General Provisions.</p> <p>See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.</p>	<p>\$40 Copayment then You pay 0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p> <p>If prescriptions are obtained at Student Health Center pharmacy, \$25 Copayment then You pay 0% of the Actual Charge for Covered Medical Expenses</p>	<p>\$40 Copayment then You pay 50% of Covered Medical Expenses up to a maximum of \$250 Copayment per prescription plus all charges in excess of the Prescription Drug Maximum Negotiated Charge</p> <p>Deductible Waived</p>
<p>TIER 3 (Including Enteral Formulas)</p> <p>For each fill up to a 30 day supply filled at a Retail Pharmacy</p> <p>Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible.</p> <p>Refer to Proof of Loss provision contained in the General Provisions.</p> <p>See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.</p>	<p>\$60 Copayment then You pay 0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p> <p>If prescriptions are obtained at Student Health Center pharmacy, \$40 Copayment then You pay 0% of the Actual Charge for Covered Medical Expenses</p>	<p>\$60 Copayment then You pay 50% of Covered Medical Expenses up to a maximum of \$250 Copayment per prescription plus all charges in excess of the Prescription Drug Maximum Negotiated Charge</p> <p>Deductible Waived</p>
<p>Specialty Prescription Drugs</p> <p>For each fill up to a 30 day supply</p> <p>Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible.</p>	<p>20% of the Negotiated Charge for Covered Medical Expenses up to a maximum of \$250 Copayment per prescription</p> <p>Deductible Waived</p>	<p>50% of Covered Medical Expenses up to a maximum of \$250 Copayment per prescription plus all charges in excess of the Prescription Drug Maximum Negotiated Charge</p> <p>Deductible Waived</p>

<p>Refer to Proof of Loss provision contained in the General Provisions.</p>	<p>If prescriptions are obtained at Student Health Center pharmacy, \$75 Copayment then You pay 0% of the Actual Charge for Covered Medical Expenses</p>	
<p>Orally administered anti-cancer prescription drugs</p>	<p>Paid the same as any other Retail Pharmacy Prescription Drug Fill. The Deductible, if any, will not apply and the total amount of Copayments and Coinsurance will not exceed \$250 for an individual prescription of up to a 30-day supply of a prescribed orally administered anti-cancer prescription drug.</p>	
<p>Diabetic Supplies (for Prescription supplies purchased at a pharmacy)</p>	<p>Paid the same as any other Retail Pharmacy Prescription Drug Fill.</p>	
<p>Other Benefits</p>		
<p style="text-align: center;">MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER BENEFITS</p> <p>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.</p>		
<p>Treatment for Mental Health Disorders, including Gender Dysphoria and Behavioral Health Treatment for Pervasive Developmental Disorder or Autism, and Substance Use Disorders</p> <p>Inpatient Benefits:</p> <p>Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p> <p>Hospital Expenses including Inpatient Psychiatric Hospitals and Residential Treatment Centers</p> <p>Physician’s Visits while Confined</p>	<p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>

<p>Outpatient Benefits:</p> <p>Pre-Certification Required for Surgery. Refer to the Pre-Certification Process provision for details.</p> <p>Physician’s Office Visits (including, but not limited to, Physician visits, individual and group therapy, hormone therapy, medication management)</p> <p>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; and Gender Transition Services including reassignment surgery</p>	<p>\$15 Copayment per visit then You pay 0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p> <p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>Deductible waived for Psycho-Educational Testing.</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>Deductible waived for Psycho-Educational Testing.</p>
<p>Allergy Testing</p>	<p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Allergy Injections/Treatment</p>	<p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Ambulance Service ground and/or air, water transportation</p>	<p>10% of the Actual Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	
<p>Bariatric Surgery</p> <p>Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p>	<p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses when performed at a Hospital or Ambulatory Surgical Facility that is designated as a Bariatric Surgery Center of Excellence.</p>	<p>When performed at a facility in one of the nine (9) Designated Southern California Counties that is not designated as a Bariatric Surgery Center of Excellence, not covered</p> <p>When performed at a facility located outside the nine (9) Designated Southern California Counties, 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>Designated Southern California counties: Imperial, Kern, Los Angeles, Orange Riverside, San Bernardino, San Diego, Santa Barbara, Ventura</p>

<p>Bariatric Surgery Travel Expenses (recipient and companion transportation) provided in connection with a covered bariatric surgical procedure. Refer to the Bariatric Surgery provision for details.</p> <p>All travel expenses must be authorized in advance.</p>	<p>0% of Actual Charge for Covered Medical Expenses up to \$3,000 maximum per surgery.</p> <p>Deductible Waived</p>	<p>Not covered</p>
<p>Covered Clinical Trials</p>	<p>Same as any other Covered Sickness</p>	
<p>Durable Medical Equipment</p> <p>Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p>	<p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Diabetic services and supplies (including equipment and training)</p> <p>Self-management and education</p> <p>Other diabetic services, supplies and equipment</p> <p>Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.</p>	<p>0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p> <p>0% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Dialysis Treatment</p>	<p>\$15 Copayment per visit then You pay 0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Hearing Aids Limited to 1 hearing aid per ear every 3 years</p> <p>Pre-Certification Required for cochlear implants. Refer to the Pre-Certification Process provision for details.</p>	<p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>

<p>Maternity Benefit</p> <p>Inpatient Benefits: Hospital Expenses</p> <p>Physician's Visits while Confined</p> <p>Outpatient Benefits: Physician's Office Visits</p> <p>Prenatal services and first postnatal visit (See the Preventive Services coverage description for additional information)</p> <p>All other outpatient services</p>	<p>\$250 Copayment per admission then You pay 10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>\$15 Copayment per visit then You pay 0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p> <p>0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p> <p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>\$500 Copayment per admission then You pay 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Enteral Formulas and Nutritional Supplements</p> <p>See the Prescription Drug section of this Schedule when purchased at a pharmacy.</p>	<p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Prosthetic and Orthotic Devices</p> <p>Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p>	<p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Reconstructive Surgery</p> <p>Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p>	<p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)</p>	<p>For other than Diagnostic and Preventive Dental Care, Pediatric Dental Care benefits are subject to the Pediatric Dental Care Deductible and Pediatric Dental Care Out-of-Pocket Maximum. See the Pediatric Dental Care Benefit coverage description in this Certificate for further information.</p>	

<p>Diagnostic and Preventive Dental Care (Type A Services) Limited to 1 dental exam every 6 months</p> <p><i>The benefit payable amount for the following services is different from the benefit payable amount for Diagnostic and Preventive Dental Care:</i></p> <p>Basic Restorative Care (Type B Services)</p> <p>Major Restorative Care (Type C Services)</p> <p>Orthodontic Services (Medically Necessary)</p> <p>Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.</p>	<p>0% of Usual and Customary Charge for Covered Medical Expenses</p> <p>Deductible Waived</p> <p>30% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>30% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>30% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19)</p> <p>Routine Eye Exam and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year</p> <p>We will cover either prescription lenses for eyeglass frames or prescription contact lenses but not both.</p> <p>Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.</p>	<p>See the Pediatric Vision Care Benefit coverage description in this Certificate for further information.</p> <p>0% of Usual and Customary Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>

<p>Abortion Expense</p> <p>Inpatient Benefits: Hospital Expenses</p> <p>Physician's Visits while Confined</p> <p>Outpatient Benefits: Physician's Office Visits</p> <p>All other outpatient services</p>	<p>0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p> <p>0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p> <p>0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p> <p>0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>\$500 Copayment per admission then You pay 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Acupuncture Expense Benefit (Medically Necessary Treatment only)</p> <p>Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p>	<p>\$25 Copayment per visit then You pay 0% of the Negotiated Charge</p> <p>Deductible Waived</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Accidental Injury Dental Treatment</p>	<p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Dental Services For Radiation</p>	<p>Same as any other Covered Sickness</p>	
<p>Chiropractic Care Benefit</p> <p>Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p>	<p>\$25 Copayment per visit then You pay 0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Gender Transition Services Benefit</p> <p>Inpatient Benefits: Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p>		

<p>Hospital Expenses</p> <p>Physician's Visits while Confined/Inpatient Surgery:</p> <p>Outpatient Benefits: Outpatient Surgery: Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p> <p>Specialist/Consultant Physician Services</p> <p>All other outpatient services</p>	<p>\$250 Copayment per admission then You pay 10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>\$25 Copayment per visit then You pay 0% of the Negotiated Charge for Covered Medical Expenses Deductible Waived</p> <p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>\$500 Copayment per admission then You pay 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Gender Transition Services Benefit Travel Expenses provided in connection with an approved transgender surgery. Refer to the Gender Transition Services Benefit provision for details.</p> <p>Must be authorized in advance.</p>	<p>0% of Actual Charge for Covered Medical Expenses up to \$10,000 maximum per surgery or series of surgical stages</p> <p>Deductible Waived</p>	
<p>Fertility Preservation Expense Benefit (When Medically Necessary due to a need for medical Treatment that may directly or indirectly cause infertility. Includes annual storage costs while an Insured Person under this Certificate.)</p> <p>Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p>		

<p>Benefits, other than outpatient prescription drugs, are limited to a maximum of \$20,000 per Insured Person's lifetime.</p> <p>Consultation</p> <p>Treatment</p> <p>Annual Storage Costs</p>	<p>\$25 Copayment per visit then You pay 0% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p> <p>\$250 Copayment per round of Treatment then You pay 10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>10% of Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>\$250 Copayment per round of Treatment then You pay 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Organ and Tissue Transplant Surgery</p> <p>Pre-Certification Required Refer to the Pre-Certification Process provision for details.</p> <p>Inpatient Benefits: Hospital Expenses</p> <p>Physician's Visits while Confined</p> <p>Outpatient Benefits: Physician's Office Visits</p> <p>Specialist/Consultant Physician Services</p> <p>All other outpatient services</p> <p>An unrelated donor search is limited to \$30,000 per transplant</p>	<p>\$250 Copayment per admission then You pay 10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>\$15 Copayment per visit then You pay 0% of the Negotiated Charge</p> <p>Deductible Waived</p> <p>\$25 Copayment per visit then You pay 0% of the Negotiated Charge</p> <p>Deductible Waived</p> <p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>\$500 Copayment per admission then You pay 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>

<p>Organ and Tissue Transplant Surgery Travel Expenses (recipient and companion or donor transportation) provided in connection with a covered organ or tissue transplant. Refer to the Organ and Tissue Transplant Surgery provision for details.</p> <p>All travel expenses must be authorized in advance.</p>	<p>0% of Actual Charge for Covered Medical Expenses up to \$10,000 maximum per transplant.</p> <p>Deductible Waived</p>	
<p>Shots and Injections, unless considered under Preventive Services:</p> <p>Diphtheria/Tetanus/ Pertussis, Measles, Mumps and Rubella; Meningococcal; Varicella; Influenza; Hepatitis A and Hepatitis B; Pneumococcal; Polio; Human Papillomavirus; Cholera; Typhoid; Yellow Fever; Japanese B. Encephalitis; and Lyme Vaccine.</p> <p>All other immunizations</p>	<p>0% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Treatment for Temporomandibular Joint (TMJ) Disorders</p>	<p>10% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Tuberculosis screening, Titers, Quantiferon B tests including shots (other than covered under preventive services)</p>	<p>0% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Non-emergency Care While Traveling Outside of the United States</p> <p>Inpatient Benefits: Hospital Expenses</p> <p>Physician's Visits while Confined</p>	<p>\$250 Copayment per admission then You pay 10% of Actual Charge after Deductible for Covered Medical Expenses</p> <p>10% of Actual Charge after Deductible for Covered Medical Expenses</p>	

Outpatient Benefits:	
Physician's Office Visits	\$15 Copayment per visit then You pay 0% of the Actual Charge Deductible Waived
Specialist/Consultant Physician Services	\$25 Copayment per visit then You pay 0% of the Actual Charge Deductible Waived
All other outpatient services	10% of the Actual Charge after Deductible for Covered Medical Expenses

Mandated Benefits

AIDS Vaccine	Same as any other Preventive Service
Alzheimer's Disease Coverage	Same as any other Covered Sickness
Behavioral Health Treatment for Pervasive Developmental Disorder or Autism	Same as any other Covered Sickness
Dental Anesthesia	Same as any other Covered Sickness
Mastectomy Benefit	Same as any other Covered Sickness
Pediatric Asthma Services	Same as any other Covered Sickness
Special Shoe Benefit	Same as any other Covered Sickness

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

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 be enrolled in classes at the Policyholder's School for at least the first day of instruction following the Effective Date 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 purchased.

Except in the case of medical withdrawal from School due to Sickness or Injury, any student who cancels enrollment or withdraws from the Policyholder's School prior to attending at least the first day of classes for 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 attending the first day of classes for 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 may be eligible to continue coverage under this Certificate for himself/herself and his or her previously insured Dependents for one semester with the payment of any required premium. To be eligible, the student must have been enrolled in the Policyholder's Student Health Insurance Plan the semester immediately preceding the semester for which he or she is withdrawing due to a Sickness or Injury. The student must submit documentation or certification of the medical withdrawal and payment of any required premium must be made 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.

All International Students are required to have a J-1 or F-1 Visa and their eligible Dependents (who are not U.S. citizens) are required to have a J-2 or F-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

1

Description of Class(es)

All eligible full-time registered domestic and international undergraduate and graduate students of the Policyholder who carry at least 12 units per term, or who are approved by the Policyholder to be below 12 units per term.

2

All non-registered graduate students of the Policyholder on filing fee status; and all non-registered undergraduate students of the Policyholder on concurrent enrollment status.

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

Class 2: All students, as determined by the Policyholder, are eligible for coverage under the Policy. Eligible students are eligible to enroll in this Student Health Insurance Plan for a maximum of one semester on a voluntary basis. To be eligible, the student must have been enrolled in the Student Health Insurance Plan the semester immediately preceding the semester for which he or she is enrolling. Enrollment must be completed by the Policyholder's enrollment deadline date. Please call (510) 642-5700 for enrollment information.

Who is not Eligible:

Students in the following University of California Berkeley programs may not be eligible to enroll in the insurance plan. This list is determined by the Policyholder and is subject to change. Please call (510) 642-5700 for enrollment information.

- Master of Advanced Study in Integrated Circuits
- Master of Information and Data Science, except students in the 5th year Masters of Information and Data Science Program
- Master of Information in Cybersecurity
- Evening and Weekend Master of Business Administration
- Executive Master of Business Administration
- Online/On-Campus Master of Public Health

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 are received by Us, Our authorized agent or the School.

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 beginning date of the term for which premium has been paid; or
4. 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
5. The Policy Effective Date.

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:

- a. Involuntary termination of the other health plan;
- b. Death of the Spouse;
- c. Legal separation, divorce or annulment;
- d. 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 or placement for adoption.

We, or Our authorized agent, or the Policyholder, 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, or Our authorized agent, or the Policyholder, 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 Medi-Cal or a state child health plan.
2. You or Your Spouse or Child become eligible for Medi-Cal 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. 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 Medically Necessary health care services 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, or Our authorized agent, 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, or Our authorized agent, of the birth to ensure proper claims adjudication.

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

We must receive:

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

We will provide coverage for the child placed for adoption as long as 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 or placement for adoption, an individual who has not attained the age of 18 as of the date of the adoption or placement for adoption.

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

Disabled 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 if You are Hospital Confined for a Covered Injury or Covered Sickness and under a Physician's care on the date Your insurance coverage terminates. We will continue to pay benefits for that Covered Injury or Covered Sickness until the earliest of: (1) the date the Hospital Confinement ends; or (2) the end of the 30-day period following the date Your coverage terminated.

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

Reinstatement Of Reservist After Release From Active Duty: If 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 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. Insurance for the student's covered Dependent(s) will end when insurance for the student ends. If an Insured Student's Dependent enters the Armed Forces of any country, such a Dependent 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, or Our authorized agent, within 45 days of the Dependent's entry into service.

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 Medically Necessary transportation to or from a Hospital by a licensed Ambulance whether ground, air or water Ambulance.

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 You 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 seventy-two (72) hour period, will be considered a continuation of the Confinement. Confinement does not include Observation Services, which is a review or assessment of eighteen (18) 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.

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.

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 or Domestic Partner who resides with the Insured Student;
2. An Insured Student's or Spouse's or Domestic Partner's dependent biological or adopted child or stepchild under age 26; or
3. A child under age 26 who is under the Insured Student's legal guardianship or who the Insured Student is required to cover due to a Qualified Medical Child Support Order (QMCSO); and
4. An Insured Student's or Spouse's or Domestic Partner's unmarried biological or adopted child or stepchild or child who is under the Insured Student's legal guardianship or child who the Insured Student is required to cover due to QMCSA 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 disability.

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.

Domestic Partner means two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring.

A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division, and, at the time of filing, all of the following requirements are met:

1. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
2. The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
3. Both persons are at least 18 years of age, except as provided in Section 297.1.
4. Both persons are capable of consenting to the domestic partnership.

A domestic partnership that has not been registered with the State of California must meet the following requirements to be considered a domestic partnership under this Certificate:

1. Both persons must be each other's sole Domestic Partner in a long-term, committed relationship and must intend to remain so indefinitely.
2. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
3. The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
4. Both persons must be at least 18 years of age and capable of consenting to the relationship.
5. Both persons must be financially interdependent.
6. The two persons must share a common residence.
7. The Policyholder's Declaration of Domestic Partnership Form must be completed and accepted by the Policyholder.

Any references herein to Spouse and marriage include Domestic Partners and domestic partnerships.

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 or covered Gender Transition Services.

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

Emergency Medical Condition means a Covered Sickness or Injury for which immediate medical Treatment is sought at the nearest available facility. The Condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition: transportation services, including but not limited to Ambulance Services, a medical screening examination that is within the capability of the emergency department, including ancillary services routinely available to the emergency department, and covered inpatient and outpatient services furnished by a Hospital, independent freestanding emergency department, or Physician qualified to furnish those services 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 covered 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.

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

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

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

Home Country means 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 Spouse's.

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

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

Insured Person means an Insured Student 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.

Medical Facility is a Hospital; Ambulatory Surgical Center; bariatric surgery center; dialysis center; rehabilitation facility; Skilled Nursing Facility; Hospice; Urgent Care Center; Home Health Agency; Student Health Center; or other duly licensed healthcare facility legally operating within the scope of their license.

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

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

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

Mental Health Disorder and/or Substance Use Disorder means a mental health condition or substance use disorder listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems (ICD-10).

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.

Orthotic Devices means rigid or semi-rigid devices supporting a weak or deformed leg, foot, arm, hand, back or neck or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck. Benefits for Orthotic Devices include orthopedic appliances or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body. An Orthotic Device differs from a prosthetic in that, rather than replacing a body part, it supports and/or rehabilitates existing body parts. Orthotic Devices are usually customized for an Insured Person's use and are not appropriate for anyone else. Examples of Orthotic Devices include but are not limited to Ankle Foot Orthosis (AFO), Knee Ankle Foot Orthosis (KAFO), Lumbosacral Orthosis (LSO), Cranial Orthotic Device.

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.

Psycho-Educational Testing is testing conducted by a licensed clinical, educational, or counseling psychologist in order to assess and diagnose functional limitations due to learning disabilities, including but not limited to attention deficit hyperactivity disorder (ADHD).

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 the lesser of:

1. the Actual Amount billed by the provider or facility; or
2. 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 daily skilled care given by, or under the direct supervision of, skilled nursing or therapy staff;
3. Provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. Is not a place primarily for the care of the aged, Custodial or Domiciliary Care, or Treatment of alcohol or drug dependency; and
5. Is not a rest, educational, or custodial facility or similar place.

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

Spouse means an eligible individual who is legally married to the Insured Student under the laws of the state or jurisdiction in which the marriage was performed. A Spouse also includes the Insured Student's Domestic Partner with whom an affidavit of domestic partnership has been established, attesting to the relationship with another person; or a substantially equivalent partnership or union, other than a marriage, legally formed in another state or jurisdiction.

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

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

1. Medical care and Treatment to Sick or Injured students; and
2. Nursing services.

A Student Health Center does not include:

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

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	<p>The lesser of:</p> <ol style="list-style-type: none"> 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, including Ambulance Services, and non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center without Your consent, 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 - STUDENT HEALTH CENTER REFERRAL

This Certificate requires that the Student Health Center (SHC) act as a Primary Care Physician. Where available, the student must first use the resources of the SHC where Treatment will be administered or a referral will be issued. Unless an exception to the Student Health Center Referral applies, expenses incurred for medical Treatment rendered outside of the SHC for which no prior approval or referral is obtained will be excluded from coverage. A referral issued by the SHC must accompany the claim when submitted.

A SHC referral for outside care is not necessary **ONLY** under the following conditions:

1. For an Emergency Medical Condition or Urgent Care. In the event of an Emergency Medical Condition, go to the nearest emergency department or call 911 if an Ambulance is needed;
2. For medical care received when the student is outside the U.S.;
3. For Telemedicine or Telehealth Services; and
4. Limited Preventive Services and wellness visit services.

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

The applicable Deductible(s); Coinsurance and Copayment(s) shall apply to all of the exceptions to the referral requirement shown above.

Except for couples counseling and limited services open to the general public, Dependent Spouses and children are not eligible to use the SHC and are exempt from the above limitation and requirements. For Gender Transition Services, a SHC referral is required.

SECTION V – HOW THE PLAN WORKS AND DESCRIPTION OF BENEFITS

Schedule of Benefits

The following are shown in the Schedule of Benefits:

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

How the Deductible Works

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 or family 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.

The medical Policy Year Deductible will not be applied to satisfy the Pediatric Dental Care Policy Year Deductible. The Pediatric Dental Care Deductible will not be applied to satisfy the medical Policy Year 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 Policy Year Deductible, this plan will pay for Covered Medical Expenses as shown on the Schedule of Benefits for the rest of the Policy Year.

Family

This is the amount of Covered Medical Expenses You and Your Covered Dependents must incur for In-Network Provider and Out-of-Network Provider Covered Medical Expenses. After the amount of Covered Medical Expenses You and Your Covered Dependents incur reach this Family Policy Year Deductible, then this plan will begin to pay for Covered Medical Expenses as shown on the Schedule of Benefits for the rest of the Policy Year.

To satisfy this Family Policy Year Deductible limit for the rest of the Policy Year, the following must happen:

- The combined Covered Medical Expenses that You and each of Your Covered Dependents incur towards the individual Policy Year Deductibles must reach this Family Policy Year Deductible limit in a Policy Year.

When this occurs in a Policy Year, the individual Policy Year Deductibles for You and Your covered Dependents will be considered to be met for the rest of the Policy Year.

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

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

How Your Out-of-Pocket Maximum Works

The In-Network Provider and Out-of-Network Provider Out-of-Pocket Maximums are shown in the Schedule of Benefits. The Out-of-Pocket Maximum provides is the amount of Covered Medical Expenses You have to incur before Covered Medical Expense will be paid at 100% for the remainder of the Policy Year 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. There may also be certain non-Essential Benefits that do count toward the Out-of-Pocket Maximum. Please refer to the Schedule of Benefits for any non-Essential Benefits that do not count toward this maximum.

Covered Medical Expenses applied to the In-Network Provider and Student Health Center 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 Policy Year 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 Policy Year 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 Policy Year 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 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 Providers 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, You 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, You 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 within a 25-mile radius of 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 provides proper notice and consent, 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 without consent is the In-Network cost sharing amount. You can't be balance billed or asked to give up Your protections for ancillary services, including emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, Assistant Surgeon, hospitalist, intensivist services, and items and services provided by an Out-of-Network Provider if there is no In-Network Provider who can furnish such item or service at such facility, or items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network Provider satisfied proper notice and consent.

However, if You received notice from the Out-of-Network Provider of their non-network status under the following circumstances, We will pay Covered Medical Expenses at the Out-of-Network level as shown in the Schedule of Benefits:

- If the appointment is scheduled at least 72 hours prior to the date of service, and notice is provided not later than 72 hours prior to the date of service;
- If the appointment is scheduled within 72 hours prior to the date of service, and notice is provided on the date the appointment is scheduled; or
- If the appointment is scheduled on the date of service, and notice is provided no later than 3 hours prior to 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.

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 until the earlier of (a) such services are completed, unless reasonable and medically appropriate arrangements for assumption of such services by another In-Network Provider are made, or (b) Your coverage under this Certificate terminates.

Treatment will be continued for the following conditions:

1. An Acute Condition – for the duration of the acute condition, not to exceed 90 days from the date of the notice to You terminates. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration;
2. Serious Chronic Condition – for the period of time necessary to complete a course of Treatment and to arrange for a safe transfer to another Provider, as determined by Us in consultation with the Insured Person and the terminated Provider and consistent with good professional practice, not to exceed 12 months from the contract termination or 12 months from the Effective Date of coverage for a newly covered Insured Person. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing Treatment to maintain remission or prevent deterioration;
3. A pregnancy – for the duration of the pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period;
4. A maternal mental health condition – until completion of covered services for the maternal health condition, which may not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later;
5. A terminal illness – for the duration of the terminal illness, which may not exceed 12 months from the contract termination date or 12 months from the Effective Date of coverage for a newly covered Insured Person. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less;

6. Care of a Newly Born Child – between birth and 36 months of age, not to exceed 12 months from the contract termination date or 12 months from the Effective Date of coverage for a newly covered Insured Person;
7. Surgery or other procedure that is recommended and documented by the Provider to take place within 180 days of the contract’s termination date or within 180 days of the Effective Date of coverage for a newly covered Insured Person;
8. Institutional or Inpatient Care – for the duration of an undergoing course of institutional or inpatient care from the provider or facility, not to exceed 90 days from the date of the notice to You of the termination.

We shall notify You of the termination of the In-Network Providers contract at least 60 days in advance. When circumstances related to the termination render such notice impossible, We shall provide You 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.

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. For other than Emergency Services, failure to obtain the necessary Pre-Certification may result in a Retrospective review which may result in a possible denial of Your claim.

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 hours following a vaginal delivery/96 hours following a cesarean section;
3. Durable Medical Equipment over \$500;
4. Surgery;
5. Transplant Services;
6. Diagnostic testing/radiology as follows, wherever performed, except when provided for an outpatient Mental Health Disorder or Substance Use Disorder:
 - Coronary artery Ca score;
 - 3D rendering of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality;
 - MRS;
 - MRI Breast;
 - PET scan;
 - HEART SYMP IMAGE PLNR;
 - Ultrafast CT, Cine CT;
7. Chemotherapy/radiation;
8. Infusions/injectables;
10. Botox Injections;
11. Genetic Testing, except for BRCA;
12. Orthotics/prosthetics;
13. Physical Therapy (Outpatient) precertification required after the 12th visit;
14. Occupational Therapy (Outpatient) precertification required after the 12th visit;
15. Chiropractic Services (Outpatient) precertification required after the 12th visit;
16. Acupuncture (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 hours following a vaginal delivery/96 hours following a cesarean section of maternity care; or Hospital Confinement for mastectomy surgery, including length of Hospital stays associated with mastectomy and breast reconstructive surgery for breast cancer; or for services rendered at the Student Health Center.

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

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

Your Physician will be notified of Our decision as follows:

- 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;
- 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;
- For any other covered services requiring Pre-Certification, We will contact the Provider in writing or by telephone regarding Our decision.

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

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

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

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

COVERED MEDICAL EXPENSES

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

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, including FDA-approved contraceptive drugs, devices, and procedures available over the counter, as prescribed by a Physician. Examples of covered contraceptive services are: office visits, consultations, education and counseling on contraceptives, examinations and services related to the use of federal legend oral contraception or IUD insertion, diaphragm fitting, voluntary sterilization procedures (male and female), 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.

Preventive Services (including services for the detection of asymptomatic diseases), shall include, under a Physician's supervision:

1. Routine physical maintenance exams, including well woman exams, well baby and well child preventive care.
 - Screening and counseling services, such as obesity counseling, routine vision and hearing screenings and hearing exams to determine the need for hearing correction (diagnostic audiometry), health education, and depression screening.
 - Alcohol and Substance Abuse screenings.
 - Developmental screenings to diagnose and assess potential developmental delays.
2. Scheduled routine prenatal and postpartum exams.
 - Regularly scheduled preventive prenatal care exams after confirmation of pregnancy.
 - Postpartum consultations and exams that primarily deliver or coordinate preventive care services, such as breastfeeding support and counseling, in accordance with recommendations of the United States Preventive Services Task Force (USPSTF).
3. Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided under this Certificate.
 - Tobacco use, tobacco use-related diseases, and smoking cessation.
 - Chronic conditions including diabetes and asthma.
 - Stress management.
4. Routine preventive imaging and laboratory services.
 - Mammograms for screening or diagnostic purposes upon referral by a participating nurse practitioner, participating certified nurse-midwife, participating Physician's Assistant, or participating Physician, providing care to the Insured Person and operating within the scope of practice provided under existing law.
 - Abdominal aortic aneurysm ultrasound screenings.
 - Bone density scans for osteoporosis.
 - Routine laboratory tests including annual cervical cancer screenings (including HPV testing), prostate specific antigen tests, cholesterol tests, screening for blood lead levels, blood glucose tests, glucose tolerance tests, genetic testing for breast cancer susceptibility, certain sexually transmitted infection tests, HIV tests.
 - Flexible sigmoidoscopies and screening colonoscopies.
5. Preventive care and screening services for women, in addition to the services listed above, provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), including:
 - Well woman visits that are age and developmentally appropriate, including preconception and prenatal care.
 - Gestational diabetes screening.
 - Screening and counseling for interpersonal and domestic violence.
 - Breastfeeding support, supplies, and counseling, including breast pumps. Coverage of breast pumps is limited to one breast pump per pregnancy or as required by law.

Preventive Care Services for Adults:

Covered services include but are not limited to:

1. [Abdominal Aortic Aneurysm one-time screening](#) for men of specified ages who have ever smoked.
2. [Alcohol Use screening and counseling](#).
3. [Aspirin use](#) to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk.
4. [Blood Pressure screening](#) for all adults.
5. [Cholesterol screening](#) for adults of certain ages or at higher risk.

6. [Colorectal Cancer screening](#) for adults 45 to 75.
7. [Depression screening](#) for all adults.
8. [Diabetes \(Type 2\) screening](#) for adults 40 to 70 who are overweight or obese.
9. [Diet counseling](#) for adults at higher risk for chronic disease.
10. Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting.
11. Hepatitis B screening- for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
12. Hepatitis C screening for adults age 18 to 79.
13. [HIV screening](#) for everyone ages 15 to 65, and other ages at increased risk.
14. [Immunization vaccines](#) for adults--doses, recommended ages, and recommended populations vary:
 - Diphtheria
 - [Hepatitis A](#)
 - [Hepatitis B](#)
 - [Herpes Zoster](#) (Shingles)
 - [Human Papillomavirus](#) (HPV)
 - [Influenza \(Flu Shot\)](#)
 - [Measles, Mumps, Rubella](#)
 - [Meningococcal](#)
 - [Pneumococcal](#)
 - [Tetanus, Diphtheria, Pertussis](#)
 - [Varicella](#) (Chickenpox)
15. Lung cancer screening for adults 50-80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years.
16. [Obesity screening and counseling](#) for all adults, including intensive, multicomponent weight management behavioral interventions.
17. Physical examination procedures- Critical Congenital Heart Defect Screening.
18. Preexposure Prophylaxis (PrEP) **HIV prevention medication** for HIV negative adults at high risk for getting HIV through sex or injection drug use.
19. Screening for physical, mental, sexual, and reproductive health care needs that arise from a sexual assault.
20. [Sexually Transmitted Infection \(STI\) prevention counseling](#) for adults at higher risk.
21. Statin preventive medication for adults 40 to 75 at high risk.
22. [Syphilis screening](#) for adults at higher risk.
23. Sterilization procedures except for reversals.
24. [Tobacco Use screening](#) for all adults and cessation interventions for tobacco users.
25. Tuberculosis adult screening for certain adults without symptoms at high risk.

Preventive Care Services for Women (including pregnant woman):

Covered services include but are not limited to:

1. [Anemia screening](#) on a routine basis for pregnant women.
2. [Breast Cancer Genetic Test Counseling \(BRCA\)](#) for women at higher risk for breast cancer.
3. [Breast Cancer Mammography screenings](#):
 - Every 2 years for women 50 and over
 - As recommended by a provider for women 40 to 49 or women at higher risk for breast cancer.
4. [Breast Cancer Chemoprevention counseling](#) for women at higher risk.
5. [Breastfeeding comprehensive support and counseling](#) from trained providers, and access to breastfeeding supplies, for pregnant and nursing women.
6. [Cervical Cancer screening](#) for sexually active women:
 - Pap test (also called a Pap smear) every 3 years for women 21 to 65
 - Human Papillomavirus (HPV) DNA test with the combination of a Pap smear every 5 years for women 30 to 65 who don't want a Pap smear every 3 years.
7. [Chlamydia Infection screening](#) for younger women and other women at higher risk.

8. [Contraception](#): Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers".
9. Diabetes screening for women with a history of gestational diabetes who are not currently pregnant and who haven't been diagnosed with type 2 diabetes before.
10. [Domestic and interpersonal violence screening and counseling](#) for all women.
11. [Folic Acid](#) supplements for women who may become pregnant.
12. [Gestational diabetes screening](#) for women 24 weeks pregnant (or later) and those at high risk of developing gestational diabetes.
13. [Gonorrhea screening](#) for all women at higher risk.
14. [Hepatitis B screening](#) for pregnant women at their first prenatal visit.
15. [HIV screening and counseling](#) for everyone age 15 to 65, and other ages at increased risk.
16. [Human Papillomavirus \(HPV\) DNA Test](#) every 3 years for women with normal cytology results who are 30 or older.
17. **Maternal depression screening** for mothers of infants at 1, 2, 4 and 6 month visits.
18. [Osteoporosis screening](#) for women over age 65 or women ages 64 and younger that have gone through menopause.
19. Preeclampsia prevention and screening for pregnant women with high blood pressure: aspirin.
20. **PrEP (pre-exposure prophylaxis)** HIV prevention medication for HIV-negative women at high risk for getting HIV through sex or injection drug use.
21. [Rh Incompatibility screening](#) for all pregnant women and follow-up testing for women at higher risk.
22. [Sexually Transmitted Infections counseling](#) for sexually active women.
23. [Syphilis screening](#) for all pregnant women or other women at increased risk.
24. [Tobacco Use screening and interventions, including medications for tobacco cessation](#) for all women, and expanded counseling for pregnant tobacco users.
25. [Urinary tract or other infection screening](#) for pregnant women.
26. Urinary incontinence screening for women yearly.
27. [Well-woman visits](#) to get recommended services for all women.

Preventive Care Services for Children:

Covered services include but are not limited to:

1. Alcohol, tobacco, and drug use assessments for adolescents.
2. [Autism screening](#) for children at 18 and 24 months.
3. Behavioral assessments for children at the following ages: [0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years](#).
4. Bilirubin concentration screening for newborns.
5. Blood Screening for newborns.
6. Blood Pressure screening for children at the following ages: [0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years](#).
7. [Cervical Dysplasia screening](#) for sexually active females.
8. [Depression screening](#) for adolescents beginning routinely at age 12.
9. [Developmental screening](#) for children under age 3.
10. Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders .
11. Fluoride supplements for children without fluoride in their water source. Fluoride varnish for all infants and children as soon as teeth are present.
12. [Gonorrhea preventive medication](#) for the eyes of all newborns.
13. [Hearing screening](#) for all newborns; and regular screenings for children and adolescents as recommended by their provider.
14. Height, Weight and Body Mass Index measurements taken regularly for all children .
15. [Hematocrit, or Hemoglobin screening](#) for all children.
16. [Hemoglobinopathies or sickle cell screening](#) for newborns.
17. Hepatitis B screening for adolescents at high risk.
18. [HIV screening](#) for adolescents at higher risk.

19. [Hypothyroidism screening](#) for newborns.
20. [Immunization vaccines](#) for children from birth to age 18 -doses, recommended ages, and recommended populations vary:
 - [Diphtheria, Tetanus, Pertussis \(DTap\)](#)
 - [Haemophilus influenzae type b](#)
 - [Hepatitis A](#)
 - [Hepatitis B](#)
 - [Human Papillomavirus \(HPV\)](#)
 - [Inactivated Poliovirus](#)
 - [Influenza \(Flu Shot\)](#)
 - [Measles](#)
 - [Meningococcal](#)
 - Mumps
 - [Pneumococcal](#)
 - Rubella
 - [Rotavirus](#)
 - [Varicella](#) (Chickenpox)
 - any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.
21. [Iron supplements](#) for children ages 6 to 12 months at risk for anemia.
22. [Lead screening](#) for children at risk of exposure.
23. Obesity screening and counseling, including intensive, multicomponent weight management behavioral interventions.
22. Oral Health risk assessment for young children from 6 months to 6 years .
23. [Phenylketonuria \(PKU\) screening](#) for newborns.
24. PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use.
25. Prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.
26. Screening for physical, mental, sexual, and reproductive health care needs that arise from a sexual assault.
27. [Sexually Transmitted Infection \(STI\) prevention counseling and screening](#) for adolescents at higher risk.
28. Tuberculin testing for children at higher risk of tuberculosis at the following ages: [0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years](#).
29. [Vision screening](#) for all children.
30. Well-baby and well-child visits.

If the covered Preventive Service is provided during a Physician's Office Visit and it is billed separately from the office visit, You may be responsible for any Deductible, Coinsurance and/or Copayment applicable to the Physician's Office Visit only. If the Physician's Office Visit and the covered Preventive Service are billed together and the primary purpose of the visit was not the Preventive Service, You may be responsible for any Deductible, Coinsurance and/or Copayment applicable to the Physician's Office Visit, including the covered Preventive Service.

Preventive Services recommendations and guidelines can be found on the HealthCare.gov website at the following links:

- For all adults: <https://www.healthcare.gov/preventive-care-adults/>
- For woman: <https://www.healthcare.gov/preventive-care-women/>
- For children: <https://www.healthcare.gov/preventive-care-children/>

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 Benefits – Coverage Descriptions

1. **Hospital Care-** Covered Medical Expenses include the following:
 - Room and Board Expense, including general nursing care. Benefit may not exceed the daily semi-private room rate unless intensive care unit is required.
 - Intensive Care Unit, including 24-hour nursing care.
 - Hospital Miscellaneous Expenses, while Hospital Confined or as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as:
 - a. The cost for use of an operating room;
 - b. Prescribed medicines (excluding take-home drugs);
 - c. Laboratory tests;
 - d. Therapeutic services;
 - e. X-ray examinations;
 - f. Casts and temporary surgical appliances;
 - g. Oxygen, oxygen tent; and
 - h. Blood and blood plasma.
2. **Preadmission Testing** for routine tests performed as a preliminary to Your being admitted to a Hospital. These tests must be performed within 5 working days prior to admission. This benefit is limited to routine tests such as complete blood count, urinalysis, and chest x-rays. Unless otherwise payable under this Certificate, We will pay for major diagnostic procedures under the Hospital Miscellaneous Expense Benefit. This includes tests such as CAT scans, cardiac catheterization, MRI's, NMR's, and blood chemistries.
3. **Physician's Visits while Confined.** 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. **Inpatient 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.

5. **Physical Therapy while Confined** when prescribed by the attending Physician.
6. **Skilled Nursing Facility Benefit** for services received in a licensed Skilled Nursing Facility. Services must be Medically Necessary. A skilled nursing benefit period begins on the date You are admitted to a Hospital or Skilled Nursing Facility at a skilled level of care. The benefit period ends on the date You have not been an inpatient in a Hospital or Skilled Nursing Facility receiving a skilled level of care for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. Confinement for Custodial Care or residential care is not covered.
7. **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
8. **Autologous Blood Banking Services Expense** for Your self-donated blood collection, testing, processing and storage prior to a covered surgery. In such instances, We cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

Outpatient Benefits – Coverage Descriptions

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

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

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

- b. **Through Different Incisions.** If Covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
 - For the procedure with the highest allowed amount; and
 - 50% of the amount We would otherwise pay for the other procedures.
2. **Outpatient Surgical Facility and Miscellaneous** expense benefit. Benefits will be paid for services and supplies, including:
 - a. Operating room;
 - b. Therapeutic services;
 - c. Oxygen, oxygen tent; and
 - d. Blood and blood plasma.
3. **Physician's Office or Home Visits.** Physician's Visits include second surgical and second medical opinions. 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.
4. **Specialist/Consultant Physician's Services.** When requested and approved by the attending Physician.
5. **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.
6. **Retail Health Clinics** for limited basic health care services to Insured Persons on a "walk-in" basis at retail health clinics. These clinics are normally found in major pharmacies or retail stores. Health care services are typically provided by Physician's Assistants or Nurse Practitioners. Covered services available at retail health clinics are limited to routine care and Treatment of common illnesses.
7. **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.
8. **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.
9. **Rehabilitation Therapy** when prescribed by the attending Physician, limited to 1 visit per day.
10. **Habilitation Services** when prescribed by the attending Physician, limited to 1 visit per day.
11. **Emergency Services and Supplies** 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 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 provides proper notice and consent, 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:

In the event You require Treatment for an Emergency Medical Condition, seek immediate care at the nearest emergency department or call 911. If possible, call Your Physician but only if a delay will not harm Your health.

12. **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.
13. **Diagnostic Imaging Services** for diagnostic X-ray services as shown in the Schedule of Benefits when prescribed by a Physician.
14. **CT Scan, MRI and/or PET Scans** for diagnostic services when prescribed by a Physician.
15. **Laboratory Procedures (Outpatient)** for laboratory procedures as shown in the Schedule of Benefits when prescribed by a Physician.
16. **Chemotherapy and Radiation Therapy** for chemotherapy and radiation therapy to treat or control a serious illness, as shown in the Schedule of Benefits.
17. **Infusion Therapy** when Physician prescribed for the administration of antibiotics, nutrients, or other therapeutic agents by direct infusion. If services are performed in the home, those services must be billed by and performed by a Provider licensed by state and local laws. Benefits include:
 - a. Drugs and other substances used in Infusion Therapy.
 - b. Professional services to order, prepare, dispense, deliver, administer, train or monitor, including clinical pharmacy support and any drugs or other substances used in a course of therapy.
 - c. Durable, reusable supplies, and Durable Medical Equipment including, but not limited to, pump, pole and electric monitor. Other supplies such as infusion sets and supplies for external infusion pumps and replacement batteries for infusion pumps.
 - d. Blood transfusions, including blood processing and the cost of un-replaced blood and blood products.
18. **Home Health Care Expenses** for Home Health Care for You when, otherwise, Hospitalization or Confinement in a Skilled Nursing Facility would have been necessary. Such Home Health Care services shall include diagnostic and treatment services which can reasonably be provided in the home, including nursing care, performed by a registered nurse, public health nurse, licensed vocational nurse or licensed Home Health Care Agency. This does not include Private Duty Nursing.
19. **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 12 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 Medi-Cal, or outside of California, Medicare.

20. **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. Some preventive drugs are available at \$0 if pre-certification is approved. These prescription requirements help Your prescriber and pharmacists check that Your outpatient prescription drug is clinically appropriate using evidence-based criteria. Coverage includes disposable devices that are Medically Necessary for the administration of a covered outpatient prescription drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs and syringes for self-injectable outpatient prescription drugs that are not dispensed in pre-filled syringes.

- 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 or two separate articles in a major peer reviewed medical journals/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 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.

- 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 on Our website or by calling the toll-free number on Your ID card

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

- g. **Step Therapy** – When medications for the Treatment of any medical condition are restricted for use by a step therapy or fail-first protocol, the prescribing practitioner shall have access to a clear and convenient process to request an override of the restriction from Us. An override of that restriction will be granted by Us upon completion of the review if all necessary information to perform the override review has been provided, under the following documented circumstances:
 - (a) 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
 - (b) Based on sound clinical evidence or medical and scientific evidence:
 - 1. 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
 - 2. 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 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 (or is listed as excluded), 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 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. The request 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 or call the number on Your ID card to find out more about this process.

- l. **Tobacco cessation prescription and over-the-counter drugs** – Tobacco cessation prescription drugs and OTC drugs for at least two tobacco cessation attempts per Policy Year will be covered with no cost sharing. Coverage includes all FDA-approved tobacco cessation medications when prescribed by a Physician. 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, refer to the Formulary posted on Our website or call the toll-free number on Your ID card.
- m. **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 or by 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. Up to a 12-month supply of contraceptives may be dispensed with a single prescription order.

- n. **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.

- o. **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 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.

- p. **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.
- q. **Partial Fill of Schedule II Controlled Substances** – We will allow a partial fill of prescriptions for a Schedule II controlled substance if requested by You or Your prescribing Physician. Your out-of-pocket expenses will be prorated accordingly. The pharmacist will retain the original prescription with a notation of the amount filled until the full prescription has been dispensed. The total quantity dispensed will not exceed the total quantity prescribed.
- r. **Pain Management Medication** for Terminally Ill Insured Persons when Medically Necessary. We shall approve or deny the request by the Provider for authorization of coverage for an Insured Person who has been determined to be terminally ill in a timely fashion, appropriate for the nature of the Insured Person’s condition, not to exceed 72 hours of Our receipt of the information requested to make the decision. If the request is denied or if additional information is required, We shall contact the Provider within one working day of the determination, with an explanation of the reason for the denial or the need for additional information. The requested Treatment shall be deemed authorized as of the expiration of the applicable timeframe. The Provider shall contact Us within one business day of proceeding with the deemed authorized Treatment, to do all of the following:
 - a. Confirm that the timeframe has expired.
 - b. Provide the Insured Person’s identification.
 - c. Notify Us of the Provider or Providers performing the Treatment.
 - d. Notify Us of the facility or location where the Treatment was rendered.

This benefit does not apply to coverage for any drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA.

Other Benefits – Coverage Descriptions

- 1. **Mental Health Disorder and Substance Use Disorder Benefits** for Medically Necessary Treatment of a Mental Health Disorder and Substance Use Disorder, under the same terms and conditions applied to other medical conditions under this Certificate. Covered Medical Expenses include but are not limited to the following:

Inpatient Benefits:

- a. Diagnostic evaluation;
- b. Medication evaluation and management (pharmacotherapy);
- c. Treatment and counseling (including individual or group visits);
- d. Inpatient professional fees;
- e. Psychiatric and Neuro Psychiatric testing; and

- f. Inpatient Hospital and inpatient residential Treatment centers services, which includes:
- 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.

Outpatient Benefits - Outpatient Services, other than office visits:

- a. Intensive Outpatient Programs;
- b. Partial Hospitalization;
- c. Electronic Convulsive Therapy;
- d. Psychiatric and Neuro Psychiatric testing;
- e. Repetitive Transcranial Magnetic Stimulation (rTMS);
- f. Gender Transition Surgery;
- g. Emergency Services in an emergency department; and
- h. Prescription Drugs.

Outpatient Office Visits:

- a. Physician visits;
- b. Medication evaluation and management (pharmacotherapy);
- c. Treatment and counseling (including individual or group visits); and
- d. Psychological testing when necessary, to evaluate a Mental Health Disorder.

Refer to the Schedule of Benefits for details.

We will base any Medical Necessity determination or utilization review criteria that We apply to determine the Medical Necessity of health care services and benefits for the diagnosis, prevention, and Treatment of a Mental Health Disorder and Substance Use Disorder on current generally accepted standards of Mental Health and Substance Use Disorder care. We apply the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

Changes in terminology, organization, or classification of a Mental Health Disorder and Substance Use Disorder in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this benefit as long as a condition is commonly understood to be a Mental Health Disorder or Substance Use Disorder by health care providers practicing in relevant clinical specialties.

As used in this benefit:

Medically Necessary Treatment of a Mental Health Disorder or Substance Use Disorder means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of Mental Health Disorder and Substance Use Disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of Us and the Insured Person or for the convenience of the Insured Person, treating Physician, or other health care provider.

Generally accepted standards of Mental Health Disorder and Substance Use Disorder care means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health Treatment pursuant to Cal Ins Code § 10144.51. Valid, evidence-based sources establishing generally accepted standards of Mental Health Disorder and Substance Use Disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

Health care provider means any of the following:

- A person who is licensed under Cal Bus & Prof Code § 500 et seq. (Healing Arts).
- An associate marriage and family therapist or marriage and family therapist trainee.
- A qualified autism service provider or qualified autism service professional certified by a national entity.
- An associate clinical social worker.
- An associate professional clinical counselor or professional clinical counselor trainee.
- A registered psychologist.
- A registered psychological assistant.
- A psychology trainee or person supervised.

Outpatient Mental Health Disorder benefits also include coverage for Psycho-Educational Testing. This covers psycho-educational test batteries including aptitude, achievement, and cognitive tests to assess for cognitive and learning disabilities; a written report listing test scores, testing procedures followed, interpretation of test results, and date(s) of testing. Consultation with You to review test results and recommendations for appropriate academic accommodation are also covered under this benefit.

2. **Allergy Testing** this includes tests that You need such as PRIST, RAST, and scratch tests.
3. **Allergy Injections/Treatment** 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. **Ambulance Service:**
 - A. Emergency Ambulance Service, with respect to an Emergency Medical Condition, for transportation provided as a result of a 911 emergency response system request for assistance to a Hospital by a licensed Ambulance, whether a ground, air or water Ambulance; or
 - B. Non-Emergency Ambulance Service for transportation by a licensed Ambulance, whether by ground or air Ambulance (as appropriate), or psychiatric transport van when the transportation is approved by Us and 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;
 - From an acute care Hospital/facility to a sub-acute setting; or
 - Determined by Your Physician that Your condition requires the use of services that only a licensed Ambulance or psychiatric transport van can provide and the use of other means of transportation would endanger Your health.

Transportation from a facility to Your home is not covered

5. **Bariatric Surgery** when it is Medically Necessary for the Treatment of morbid obesity. This benefit requires prior approval.

Bariatric Surgery Travel Expenses: Certain travel expenses will be covered when incurred in connection with a covered bariatric surgical procedure. Covered travel expenses include the following for You and one companion:

- Ground transportation to and from the Medical Facility when the Medical Facility performing the Medically Necessary bariatric surgery is located 50 miles or more from Your home;
 - Lodging, limited to one room, double occupancy. Reimbursement not to exceed the CONUS daily rate for the city where the Medical Facility is located;
 - Other reasonable expenses;
- subject to the maximum benefit amount shown on the Schedule of Benefits.

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

- a. Childcare;
- b. Mileage within the city where the Medical Facility is located;
- 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 covered surgery;
- h. Telephone calls;
- i. Laundry;
- j. Postage;
- k. Entertainment;
- l. Interim visits to a Medical Facility while waiting for the actual Surgery;
- m. Tobacco, alcohol, drug, and meal expenses.

Travel expenses must be authorized in advance for these benefits to be payable. For assistance, You may contact Us at the number on Your ID card.

6. **Covered Clinical Trials** includes coverage for costs associated with Your participation in a controlled clinical trial approved by specified institutions. A covered clinical trial means a phase I, phase II, phase III, or phase IV clinical trial conducted for the prevention, detection, or Treatment of cancer or another life-threatening disease or condition that meets at least one of the following:
- (a) Federally funded trials – the study or investigation is approved or funded (which may include funding through in-kind contributions) by one of the following:
 - (1) The National Institutes of Health (NIH);
 - (2) The Centers for Disease Control and Prevention;
 - (3) The Agency for Health Care Research and Quality;
 - (4) The Centers for Medicare & Medicaid Services;
 - (5) Cooperative group or center of any of the entities described in items (1) through (4) above or the Department of Defense or the United States Department of Veterans Affairs;
 - (6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; and
 - (7) Any of the following if:
 - a) the Secretary of the United States Department of Health and Human Services (HHS) deemed that its system of peer review is comparable to that of National Institutes of Health (NIH); and
 - b) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
 - i. The United States Department of Veterans Affairs;
 - ii. The United States Department of Defense; and
 - iii. The United States Department of Energy.
 - (b) the study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.

- (c) the study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration; and
- (d) the facility and personnel providing the Treatment are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise.

Coverage also includes the routine patient costs for drugs, items, devices, and services furnished in connection with Your participation in the trial. Coverage for routine patient costs does not include the studied item, device or equipment, data collection services and any service not associated with direct clinical care to You.

As used in this benefit:

Controlled clinical trial means a Treatment that is:

- (a) Approved by an institutional review board;
- (b) Conducted for the primary purpose of determining whether or not a particular Treatment is safe and efficacious; and
- (c) Approved by:
 - (i) An institute or center of the National Institutes of Health;
 - (ii) The United States Food and Drug Administration;
 - (iii) The United States Department of Veteran's Affairs; or
 - (iv) The United States Department of Defense.

Life-threatening disease or condition means a disease or condition from which the likelihood of Your death is probable unless the course of the disease or condition is interrupted.

7. **Durable Medical Equipment (for home use)** and Prosthetic and Orthotic Devices for rental or purchase, the fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and services to determine whether You need a device, including, but not limited to:
- a. Diabetic Shoes and Inserts: off-the-shelf depth-inlay shoes; custom-molded shoes; custom-molded multiple density inserts; fitting, modification, and follow-up care for podiatric devices; repair or replacement of podiatric devices.
 - b. Glucose Monitors, Infusion Pumps, and Related Supplies: external single or multiple channel electric or battery-operated ambulatory infusion pumps; home blood glucose monitors; blood glucose test or reagent strips for home blood glucose monitors; interstitial glucose monitors; programmable and non-programmable implantable infusion pumps; infusion pump used for uninterrupted parenteral administration of medication; infusion sets for external insulin pumps; infusion supplies for external drug infusion pumps; lancets; calibrator solution/chips; single or multi-channel stationary parenteral infusion pumps; replacement batteries for home blood glucose monitors and infusion pumps; spring-powered device for lancet; syringe with needle for insulin pump.
 - c. Respiratory Drug Delivery Devices: large and small volume nebulizers; disposable and non-disposable administration sets; aerosol compressors; aerosol mask; disposable and non-disposable corrugated tubing for nebulizers; disposable and non-disposable filters for aerosol compressors; peak expiratory flow rate meter; distilled water for nebulizer; water collection device for nebulizer.
 - d. Tracheostomy Equipment: artificial larynx; replacement battery for artificial larynx; tracheo-esophageal voice prosthesis; tracheostomy supplies, including: adhesive disc, filter, inner cannula, tube, tube plug/stop, tube collar/holder, cleaning brush, mask, speaking valve, gauze, sterile water, waterproof tape, and tracheostomy care kits.
 - e. Canes and Crutches: adjustable and fixed canes, including standard curved handle and quad canes; adjustable and fixed crutches, including underarm and forearm crutches; replacement supplies for canes and crutches, including handgrips, tips, and underarm pads.
 - f. Dry pressure pad for a mattress.
 - g. Cervical traction equipment (over door).
 - h. Osteogenesis Stimulation Devices: non-invasive electrical osteogenesis stimulators, for spinal and non-spinal applications; non-invasive low density ultrasound osteogenesis stimulator.
 - i. Enteral and Parenteral Nutrition: enteral formula and additives, adult and pediatric, including for inherited diseases of metabolism; enteral feeding supply kits; enteral nutrition infusion pump; enteral tubing; gastrostomy/jejunostomy tube and tubing adaptor; nasogastric tubing; parenteral nutrition infusion pump; parenteral nutrition solutions; stomach tube; supplies for self-administered injections.
 - j. Hospital grade breast pump and double breast pump kit.
 - k. IV pole.

- l. Phototherapy (bilirubin) light with photometer.
- m. Compression burn garment; lymphedema gradient compression stocking; light compression bandage; manual compression garment; moderate compression bandage.
- n. Non-segmental home model pneumatic compressor for the lower extremities.
- o. Prosthetic Devices Incident to Mastectomy: prosthetic devices incident to a mastectomy, including custom-made prostheses when medically necessary; adhesive skin support attachment for use with external breast prosthesis; and brassieres for breast prostheses.
- p. Prosthetic devices to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect.
- q. Hospital beds, wheelchairs, and walkers. 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 for the rental or purchase of Durable Medical Equipment, including, but not limited to, Hospital beds, wheel chairs, walkers, ostomy and urological supplies, braces that stabilize an injured body part and braces to treat curvature of the spine. We will pay the lesser of either the rental or purchase charges, but not both. Such equipment must be prescribed by a Physician and a copy of the written prescription must accompany the claim.

Durable Medical Equipment must:

- a. Be primarily and customarily used to serve a medical, Rehabilitation purpose;
 - b. Be able to withstand repeated use; and
 - c. Generally, not be useful to a person in the absence of Injury or Sickness.
8. **Diabetic services and supplies (including equipment and training)** Benefits will be paid as shown on the Schedule of Benefits 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 glucagons
- 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.

9. **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. Includes hemodialysis, home hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered services for home Treatment will include equipment, training and medical supplies. Private Duty Nursing is not covered.
10. **Hearing Aids** (external hearing aids and cochlear implants) for Insured Persons when Medically Necessary and prescribed by a Physician. Benefits are limited as shown in the Schedule of Benefits.
11. **Maternity Benefit** for maternity charges as follows:
 - a. Routine prenatal and postnatal care.
 - b. **Prenatal Diagnosis of Genetic Disorders of Fetus** by means of diagnostic procedures, which are genetic or chromosomal tests of the fetus, in cases of high-risk pregnancy.
 - c. **California Prenatal Screening Program**, for participation in the statewide prenatal testing program administered by the State Department of Health Services. Cost sharing will not be required for services You receive as part of this program.
 - d. **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. Services of licensed 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 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. Benefits also include circumcision of a covered Dependent male child.

- e. **Inpatient Physician charges or Surgeon charges** will be covered the same as for any other Covered Sickness for both mother and newborn child.
- f. **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 48 hours after discharge, when prescribed by the treating Physician. 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.

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

12. **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 (PKU)
- Eosinophilic gastrointestinal disorders
- Inherited diseases of amino acids and organic acids
- Multiple severe food allergies
- Branched-chain ketonuria,
- Galactosemia
- Homocystinuria

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

13. **Prosthetic and Orthotic Devices** that are Medically Necessary to restore or maintain the ability to complete activities of daily living that replace all or part of a permanently inoperative or malfunctioning internal or external organ. The device must be furnished based on a Physician's order and not be solely for comfort or convenience. Benefits include coverage of all services and supplies Medically Necessary for the effective use of a Prosthetic or Orthotic Device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing You in the use of the device. This benefit includes coverage for prosthetic devices for post laryngectomy. Benefits also include coverage for any repair or replacement of such a Prosthetic or Orthotic Device. Refer to the Durable Medical Equipment For Home Use and Prosthetic Devices provision for prosthetic and orthotic devices covered under the Durable Medical Equipment For Home Use and Prosthetic Devices benefit.

14. **Reconstructive Surgery** covers surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following:

- a. Improve function; or
- b. Create a normal appearance, to the extent possible.

Reconstructive surgery also includes Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for Cleft Palate procedures.

As used in this benefit:

Cleft Palate means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

15. **Pediatric Dental Care Benefit.** Coverage is limited to dental care services for Insured Persons to the end of the month in which the Insured Person turns age 19. Please refer to the Schedule of Benefits section of this Certificate for cost-sharing requirements. We cover the following diagnostic and preventive, basic restorative, major and general, and Medically Necessary orthodontia care.

Diagnostic and preventive care (Type A Services)

- D0120 Periodic oral exam
- D0140 Limited oral evaluation - problem focused
- D0145 Oral evaluation - child under 3
- D0150 Comprehensive oral exam
- D0160 Detailed and extensive oral evaluation - by report
- D0170 Reevaluation - limited, problem focused
- D0180 Comprehensive periodontal evaluation
- D0210 Complete full mouth images
- D0220 Periapical - first image
- D0230 Periapical - each additional image
- D0260 Extraoral - each additional radiographic image
- D0270 Bitewing - single image
- D0272 Bitewing - two images
- D0273 Bitewing – three images
- D0274 Bitewing - four images
- D0277 Vertical bitewings - 7 to 8 images
- D0290 Posterior - anterior or lateral skull and facila bone survey radiographic image
- D0310 Sialography
- D0320 TMJ arthrogram, including injection
- D0322 Tomographic survey
- D0330 Panoramic image (once in a 36-month period per provider)
- D0340 2D cephalometric radiographic image – acquisition, measurement and analysis
- D0350 2D oral/facial photographic image obtained intra-orally or extra-orally
- D0502 Other oral pathology procedures, by report
- D0601 Caries risk assessment (CRA) and documentation, with a finding of low risk
- D0602 Caries risk assessment (CRA) and documentation, with a finding of moderate risk
- D0603 Caries risk assessment (CRA) and documentation, with a finding of high risk
- D0999 Unspecified diagnostic procedure, by report
- D1110 Prophylaxis - adult (2 per year)
- D1120 Prophylaxis - child (2 per year)
- D1206 Topical fluoride varnish (2 per year)
- D1208 Topical application of fluoride - excluding varnish (2 per year)
- D1351 Sealant - per tooth (for 1st, 2nd & 3rd, permanent molars - no limit)
- D1352 Preventive resin restoration - permanent (for 1st, 2nd & 3rd, permanent molars - no limit)
- D1353 Sealant repair - per tooth
- D1354 Interim caries arresting medicament application (for 1st, 2nd & 3rd, permanent molars - no limit)
- D1510 Space maintainer - fixed - unilateral
- D1515 Space maintainer - fixed - bilateral
- D1520 Space maintainer - removable - unilateral
- D1525 Space maintainer - removable - bilateral
- D1550 Recementation of space maintainer
- D1555 Removal of fixed space maintainer
- D1575 Distal shoe space maintainer – fixed – unilateral
- D2990 Resin infiltration of lesion (once per tooth every 3 years, permanent molars only)
- D4346 Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation
- D9110 Palliative Treatment of dental pain, minor

Basic restorative care (Type B Services)

- D0240 Occulusal image
- D0250 Extra-oral – 2D projection radiographic image
- D0251 Extra-oral posterior dental radiographic image
- D2140 Amalgam - 1 surface
- D2150 Amalgam - 2 surfaces
- D2160 Amalgam - 3 surfaces
- D2161 Amalgam - 4 or more surfaces
- D2330 Resin - 1 surface - anterior
- D2331 Resin - 2 surfaces - anterior
- D2332 Resin - 3 surfaces - anterior
- D2335 Resin - 4 or more surfaces - anterior
- D2390 Resin - based composite crown, anterior
- D2391 Resin one surface - posterior
- D2392 Resin - two surfaces - posterior
- D2393 Resin - three surfaces - posterior
- D2394 Resin - four or more surfaces - posterior
- D2910 Recement or re-bond inlay, onlay, veneer or partial coverage restoration
- D2915 Recement or re-bond indirectly fabricated or prefabricated post and core
- D2920 Recement crown
- D2921 Reattachment of tooth fragment, incisal edge or cusp
- D2929 Prefabricated porcelain/ceramic crown - primary tooth
- D2930 Stainless steel crown - primary
- D2931 Stainless steel crown - permanent
- D2932 Prefabricated resin crown
- D2933 Stainless steel crown with resin window
- D2934 Prefabricated stainless crown - primary tooth
- D2940 Protective restoration
- D2941 Interim therapeutic restoration – primary dentition
- D2951 Pin retention - per tooth in addition to restoration
- D2970 Temporary crown (fractured tooth)
- D2999 Unspecified restorative procedure, by report
- D3110 Pulp cap - direct
- D3120 Pulp cap - indirect
- D3220 Pulpotomy (therapeutic)
- D3221 Gross pulpal debridement primary and permanent
- D3222 Partial pulpotomy for apexogenesis
- D3230 Pulpal therapy - anterior primary tooth
- D3240 Pulpal therapy - posterior primary tooth
- D3310 Root canal - anterior excluding final restoration
- D3320 Root canal - bicuspid excluding final restoration
- D3331 Treatment of root canal obstruct-non surgical access
- D3332 Incomplete endodontic therapy inoperable or fractured tooth
- D3333 Internal root repair of perforation defects
- D3346 Retreatment-root canal Treatment - anterior
- D3347 Retreatment-root canal Treatment - bicuspid
- D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
- D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
- D3353 Apexification/recalcification - final
- D3355 Pulpal regeneration - initial visit
- D3356 Pulpal regeneration – interim medication replacement

- D3357 Pulpal regeneration – completion of Treatment
- D3410 Apicoectomy - anterior
- D3421 Apicoectomy- bicuspid (first root)
- D3425 Apicoectomy- molar (first root)
- D3426 Apicoectomy- each additional root
- D3427 Periradicular surgery without apicoectomy
- D3430 Retrograde filling - per root
- D3450 Root amputation - per root
- D3920 Hemisection - not including root canal therapy
- D4210 Gingivectomy/gingivoplasty, 4+ teeth (1 per quadrant/tooth every 3 years)
- D4211 Gingivectomy/gingivoplasty, 1 To 3 teeth (1 per quadrant/tooth every 3 years)
- D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth (1 per quadrant/tooth every 3 years)
- D4240 Gingival flap –with root planing, 4 or more contiguous teeth (1 per quadrant/tooth every 3 years)
- D4241 Gingival flap - includes root planing, 1-3 teeth (1 per quadrant/tooth every 3 years)
- D4245 Apically positioned flap
- D4268 Surgical revision procedure per tooth
- D4341 Periodontal scaling and root planing, 4 or more teeth per quadrant (1 per quadrant every 2 rolling years)
- D4342 Periodontal scaling and root planing, 1-3 teeth (1 per separate quadrant every 2 rolling years)
- D4910 Periodontal maintenance - procedures (2 per calendar year following active periodontal Treatment)
- D4920 Unscheduled dressing change (by someone other than treating dentist or their staff)
- D4999 Unspecified periodontal procedure, by report
- D5731 Reline complete mandibular denture (chairside)
- D5740 Reline maxillary partial denture (chairside)
- D5860 Overdenture – complete, by report
- D6053 Implant/Abutment supported removable denture for completely edentulous arch By Report
- D6054 Implant/Abutment supported removable denture for partially edentulous arch By Report
- D6078 Implant/Abutment supported fixed denture for completely edentulous arch By Report
- D6079 Implant/Abutment supported fixed denture for partially edentulous arch By Report
- D6092 Recement implant/abutment supported crown
- D6093 Recement implant/abutment supported partial
- D6930 Recement or re-bond fixed partial denture retainers
- D7111 Extract coronal remnants - deciduous tooth
- D7140 Extraction - erupted tooth or exposed root
- D7210 Surgical removal of erupted tooth
- D7220 Removal of impacted tooth - soft tissue
- D7250 Surgical removal of residual tooth roots
- D7260 Oroantral fistula closure
- D7261 Primary closure of a sinus perforation
- D7270 Tooth re-implantation of accidental displaced tooth
- D7272 Tooth transplantation
- D7280 Surgical access of unerupted tooth
- D7282 Mobilization of erupted or malpositioned tooth to aid eruption
- D7283 Device to aid eruption of impacted tooth
- D7285 Incisional biopsy of oral tissue-hard (bone/tooth)
- D7286 Incisional biopsy of oral tissue-soft
- D7310 Alveoloplasty in conjunction with extraction
- D7311 Alveoloplasty in conjunction with extraction, 1-3 teeth
- D7320 Alveoloplasty not in conjunction with extraction

- D7321 Alveoloplasty not in conjunction with/extraction, 1-3 teeth
- D7450 Removal of odontogenic cyst/tumor up to 1.25 cm
- D7451 Removal of odontogenic cyst/tumor greater than 1.25 cm
- D7471 Removal of lateral exostosis (maxilla or mandible)
- D7472 Removal of torus palatinus
- D7473 Removal of torus mandibularis
- D7485 Surgical reduction of osseous tuberosity
- D7510 Incision and drainage of abscess intraoral
- D7511 Incision and drainage of abscess - intraoral soft tissue, complex
- D7520 Incision and drainage of abscess - extraoral, soft tissue
- D7521 Incision and drainage- extraoral complex
- D7530 Removal foreign body, mucosa, skin, tissue
- D7540 Removal of reaction producing foreign body
- D7550 Partial ostectomy/sequestrectomy
- D7910 Suture of recent small wound less than 5 cm
- D7960 Frenulectomy
- D7963 Frenuloplasty
- D7970 Excision of hyperplastic tissue - per arch
- D7971 Excision of pericoronal gingiva
- D7972 Surgical reduction of fibrous tuberosity
- D7999 Unspecified oral surgery procedure
- D9410 House call
- D9430 Office visit for observation (during regular hours)
- D9440 Office visit after hours
- D9930 Treatment of complications post-surgical
- D9950 Occlusal analysis
- D9951 Occlusal adjustment - limited
- D9952 Occlusal adjustment - complete
- D3999 Unspecified endodontic procedure, by report
- D7911 Complicated suture - up to 5 cm
- D7912 Complicated suture - greater than 5 cm

Major restorative care (Type C Services)

- D2510 Inlay - metallic - 1 surface (1 per tooth every 5 years)
- D2520 Inlay - metallic - 2 surfaces (1 per tooth every 5 years)
- D2530 Inlay - metallic - 3 or more surfaces (1 per tooth every 5 years)
- D2542 Onlay - metallic - 2 surfaces (1 per tooth every 5 years)
- D2543 Onlay - metallic - 3 surfaces (1 per tooth every 5 years)
- D2544 Onlay - metallic - 4 or more surfaces (1 per tooth every 5 years)
- D2610 Inlay - porcelain/ceramic - 1 surface (1 per tooth every 5 years)
- D2620 Inlay - porcelain/ceramic - 2 surfaces (1 per tooth every 5 years)
- D2630 Inlay - porcelain/ceramic - 3 or more surfaces (1 per tooth every 5 years)
- D2642 Onlay - porcelain/ceramic - 2 surfaces (1 per tooth every 5 years)
- D2643 Onlay - porcelain/ceramic - 3 surfaces (1 per tooth every 5 years)
- D2644 Onlay - porcelain/ceramic - in addition to inlay (1 per tooth every 5 years)
- D2650 Inlay - composite/resin - 1 surface (1 per tooth every 5 years)
- D2651 Inlay - composite/resin - 2 surfaces (1 per tooth every 5 years)
- D2652 Inlay - composite/resin - 3 surfaces (1 per tooth every 5 years)
- D2662 Onlay - composite/resin - 2 surfaces (1 per tooth every 5 years)
- D2663 Onlay - composite/resin - 3 surface (1 per tooth every 5 years)
- D2664 Onlay - composite/resin - 4 or more surfaces (1 per tooth every 5 years)
- D2710 Crown - resin-based composite, indirect (1 per tooth every 5 years)

- D2712 Crown – ¾ resin-based composite, indirect (1 per tooth every 5 years)
- D2720 Crown - resin with high noble metal (1 per tooth every 5 years)
- D2721 Crown - resin with predominantly base metal (1 per tooth every 5 years)
- D2722 Crown - resin with noble metal (1 per tooth every 5 years)
- D2740 Crown - porcelain/ceramic substrate (1 per tooth every 5 years)
- D2750 Crown - porcelain fused high noble metal (1 per tooth every 5 years)
- D2751 Crown -porcelain fused predominantly base metal (1 per tooth every 5 years)
- D2752 Crown - porcelain fused to noble metal (1 per tooth every 5 years)
- D2780 Crown - 3/4 cast high noble metal (1 per tooth every 5 years)
- D2781 Crown -3/4 cast predominantly base metal (1 per tooth every 5 years)
- D2782 Crown - 3/4 cast noble metal (1 per tooth every 5 years)
- D2783 Crown – ¾ porcelain/ceramic (1 per tooth every 5 years)
- D2790 Crown - full cast high noble metal (1 per tooth every 5 years)
- D2791 Crown - full cast predominantly based metal (1 per tooth every 5 years)
- D2792 Crown - full cast noble metal (1 per tooth every 5 years)
- D2794 Crown - titanium (1 per tooth every 5 years)
- D2950 Core buildup, including any pins when required
- D2952 Cast post and core in addition to crown
- D2953 Cast post - each Additional - same tooth
- D2954 Prefab post and core in addition to crown
- D2957 Prefabricated post - each add - same tooth
- D2960 Labial veneer – chairside (1 per tooth every 5 years)
- D2961 Labial veneer -lab (1 per tooth every 5 years)
- D2962 Labial veneer porcelain – lab (1 per tooth every 5 years)
- D2971 Additional procedures - new crown under partial
- D2980 Crown repair
- D2981 Inlay repair - material failure
- D2982 Onlay repair - material failure
- D2983 Veneer repair - material failure
- D3330 Root canal Treatment - molar excluding final restoration
- D3348 Retreatment - root canal Treatment - molar
- D4249 Clinical crown lengthening hard tissue
- D4260 Osseous surgery, including elevation of a full thickness flap and closure – four or more contiguous teeth or tooth bounded spaces per quadrant (1 per quadrant/tooth every 3 years)
- D4261 Osseous surgery, including elevation of a full thickness flap and closure – 1 to 3 contiguous teeth or tooth bounded spaces per quadrant (1 per quadrant/tooth every 3 years)
- D4270 Pedicle soft tissue graft procedure
- D4273 Connective tissue graft procedures, including donor and recipient surgical sites - first tooth, implant, or edentulous tooth position in graft
- D4275 Non-autogenous connective tissue graft, including recipient site and donor material - first tooth, implant, or edentulous tooth position in graft
- D4276 Connective tissue/pedicle graft - tooth
- D4277 Free soft tissue graft procedure, including recipient and donor surgical site - first tooth, implant, or edentulous tooth position in graft
- D4278 Free soft tissue graft procedure, including recipient and donor surgical sites - each additional contiguous tooth, implant or edentulous tooth position in same graft site
- D4283 Autogenous connective tissue graft procedure, including donor and recipient surgical sites – each additional contiguous tooth, implant or edentulous tooth position in same graft site
- D4285 Non-autogenous connective tissue graft procedure, including recipient surgical site and donor material – each additional contiguous tooth, implant or edentulous tooth position in same graft site
- D4355 Full mouth debridement (1 per lifetime)

- D5110 Complete denture - maxillary (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5120 Complete denture - mandibular (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5130 Immediate denture – maxillary (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5140 Immediate denture – mandibular (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5211 Maxillary partial denture - resin base (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5212 Mandibular partial denture - resin base (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5213 Maxillary partial denture - cast base (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5214 Mandibular partial denture cast base (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5221 Immediate maxillary partial denture – resin base, including any conventional clasps, rests and teeth (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5222 Immediate mandibular partial denture – resin base, including any conventional clasps, rests and teeth (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5223 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 (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5224 Immediate mandibular partial denture – cast metal framework with resin denture bases, including any conventional clasps, rests and teeth (1 every 5 years - all adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure)
- D5225 Maxillary partial denture – flexible base (1 every 5 years)
- D5226 Mandibular partial denture – flexible base (1 every 5 years)
- D5281 Removable unilateral partial denture (1 every 5 years)
- D5410 Adjustments maxillary complete denture (not eligible within 6 months of denture placement, then no limit)
- D5411 Adjustments mandibular complete denture (not eligible within 6 months of denture placement, then no limit)
- D5421 Adjustments partial denture - maxillary (not eligible within 6 months of denture placement, then no limit)
- D5422 Adjustments partial denture - mandibular (not eligible within 6 months of denture placement, then no limit)
- D5510 Repair broken complete denture base
- D5520 Replace missing or broken teeth, complete denture
- D5610 Repair resin denture base
- D5620 Repair cast framework
- D5630 Repair or replace broken clasp – per tooth
- D5640 Replace broken teeth - per tooth
- D5650 Add tooth to existing partial denture
- D5660 Add clasp to existing partial denture – per tooth
- D5670 Replace all teeth - upper partial
- D5671 Replace all teeth - lower partial
- D5710 Rebase complete maxillary denture (not eligible within 6 months of denture placement, then no limit)

- D5711 Rebase complete mandibular denture (not eligible within 6 months of denture placement, then no limit)
- D5720 Rebase partial maxillary denture (not eligible within 6 months of denture placement, then no limit)
- D5721 Rebase partial mandibular denture (not eligible within 6 months of denture placement, then no limit)
- D5730 Reline complete maxillary denture, chairside (not eligible within 6 months of denture placement, then no limit)
- D5731 Reline complete mandibular denture, chairside (not eligible within 6 months of denture placement, then no limit)
- D5740 Reline complete maxillary denture, chairside (not eligible within 6 months of denture placement, then no limit)
- D5741 Reline complete mandibular partial denture, chairside (not eligible within 6 months of denture placement, then no limit)
- D5750 Reline complete maxillary denture, laboratory (not eligible within 6 months of denture placement, then no limit)
- D5751 Reline complete mandibular denture, laboratory (not eligible within 6 months of denture placement, then no limit)
- D5760 Reline maxillary partial denture, laboratory (not eligible within 6 months of denture placement, then no limit)
- D5761 Reline mandibular partial denture, laboratory (not eligible within 6 months of denture placement, then no limit)
- D5761 Reline mandibular partial denture, laboratory (not eligible within 6 months of denture placement, then no limit)
- D5820 Interim partial denture - upper (maxillary)
- D5821 Interim partial denture - lower (mandibular)
- D5850 Tissue conditioning, upper
- D5851 Tissue conditioning, lower
- D5863 Overdenture – complete maxillary (1 every 5 years)
- D5864 Overdenture - partial maxillary (1 every 5 years)
- D5865 Overdenture -complete mandibular (1 every 5 years)
- D5866 Overdenture – partial mandibular (1 every 5 years)
- D6010 Surgical placement of implant body endosteal implant
- D6013 Surgical placement of mini implant
- D6040 Surgical placement eposteal implant
- D6050 Surgical placement transosteal implant
- D6055 Dental implant supported connecting bar
- D6056 Prefabricated abutment
- D6057 Custom abutment
- D6058 Abutment supported porcelain/ceramic crown (1 every 5 years)
- D6059 Abutment supported porcelain fused metal crown high (1 every 5 years)
- D6060 Abutment supported porcelain fused metal crown base (1 every 5 years)
- D6061 Abutment supported porcelain fused metal crown noble (1 every 5 years)
- D6062 Abutment supported cast metal crown high noble (1 every 5 years)
- D6063 Abutment supported cast metal crown base noble (1 every 5 years)
- D6064 Abutment supported cast metal crown noble metal (1 every 5 years)
- D6065 Implant supported porcelain/ceramic crown (1 every 5 years)
- D6066 Implant supported porcelain fused metal crown high (1 every 5 years)
- D6067 Implant supported metal crown high (1 every 5 years)
- D6068 Abutment supported retainer for porcelain/ceramic (1 every 5 years)
- D6069 Abutment supported retainer for porcelain fused metal high (1 every 5 years)
- D6070 Abutment supported retainer for porcelain fused metal base (1 every 5 years)
- D6071 Abutment supported retained for porcelain fused metal noble (1 every 5 years)

- D6072 Abutment supported retained for cast metal full partial denture high (1 every 5 years)
- D6073 Abutment supported retainer for cast metal full partial denture base (1 every 5 years)
- D6074 Abutment supported retainer for cast metal full partial denture noble (1 every 5 years)
- D6075 Implant supported retainer for ceramic full partial denture (1 every 5 years)
- D6076 Implant supported retainer for porcelain fused metal high noble metal (1 every 5 years)
- D6077 Implant supported retainer for cast metal high (1 every 5 years)
- D6080 Implant maintenance procedures, when prostheses are removed and reinserted, including cleansing of prosthesis and abutments
- D6090 Repair implant supported prosthesis
- D6091 Replace precision attachment
- D6094 Abutment supported crown – titanium (1 every 5 years)
- D6095 Repair implant abutment prosthesis (1 every 5 years)
- D6100 Implant removal, by report (1 every 5 years)
- D6110 Implant/abutment supported removable denture for completely edentulous arch – maxillary (1 every 5 years)
- D6111 Implant/abutment supported removable denture for completely edentulous arch – mandibular (1 every 5 years)
- D6112 Implant/abutment supported removable denture for partially edentulous arch – maxillary (1 every 5 years)
- D6113 Implant/abutment supported removable denture for partially edentulous arch – mandibular (1 every 5 years)
- D6114 Implant/abutment supported fixed denture for completely edentulous arch – maxillary (1 every 5 years)
- D6115 Implant/abutment supported fixed denture for completely edentulous arch – mandibular (1 every 5 years)
- D6116 Implant/abutment supported fixed denture for partially edentulous arch – maxillary (1 every 5 years)
- D6117 Implant/abutment supported fixed denture for partially edentulous arch – mandibular (1 every 5 years)
- D6194 Abutment supported retainer crown for full partial denture (1 every 5 years)
- D6199 Unspecified implant procedure, by report
- D6205 Pontic - indirect resin based composite (1 every 5 years)
- D6210 Pontic - cast high noble metal (1 every 5 years)
- D6211 Pontic - cast predominantly base metal (1 every 5 years)
- D6212 Pontic - cast noble metal (1 every 5 years)
- D6214 Pontic – titanium (1 every 5 years)
- D6240 Pontic - porcelain fused to high noble (1 every 5 years)
- D6241 Pontic - porcelain fused to base metal (1 every 5 years)
- D6242 Pontic - porcelain fused to noble metal (1 every 5 years)
- D6245 Pontic - porcelain/ceramic (1 every 5 years)
- D6250 Pontic - resin with high noble metal (1 every 5 years)
- D6251 Pontic - resin with predominantly base metal (1 every 5 years)
- D6252 Pontic - resin with noble metal (1 every 5 years)
- D6545 Retainer - cast metal for resin bonded for fixed prosthesis (1 every 5 years)
- D6548 Retainer - porcelain/ceramic resin bonded for fixed prosthesis (1 every 5 years)
- D6600 Inlay – porcelain/ceramic, 2 surfaces (1 every 5 years)
- D6601 Inlay – porcelain/ceramic, 3 or more surfaces (1 every 5 years)
- D6602 Inlay - cast high noble metal, 2 surfaces major (1 every 5 years)
- D6603 Inlay - cast high noble metal, 3 or more surfaces (1 every 5 years)
- D6604 Inlay - cast predominately base metal 2 surfaces (1 every 5 years)
- D6605 Inlay - cast predominately base metal 3 or more surfaces (1 every 5 years)
- D6606 Inlay - cast noble metal, 2 surfaces (1 every 5 years)

- D6607 Retainer inlay - cast noble metal, three or more surfaces (1 every 5 years)
- D6608 Retainer onlay - porcelain/ceramic, 2 surfaces (1 every 5 years)
- D6609 Retainer onlay - porcelain/ceramic, 3 or more surfaces (1 every 5 years)
- D6610 Retainer onlay - cast high noble metal, 2 surfaces (1 every 5 years)
- D6611 Retainer onlay - cast high noble metal, 2 or more surfaces (1 every 5 years)
- D6612 Retainer onlay - cast predominantly base metal, 2 surfaces (1 every 5 years)
- D6613 Retainer onlay - cast predominantly base metal, 3 or more surfaces (1 every 5 years)
- D6614 Retainer onlay - cast noble metal, 2 surfaces (1 every 5 years)
- D6615 Retainer onlay - cast noble metal, 3 or more surfaces (1 every 5 years)
- D6624 Retainer inlay – titanium (1 every 5 years)
- D6634 Retainer onlay - titanium (1 every 5 years)
- D6710 Retainer crown - indirect resin based composite (1 every 5 years)
- D6720 Retainer crown - resin with high noble metal (1 every 5 years)
- D6721 Retainer crown - resin with predominantly base metal (1 every 5 years)
- D6722 Retainer crown - resin with noble metal (1 every 5 years)
- D6740 Retainer crown - porcelain/ceramic (1 every 5 years)
- D6750 Retainer crown - porcelain fused to high noble metal (1 every 5 years)
- D6751 Retainer crown - porcelain fused to predominantly base metal (1 every 5 years)
- D6752 Retainer crown - porcelain fused to noble metal (1 every 5 years)
- D6780 Retainer crown - 3/4 cast high noble metal (1 every 5 years)
- D6781 Retainer crown - 3/4 cast predominantly base metal (1 every 5 years)
- D6782 Retainer crown - 3/4 cast noble metal (1 every 5 years)
- D6783 Retainer crown - 3/4 porcelain/ceramic (1 every 5 years)
- D6790 Retainer crown - full cast high noble metal (1 every 5 years)
- D6791 Retainer crown - full cast predominantly base metal (1 every 5 years)
- D6792 Retainer crown - full cast noble metal (1 every 5 years)
- D6794 Retainer crown – titanium (1 every 5 years)
- D6940 Stress breaker
- D6980 Fixed partial denture repair
- D6985 Pediatric partial denture, fixed
- D6999 Unspecified fixed prosthodontic procedure, by report
- D7230 Removal of impacted tooth - partial bony
- D7240 Removal of impacted tooth - full bony
- D7241 Removal of impacted tooth - complication
- D7251 Coronectomy
- D7290 Surgical repositioning of teeth
- D7291 Transseptal fiberotomy, by report
- D7340 Vestibuloplasty - ridge extension (1 every 5 years)
- D7350 Vestibuloplasty - ridge extension including soft tissue grafts (once per arch)
- D7410 Excision of benign lesion up to 1.25 cm
- D7411 Excision of benign lesion more than 1.25 cm
- D7412 Excision of benign lesion, complicated
- D7413 Excision of malignant lesion up to 1.25 cm
- D7414 Excision of malignant lesion more than 1.25 cm
- D7415 Excision of malignant lesion complicated
- D7440 Excision of malignant lesion up to 1.25 cm
- D7441 Excision of malignant lesion greater than 1.25 cm
- D7460 Removal non-odontogenic cyst/tumor up to 1.25 cm
- D7461 Removal nonodontogenic cyst/tumor greater than 1.25 cm
- D7465 Destruction of lesion(s) by physical or chemical methods
- D7490 Radical resection of maxilla/mandible with bone graft
- D7560 Maxillary sinusotomy for removal of tooth

- D7610 Maxilla - open reduction
- D7620 Maxilla - closed reduction
- D7630 Mandible- open reduction
- D7640 Mandible- closed reduction
- D7650 Malar and/or zygomatic arch - open reduction
- D7660 Malar and/or zygomatic arch - closed reduction
- D7670 Alveolus - closed reduction
- D7671 Alveolus - open reduction
- D7680 Facial bones complicated reduction
- D7710 Maxilla - open reduction
- D7720 Maxilla - closed reduction
- D7730 Mandible - open reduction
- D7740 Mandible - closed reduction
- D7750 Malar and/or zygomatic arch - open
- D7760 Malar and/or zygomatic arch - closed
- D7770 Alveolus - open reduction stabilization of teeth
- D7771 Alveolus - closed reduction stabilization of teeth
- D7780 Facial bones - complicated reduction
- D7810 Open reduction of dislocation
- D7820 Closed reduction of dislocation
- D7830 Manipulation under anesthesia
- D7840 Condylectomy
- D7850 Surgical discectomy, with/without implant
- D7852 Disc repair
- D7854 Synovectomy
- D7856 Myotomy
- D7858 Joint reconstruction
- D7860 Arthrotomy
- D7865 Arthroplasty
- D7870 Arthrocentesis
- D7872 Arthroscopy - diagnosis with/without biopsy
- D7873 Arthroscopy - surgical lavage
- D7874 Arthroscopy - surgical disc reposition
- D7875 Arthroscopy - surgical synovectomy
- D7876 Arthroscopy - surgical discectomy
- D7877 Arthroscopy - surgical debridement
- D7880 Occlusal orthotic device, by report
- D7899 Unspecified temporomandibular joint dysfunctions (TMD) therapy, by report
- D7920 Skin graft
- D7940 Osteoplasty for orthognathic deformities
- D7941 Osteotomy - mandibular rami
- D7943 Osteotomy - ramus, opened with bone graft
- D7944 Osteotomy - segmented or subapical
- D7945 Osteotomy - body of mandible
- D7946 Lefort I - (maxilla -total)
- D7947 Lefort I - (maxilla - segmented)
- D7948 Lefort II/III - osteoplasty of facial bones without graft
- D7949 Lefort II/LLL - with bone graft
- D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or non autogenous, by report
- D7951 Sinus augmentation
- D7952 Sinus augmentation - vertical approach

- D7955 Repair of maxillofacial soft/hard tissue
- D7980 Sialolithotomy
- D7981 Excision of salivary gland, by report
- D7982 Sialodochoplasty
- D7983 Closure of salivary fistula
- D7990 Emergency tracheotomy
- D7991 Coronoidectomy
- D7995 Synthetic graft
- D7997 Appliance removal including removal of arch bar
- D8210 Removable appliance therapy
- D8220 Fixed or cemented appliance therapy
- D9120 Partial denture sectioning
- D9210 Local anesthesia not in conjunction with operative or surgical procedures
- D9211 Regional block anesthesia
- D9212 Trigeminal division block anesthesia
- D9215 Local anesthesia in conjunction with operative or surgical procedures
- D9219 Evaluation - deep sedation or general anesthesia
- D9223 Deep sedation/general anesthesia – each 15 minute increment
- D9230 Analgesia
- D9243 Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment
- D9248 Non-intravenous conscious sedation (includes non-IV minimal and moderate sedation)
- D9420 Hospital or ambulatory surgical center
- D9610 Therapeutic drug injection
- D9612 Therapeutic parenteral drugs
- D9910 Application of desensitizing medication
- D9932 Cleaning and inspection of removable complete denture, maxillary
- D9933 Cleaning and inspection of removable complete denture, mandibular
- D9934 Cleaning and inspection of removable partial denture, maxillary
- D9935 Cleaning and inspection of removable partial denture, mandibular
- D9940 Occlusal guards
- D9942 Repair and/or relin of occlusal guard
- D9943 Occlusal guard adjustment (not eligible within first 6 months after placement of appliance)
- D9999 Unspecified adjunctive procedure, by report
- D5899 Unspecified removable prosthodontic procedure, by report
- D5911 Facial moulage - sectional, by report
- D5912 Facial moulage - complete, by report
- D5913 Nasal prosthesis, by report
- D5914 Auricular prosthesis, by report
- D5915 Orbital prosthesis, by report
- D5916 Ocular prosthesis, by report
- D5919 Facial prosthesis, by report
- D5922 Nasal septal prosthesis, by report
- D5923 Ocular prosthesis, interim, by report
- D5924 Cranial prosthesis, by report
- D5925 Facial augmentation implant prosthesis, by report
- D5926 Nasal prosthesis, replacement, by report
- D5927 Auricular prosthesis, replacement, by report
- D5928 Orbital prosthesis, replacement, by report
- D5929 Facial prosthesis, replacement, by report
- D5931 Obturator prosthesis, surgical, by report
- D5932 Obturator prosthesis, definitive, by report
- D5933 Obturator prosthesis, modification, by report

- D5934 Mandibular resection prosthesis with flange, by report
- D5935 Mandibular resection prosthesis without flange, by report
- D5936 Obturator prosthesis, interim, by report
- D5937 Trismus appliance (not for TMJ), by report
- D5951 Feeding aid, by report
- D5952 Speech aid prosthesis, pediatric, by report
- D5953 Speech aid prosthesis, adult, by report
- D5954 Palatal augmentation prosthesis, by report
- D5955 Palatal lift prosthesis, definitive, by report
- D5958 Palatal lift prosthesis, interim, by report
- D5959 Palatal lift prosthesis, modification, by report
- D5960 Speech aid prosthesis, modification, by report
- D5982 Surgical stent, by report
- D5983 Radiation carrier, by report
- D5984 Radiation shield, by report
- D5985 Radiation cone locator, by report
- D5986 Fluoride gel carrier, by report
- D5987 Commissure splint, by report
- D5988 Surgical splint, by report
- D5991 Topical vesiculobullous disease medicament carrier, by report
- D5992 Adjust maxillofacial prosthetic appliance, by report
- D5993 Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report
- D5999 Unspecified maxillofacial prosthesis, by report

Orthodontic services (covered as Medically Necessary)

- D0470 Diagnostic casts
- D8010 Limited orthodontic Treatment of primary dentition
- D8020 Limited orthodontic Treatment - transitional dentition
- D8030 Limited orthodontic Treatment - adolescent dentition
- D8040 Limited orthodontic Treatment - adult dentition
- D8050 Interceptive Treatment - primary dentition
- D8060 Interceptive Treatment - transitional dentition
- D8070 Comprehensive Treatment - transitional dentition
- D8080 Comprehensive Treatment - adolescent dentition
- D8090 Comprehensive Treatment - adult dentition
- D8660 Pre-orthodontic Treatment examination to monitor growth and development
- D8670 Periodic orthodontic Treatment visit
- D8680 Orthodontic retention
- D8681 Removable orthodontic retainer adjustment
- D8691 Repair of orthodontic appliance
- D8693 Rebonding or recementing and/or repair, as required, of fixed retainers
- D8694 Repair of fixed retainers, includes reattachment
- D8999 Unspecified orthodontic Treatment, by report
- D8692 Replacement of lost or broken retainer (once per arch)

16. 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;
- b. Office visits to ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses;
- c. Pediatric comprehensive low vision evaluations performed by a legally qualified ophthalmologist or optometrist - limited to 1 vision evaluation every 5 years; 4 follow up visits in any 5-year period; and

- d. 1 pair of prescribed standard plastic or glass lenses (single vision, bifocal, trifocal, progressive or lenticular) and frames per Policy Year. The following lens options are included: fashion and gradient tinting; oversized and glass-grey #3 prescription sunglass lenses; blended segment lenses; intermediate vision lenses; standard, premium, select and ultra progressive lenses; photochromic glass lenses, plastic photosensitive lenses; polarized lenses, standard, premium and ultra anti-reflective coating; high index lenses, polycarbonate lenses, scratch-resistant coating; or
 - e. Prescribed contact lenses in lieu of eyeglasses (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery), limited as follows:
 - a) Daily disposables - Up to 3 month supply
 - b) Extended Wear disposable - Up to 6 month supply
 - c) Non-disposable – Up 1 set per Policy Year
 - d) Optical Devices – Limited to 1 optical device per Policy Year
 Coverage includes fitting, evaluation, and follow-up care.
 - f. Special contact lenses for aniridia only when prescribed by an Optometrist. We will cover up to 2 Medically Necessary contact lenses per eye (including fitting and dispensing) in any Policy Year to treat aniridia (missing iris) within no cost sharing. We will not cover an aniridia contact lens if We provided an allowance toward (or otherwise covered) more than one aniridia contact lens for that eye within the previous 12 months (including when We provided an allowance toward, or otherwise covered, 1 or more aniridia contact lenses under any other Plan).
17. **Abortion Expense** for all Covered Medical Expenses resulting from:
- a. An elective non-therapeutic abortion; or
 - b. A therapeutic abortion, which is a Medically Necessary abortion recommended by a Provider, performed to save the life or health of the mother, prevent harm to the women’s physical or mental health; terminate a pregnancy where indications are that the child will have a significantly increased chance of premature morbidity or mortality or be otherwise disabled; or to selectively reduce the number of fetuses to lessen health risks associated with multiple pregnancy.
18. **Acupuncture Services** that are Medically Necessary and when provided by a Physician licensed to perform such services. All supplies used in conjunction with the acupuncture Treatment will be included in the payment for the visit and will not be reimbursed in addition to the visit.
19. **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. Treatment must commence within 1 year of the Accidental Injury or within 1 year following Your Effective Date of coverage under this Certificate, whichever is later. Treatment excludes orthodontia.
20. **Dental Services For Radiation** when Medically Necessary to prepare the mouth for radiation therapy for cancer of the head or neck and to prepare for transplants. Benefits include:
- a. Evaluation;
 - b. Orthognathic (jawbone surgery);
 - c. Dental X-rays;
 - d. Extractions, including surgical extractions;
 - e. Fluoride Treatment;
 - f. Anesthesia;
 - g. Admission for dental care up to 3 days when a Hospital stay is Medically Necessary.
21. **Chiropractic Care Benefit** for Treatment of a Covered Injury or Covered Sickness and performed by a Physician.
22. **Gender Transition Services Benefit** for Medically Necessary expenses incurred for surgery, services and supplies provided in connection with gender transition when You have been diagnosed with gender identity disorder or gender dysphoria. Covered services include, but are not limited to, the following:
- a. Counseling by qualified mental health professional;
 - b. Hormone therapy, including monitoring of such therapy;

- c. Gender reassignment surgery;
- d. Hysterectomy;
- e. Genital reconstructive surgery;
- f. Top surgery for female to male (FTM) and male to female (MTF), including breast augmentation;
- g. Vocal training;
- h. Electrolysis of the neck and face;
- i. Laser hair removal of the neck and face;
- j. Gender-conforming facial surgery; and
- k. Tracheal shaving.

Gender Transition Services Travel Expenses: Certain travel expenses will be covered when incurred in connection with an approved transgender surgery. Covered travel expenses include the following for You and one companion:

- Ground transportation to and from the Medical Facility when the Medical Facility performing the approved gender transition surgery is located 50 miles or more from Your home;
- Coach airfare to and from the Medical Facility when the Medical Facility performing the approved gender transition surgery is located more than 300 miles from Your home;
- Lodging, limited to one room, double occupancy. Reimbursement not to exceed the CONUS daily rate for the city where the Medical Facility is located;
- Other reasonable expenses;

subject to the maximum benefit amount shown on the Schedule of Benefits.

Unless the travel expenses are connected to the actual approved gender transition surgery, travel expenses for non-surgical gender transition services are excluded from coverage.

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

- a. Childcare;
- b. Mileage within the city where the Medical Facility is located;
- 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 covered surgery;
- h. Telephone calls;
- i. Laundry;
- j. Postage;
- k. Entertainment;
- l. Interim visits to a Medical Facility while waiting for the actual surgery;
- m. Tobacco, alcohol, drug, and meal expenses.

Travel expenses must be authorized in advance for these benefits to be payable. For assistance, You may contact Us at the number on Your ID card.

23. **Fertility Preservation Expense** for services and annual storage costs. We will provide coverage for standard fertility preservation procedures:

- (1) Performed on You or Your covered Dependent; and
- (2) That are Medically Necessary to preserve fertility for You or Your covered Dependent due to a need for medical Treatment that may directly or indirectly cause iatrogenic infertility.

As used in this benefit:

Iatrogenic infertility means an impairment of fertility caused directly or indirectly by surgery, including gender reassignment surgery in the Treatment of gender dysphoria, chemotherapy, radiation, or other medical Treatment affecting the reproductive organs or processes.

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

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

- a) Fertility preservation procedures includes sperm and oocyte cryopreservation and evaluations, laboratory assessments, medications, and treatments associated with sperm and oocyte cryopreservation.
- b) Fertility preservation procedures does not include the storage of sperm or oocytes after the date Your insurance coverage under this Certificate terminates.

This benefit does not include testing or Treatment of infertility.

24. **Organ and Tissue Transplant Surgery**

Recipient Surgery for the following Medically Necessary, non-Experimental and non-Investigative transplants or replacements: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. This may include harvesting the organ, tissue or bone marrow and for Treatment of complications. We will provide benefits for the Hospital and medical expenses when You are the recipient of an organ transplant. If the Insured Person is infected with HIV, eligibility for this benefit is not affected.

Pre-certification is required before the Insured Person receives any transplant services. The Insured Person may be directed to an in-network facility designated as a Center of Excellence transplant facility.

Donor's Surgery for Medically Necessary transplant services required by the Insured Person who serves as an organ or tissue 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.

Organ Donation Services for actual or potential living donors, in addition to transplant services of organs, tissue, or bone marrow required as follows:

- a. Coverage for donation-related services for a living donor, or an individual identified by the plan as a potential donor, whether or not the donor is an Insured Person.
- b. Services must be directly related to a covered transplant for the Insured Person, which shall include services harvesting the organ, blood evaluations and transfusions.
- c. Donor is covered for up to 90 days following the harvest and evaluation services.

Treatment of donor complications related to stem cell donations, blood screening for stem cell donations and any issues caused by donor's non-compliance with Physician's orders and/or Treatment plan.

Organ and Tissue Transplant Surgery Travel Expenses: Certain travel expenses will be covered when incurred in connection with a covered organ or tissue transplant surgery. Covered travel expenses include the following for You (and one companion) or the donor:

- Ground transportation to and from the Medical Facility when the Medical Facility performing the Medically Necessary transplant is located 50 miles or more from Your or the donor's home;
- Coach airfare to and from the Medical Facility when the Medical Facility performing the Medically Necessary transplant is located more than 300 miles from Your or the donor's home;
- Lodging, limited to one room, double occupancy. Reimbursement not to exceed the CONUS daily rate for the city where the Medical Facility is located;
- Other reasonable expenses;

subject to the maximum benefit amount shown on the Schedule of Benefits.

Note: If You are under 18 years of age, this benefit will apply to the You and two companions or caregivers.

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

- a. Childcare;
- b. Mileage within the city where the Medical Facility is located;
- 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 covered surgery;
- h. Telephone calls;
- i. Laundry;
- j. Postage;
- k. Entertainment;
- l. Interim visits to a Medical Facility while waiting for the actual surgery;
- m. Tobacco, alcohol, drug, and meal expenses.

Travel expenses must be authorized in advance for these benefits to be payable. For assistance, You may contact Us at the number on Your ID card.

25. **Shots and Injections**, unless considered under Preventive Services, when administered in a Physician's office and charged on the Physician's statement. This includes HPV vaccines for Insured Persons over age 26.
26. **Treatment for Temporomandibular Joint (TMJ) Disorders** for medical or surgical Treatment provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders. This benefit does not include the provision of dental services.
27. **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.
28. **Non-emergency Care While Traveling Outside of the United States** for Medically Necessary Treatment when You are traveling outside of the United States.

Mandated Benefits for California

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. **AIDS Vaccine** for acquired immune deficiency syndrome (AIDS) that is approved for marketing by the FDA and that is recommended by the United States Public Health Service.
2. **Alzheimer's Disease Coverage** is provided for home-based care for You if You are diagnosed as having any significant destruction of brain tissue with resultant loss of brain function, including, but not limited to, progressive, degenerative, and dementing illness. This includes, but is not limited to, Alzheimer's disease.
3. **Behavioral Health Treatment for Pervasive Developmental Disorder or Autism** for Behavioral Health Treatment, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore to the maximum extent practicable, the functioning of an Insured Person diagnosed with the pervasive developmental disorder or autism.

The Treatment must be prescribed by a licensed Physician or developed by a licensed psychologist and must be provided under a documented treatment plan prescribed, developed and approved by a Qualified Autism Service Provider providing Treatment to the Insured Person for whom the treatment plan was developed. The Treatment must be administered by the Qualified Autism Service Provider, or by Qualified Autism Service Professionals and Paraprofessionals who are supervised by the treating Qualified Autism Service Provider or Qualified Autism Service Professional.

A licensed Physician or licensed psychologist must establish the diagnosis of pervasive development disorder or autism.

As used in this benefit:

- a) Behavioral Health Treatment means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.
- b) Qualified Autism Service Paraprofessional means an unlicensed and uncertified individual who meets all of the following criteria:
 - (1) Is supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice.
 - (2) Provides Treatment and implements services pursuant to a Treatment plan developed and approved by the Qualified Autism Service Provider.
 - (3) Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.
 - (4) Has adequate education, training and experience, as certified by a Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers.
 - (5) Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the Autism Treatment Plan.
- c) Qualified Autism Service Professional means an individual who meets all of the following criteria:
 - (1) Provides Behavioral Health Treatment which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider.
 - (2) Is supervised by a Qualified Autism Service Provider.
 - (3) Provides Treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider.
 - (4) Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an associate behavior analyst, behavior management assistant, behavior management consultant, or behavior management program.
 - (5) Has training and experience in providing services for pervasive development disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.
 - (6) Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the Autism Treatment plan.

Qualified Autism Service Provider means a person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides Treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.

4. **Dental Anesthesia** for general anesthesia and associated facility charges for dental procedures rendered in a Hospital or Ambulatory Surgical Center setting, when the clinical status or underlying medical condition requires dental procedures that ordinarily would not require general anesthesia to be rendered in a Hospital or Ambulatory Surgical Center. Benefits will be provided for:
 - a) Insured Persons who are under 7 years of age;
 - b) Insured Persons who are developmentally disabled, regardless of age; and
 - c) Insured Persons whose health is compromised and for whom general anesthesia is Medically Necessary, regardless of age.

Charges for the dental procedure itself (including the professional fee of the dentist) are not covered.

5. **Mastectomy Benefit** for inpatient care following a mastectomy and inpatient care following a lymph node dissection for the Treatment of breast cancer. The length of Hospital stay associated with these procedures will be determined by the attending Physician and surgeon in consultation with the Insured Person, post-surgery, consistent with sound clinical principles and processes. We will also pay the expenses incurred for reconstructive breast surgery performed as a result of a partial or total mastectomy. Because breasts are a paired organ, any such reconstructive breast surgery shall include coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with a diseased breast when reconstructive surgery on the diseased breast is performed.

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, as well as coverage for all complications in all stages of mastectomy, including lymphadema. Breast prostheses are covered following a mastectomy. Please refer to the Durable Medical Equipment provision for more information. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and reconstruction, subject to the approval of the treating Physician.

6. **Pediatric Asthma Services** for the management and Treatment of pediatric asthma. Prescription Drug Treatment is covered as stated in the Formulary. Inhaler spacers and peak flow meters used for the management and Treatment of asthma are covered when Medically Necessary. Nebulizers (including face masks and tubing) are covered under Durable Medical Equipment.
7. **Special Shoe Benefit** for special footwear as needed by an Insured Persons who suffer from foot disfigurement, including disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by Accident or development disability. When Medically Necessary, benefits are payable for orthotics (braces, boots, splints) for foot disfigurements form bone deformity, motor impairment, paralysis, or amputation.

SECTION VI - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

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

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

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

SECTION VII - EXCLUSIONS AND LIMITATIONS

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

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

1. **International Students Only** - Eligible expenses incurred within Your Home Country or country of origin or medical Treatment that is available under any governmental or national health plan except when a charge is made which You are required to pay.

2. Treatment, service or supply which is not Medically Necessary for the diagnosis, care or treatment of the sickness or injury involved. This applies even if they are prescribed, recommended or approved by the Student Health Center or by Your attending Physician or dentist.
3. Medical services rendered by a provider employed for or contracted with the Policyholder, including team Physicians or trainers, except as specifically provided in the Schedule of Benefits or as part of the Student Health Center benefits provided by this plan.
4. Professional services rendered by an Immediate Family Member or anyone who lives with You.
5. 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.
6. Infertility treatment (male or female)-this includes but is not limited to:
 - Procreative counseling;
 - Premarital examinations;
 - Genetic counseling and genetic testing;
 - Impotence, organic or otherwise;
 - Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
 - In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
 - Costs for an ovum donor or donor sperm;
 - Ovulation induction and monitoring;
 - Artificial insemination;
 - Hysteroscopy;
 - Laparoscopy;
 - Laparotomy;
 - Ovulation predictor kits;
 - Reversal of tubal ligations;
 - Reversal of vasectomies;
 - Costs for and relating to surrogate motherhood (maternity services are Covered for 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.
7. Expenses paid by any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medi-Cal, or outside of California, Medicaid.
8. 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.
9. Any expenses in excess of Usual and Customary Charges except where noted and as provided in the Certificate.
10. 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.
11. Services that are duplicated when provided by both a licensed midwife and a Physician.
12. Expenses payable under any prior policy which was in force for the person making the claim.
13. 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.
14. Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
15. Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
16. 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.
17. Treatment for obesity except surgery for morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat.
18. Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
19. Expenses for radial keratotomy.
20. Adult Vision care.

21. 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 unless otherwise covered under the Pediatric Vision Care Benefit.
22. Charges for hearing screening, hearing aids and the fitting or repair or replacement of hearing aids except as specifically provided in the Certificate.
23. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma, or otherwise covered under the Gender Transition Services Benefit.
24. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
25. Extraction of impacted wisdom teeth or dental abscesses.
26. You are:
 - committing or attempting to commit a felony, or
 - engaged in an illegal occupation.
27. Custodial Care service and supplies.
28. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
29. Services of private duty Nurse except as provided in the Certificate.
30. Expenses that are not recommended and approved by a Physician as defined in the Certificate.
31. Physician's charges for diagnosis and treatment of structural imbalance, distorting or subluxation in vertebral column or elsewhere in body by manual, mechanical means, through muscular-skeletal adjustments, manipulations, and related modalities or except as specifically covered under the Certificate.
32. 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 unless such animal or artificial organs or tissues are approved and generally accepted for use.
33. 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 in the Certificate for more information.
34. Under the Prescription Drug Benefit shown in the Schedule of Benefits in the Certificate:
 - 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;
 - Any drug or medicine for the purpose of weight control;
 - Fertility drugs, except as provided under the Fertility Preservation Expense Benefit;
 - 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;
 - Immunology products.
35. Non-chemical addictions.
 36. Non-physical, occupational, speech therapies (art, dance, etc.).
 37. Modifications made to dwellings.
 38. General fitness, exercise programs.
 39. Hypnosis, holistic medicine, homeopathy, aroma therapy, reiki therapy, herbal, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
 40. Rolfing.
 41. Biofeedback.

Third Party Refund - When:

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

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

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

COORDINATION OF BENEFITS

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

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

DEFINITIONS

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

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

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

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

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

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

- A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
- B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the Policyholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network Provider benefits.

- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, Policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two (2) Plans is reversed so that the Plan covering the person as an employee, member, Policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
 2. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
 - a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
 - ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), We will follow the rules of that plan.
 - b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - i. If a court decree states that one (1) of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
 - iii. If a court decree states that the parents have joint custody without specifying that 1 parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
 - iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The Plan covering the Custodial parent;
 - The Plan covering the spouse of the Custodial parent;
 - The Plan covering the non-custodial parent; and then
 - The Plan covering the spouse of the non-custodial parent.
 - c. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
 - d.
 - a. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.
 - b. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.
 3. Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

4. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
5. Longer or shorter length of coverage. The Plan that covered the person as an employee, member, Policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

SECTION VIII - GENERAL PROVISIONS

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

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

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

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

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

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.

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.

Dispute Resolution: Should a dispute arise concerning the policy or the payment of a claim hereunder, You should contact Us in writing at:

HealthComp
621 Santa Fe Avenue
Fresno, CA 93721
(833) 302-9785

If a dispute is not resolved to Your satisfaction, You may contact the **Consumer Services Division of the California Department of Insurance at 300 S. Spring Street, Los Angeles, CA 90013 or by phone at 1-800-927-HELP (1-800-927-4357); TDD: 800-482-4TDD (4833), www.insurance.ca.gov.**

SECTION IX - ADDITIONAL PROVISIONS

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

SECTION X – APPEALS PROCEDURE

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

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

For purposes of this Section, the following definitions apply:

Adverse Benefit Determination means:

- A determination by Us or Our designee Utilization review organization that, based upon the information provided, a request for a benefit under the Policy upon application of any utilization review technique does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be Experimental or Investigative and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;

- The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by Us or Our designee Utilization review organization of Your eligibility under the Policy;
- Any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit; or
- A rescission of coverage.

Authorized Representative means:

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

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

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

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

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

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

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

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

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

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

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

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

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

Step 1:

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

Type of Claim	You will be notified by Us that a claim is denied as soon as possible but no later than:	Extension period allowed for circumstances beyond Our control:	If additional information is needed, You must provide within:
Pre-Service Claim	15 days from receipt of claim (whether adverse or not)	One extension of 15 days	45 days of date of extension notice
Pre-Service Claim involving Urgent Care	72 hours from receipt of claim (whether adverse or not) (24 hours after receipt of claim if additional information is needed from You)	None	48 hours (We must notify You of determination within 48 hours of receipt of Your information)
Concurrent: To end or reduce Treatment prematurely (other than by policy amendment or termination) Pending the outcome of an appeal, benefits for an ongoing course of Treatment will not be reduced or terminated.	Notification to end or reduce Treatment will allow sufficient time in advance to allow You to appeal and obtain a determination on the adverse benefit determination prior to the end or reduction of prescribed Treatment	N/A	N/A
Concurrent: To deny Your request to extend Treatment	30 days from receipt of claim for Pre-Service Claim; or 60 days from receipt of claim for Post-Service Claim	On extension of 15 days	45 days of the date of extension notice
Concurrent: Involving Urgent Care	72 hours from receipt of claim (whether adverse or not) (24 hours after receipt of claim if additional information is needed from You; or 24 hours after receipt of claim provided that any such claim is made at least 24 hours prior to the end or reduction of prescribed Treatment)	None	48 hours (We must notify You of determination within 48 hours of receipt of Your information)

Post-Service Claim	30 days from receipt of claim	One extension of 15 days	45 days of the date of extension notice
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Once You have received notice from Us, You should review it carefully. The notice will contain:

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

INTERNAL APPEAL

Step 2:

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

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

Appeals should be sent to:
Wellfleet Insurance Company
Attention: Appeals Unit
HealthComp
621 Santa Fe Avenue
Fresno, CA 93721
(833) 302-9785

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

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

Step 3:

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

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

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

STANDARD EXTERNAL REVIEW

Within 6 months after the date of receipt of a notice of an Adverse Benefit Determination, You may file a request for an external review with Us or the California Commissioner of Insurance.

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

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

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

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

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

- We waive the Internal Appeal process;
- You have an Urgent Care situation or a claim that involves ongoing Treatment. In these situations, You may have Your claim go through the External Review at the same time as the Internal Appeal process; and

- We did not follow all of the State or Federal claim determination and appeal requirements. However, You will not be able to proceed directly to an External Review if:
 - The rule violation was minor and not likely to influence a decision or harm You;
 - The violation was for a good cause or a matter beyond Our control;
 - The violation was part of an ongoing good faith exchange of information between You and Us.

Within 1 business day of making a determination, You will be notified if the external review request is denied and You will be provided with: (1) the reasons why the claim is initially ineligible for external review; or (2) the information or materials needed for a complete request. In the event Your request is denied due to lack of information or materials, You must perfect Your claim by the later of the end of the 6-month period following the final internal Adverse Benefit Determination or 48 hours following notification that Your request for external review was denied.

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

EXPEDITED EXTERNAL REVIEW

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

IMPORTANT INFORMATION

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

CONTACT INFORMATION

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

Wellfleet Insurance Company

Attention: Appeals Unit

HealthComp

621 Santa Fe Avenue

Fresno, CA 93721

(833) 302-9785

**California Department of Insurance
Health Claims Bureau, IMR Unit
300 S. Spring Street
11th Floor
Los Angeles, CA 90013**

**Inside State Toll-Free: 1-800-927-4357
Outside State: 1-213-897-8921**

**Fax: 1-213-897-9641
TDD: 1-800-482-4833
www.insurance.ca.gov**

Wellfleet Insurance Company
5814 Reed Road
Fort Wayne, IN 46835
877-657-5030

Notice of Availability of Language Assistance Services

Wellfleet Insurance Company does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Wellfleet Insurance Company:

- Provides free language assistance services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

- Provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified interpreters
 - Information in other formats

If you need these services, please contact Wellfleet Insurance Company.

If you believe Wellfleet Insurance Company has failed to provide these services or discriminated in another way, you can file a complaint with:

- c/o Wellfleet Group, LLC dba Wellfleet Administrators, LLC
877-657-5030
413-244-7761
appeals@wellfleetinsurance.com

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, our appeals unit is available to help you.

You can also submit a complaint to the Department of Insurance for review:

Wellfleet Insurance Company
5814 Reed Road
Fort Wayne, IN 46835
877-657-5030

- Electronically, through the Department of Insurance Consumer Complaint Center at <https://cdiapps.insurance.ca.gov/CP/login/>; or
- By printing a complaint form to mail to:
 - California Department of Insurance
Consumer Services Division
300 S. Spring Street
Los Angeles, CA 90013
Inside State Toll-Free: 1-800-927-4357
Outside State: 1-213-897-8921
Fax: 1-213-897-9641
TDD: 1-800-482-4833
- The complaint form is available at http://www.insurance.ca.gov/01-consumers/101-help/upload/CSD002RFAHealth20151224_092616.pdf.

You can also file a discrimination complaint with the U.S. Department of Health and Human Services, Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex:

- 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, D.C. 20201
Phone: 1-800-368-1019
TDD: 800-537-7697
- Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, an individual is covered by the Association if the insurer was a member of the Association and the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payee or assignees, whether or not they live in California.

Amounts of Coverage

The basic coverage protections provided by the Association are as follows.

Life Insurance, Annuities and Structured Settlement Annuities

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

Life Insurance

- 80% of death benefits but not to exceed \$300,000
- 80% of cash surrender or withdrawal values but not to exceed \$100,000

Annuities and Structured Settlement Annuities

- 80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not exceed \$250,000

The maximum amount of protection provided by the Association to an individual, for all life insurance, annuities and structured settlement annuities is \$300,000, regardless of the number of policies or contracts covering the individual.

Health Insurance

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is \$546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- 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 certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance Guarantee Association	California Department of Insurance Consumer Communications Bureau
P.O Box 16860, Beverly Hills, CA 90209-3319	300 South Spring Street Los Angeles, CA 90013
(323) 782-0182	(800) 927- 4357

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

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, “ we”, “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 compiled 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 ACCESSIBILITY 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.

میںینت: اذا تنك تحدثت **بالتیبرعلا (Arabic)**، نإف تامدخ ددعاسملا تیوغللا تیناجملما تحاتمكلا. عاجرلا لاصتلاً ب (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)**, udostępniłmy 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。

ی سراف امشد نابز رگا: موجود (Farsi) دشاب ی م امشد رایتخا رد ن انگیار روط هج ی نابز دادما تامدخ، تسا. (877) 657-5030 تمس یا بیگرید.

कृपा ध्या दः यद आप हंद (Hindi) भाषी ह तो आपके लए भाषा सहायता सेवाएंनःशुल् उपलब् ह। कृपा पर काल कर (877) 657-5030

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

ប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ(Khmer) 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.

DÍI 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 kohjí' (877) 657-5030 hodílnih.

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

ગુજરાતી (Gujarati) યુ ના: જો તમે જરાતી બોલતા હો, તો િન:લુ ભાષા સહાય સેવાઓ તમારા માટ 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 አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በገዳ ሊያገዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደው(877) 657-5030

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

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