AMERICAN COLLEGIATE
Los Angeles

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2021/2022

DESIGNED EXCLUSIVELY FOR THE STUDENTS

AMERICAN COLLEGIATE, LOS ANGELES

Los Angeles, CA ("the Policyholder")
Group Number: ST1464SH
Fall Policy Number: WI2122CASHIP166-00
Fall Annual Effective: 9/6/2021– 9/5/2022
Winter Policy Number: WI2122CASHIP166-01
Winter Annual Effective: 12/20/21 – 12/19/2022
Spring Policy Number: WI2122CASHIP166-02
Spring Annual Effective: 3/14/2022– 3/13/2023
Summer Policy Number: WI2122CASHIP166-03
Summer Annual Effective: 6/6/2022 – 6/5/2023

UNDERWRITTEN BY:
Wellfleet Insurance Company | Fort Wayne, IN
("the Company")

ADMINISTERED BY:
Wellfleet Group, LLC. dba Wellfleet Administrators, LLC

WELLFLEET STUDENT

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Welcome Students…

We are pleased to provide you with this summary of the 2021 – 2022 Student Health Insurance Plan ("Plan"), which is fully compliant with the Affordable Care Act. "Benefits at a Glance" includes effective dates and costs of coverage, as well as other helpful information. For additional details about the Plan, please consult the Plan Certificate and other materials at **www.wellfleetstudent.com**. If you have questions about Enrollment into the Plan, please call University Health Plans at (800) 437-6448 **www.universityhealthplans.com/acla**. For questions about medical benefits or claims, please call Wellfleet Student at (877) 657-5030, TTY 711.

Where to Find Help

For Questions About:	Please Contact:
Servicing Agent **Enrollment**	**University Health Plans** **15 Pacella Park Drive, Suite 130** **Randolph, MA 02368** **www.universityhealthplans.com/acla** (800) 437-6448
Insurance Benefits **Claims Processing** **ID Cards** **Preferred Provider Listings**	**Wellfleet Group, LLC dba Wellfleet Administrators, LLC** **PO Box 15369** **Springfield, Massachusetts 01115-5369** **(877) 657-5030, TTY 711** **www.wellfleetstudent.com**
Preferred PPO Provider Listings **Cigna Claims**	**Wellfleet Student** **www.wellfleetstudent.com** or **www.cigna.com** **Send Cigna claims to:** **CIGNA** **PO Box 188061** **Chattanooga, TN 37422 – 8061** **Electronic Payor ID: 62308**
Prescription Drug Provider	**For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit www.wellfleetstudent.com** **Your plan includes Wellfleet Rx – offering over 40 generics at a $0 copay. Please ask your health care provider to review our formulary to see if these medications are right for you. Click here http://wellfleetrx.com/students/formularies/ for more information.**

Am I Eligible?

All eligible International students are required to have health insurance coverage and will be automatically enrolled in this health insurance plan and billed the plan costs for the health insurance plan. Eligible students do not have the option to waive coverage.

Insured Students who are enrolled in the Student Health Plan may also enroll their eligible dependents.

How Do I Enroll My Dependents?

To Enroll your eligible dependents:

- Go to **www.universityhealthplans.com/acla**.
- Click the "Enroll" tab and proceed as directed to enroll in and purchase the student health insurance plan.

Refer to the dates below for the deadline to purchase dependent coverage.

Effective Dates & Costs

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

Coverage Period	Coverage Start Date	Coverage End Date	Dependent Enrollment Deadline
Fall Annual	9/6/2021	9/5/2022	9/20/2021
Winter Annual	12/20/2021	12/19/2022	1/1/2022
Spring Annual	3/14/2022	3/13/2023	3/20/2022
Summer Annual	6/6/2022	6/5/2023	6/30/2022

Plan Costs for International Students and their Dependents

	Fall Annual	Winter Annual	Spring Annual	Summer Annual
Student	$2,000	$2,000	$2,000	$2,000
Spouse	$2,000	$2,000	$2,000	$2,000
Each Child	$2,000	$2,000	$2,000	$2,000
3 or more Children	$6,000	$6,000	$6,000	$6,000

***The above plan costs include an administrative service fee.**
The plan costs for Dependents are in addition to the plan costs for student.

Preferred Provider Organization (PPO) Network

…providing access to quality health care at discounted costs!

By enrolling in this Student Health Plan, you have the Cigna PPO Network of participating Providers. To find a complete listing of the Network's participating Providers, go to **www.cigna.com,** or contact Wellfleet Student toll-free at (877) 657-5030, TTY 711, or **www.wellfleetstudent.com** for assistance.

American Collegiate, Los Angeles Schedule of Benefits

This is only a brief description of coverage available under Certificate form CA SHIP CERT (2019). The Certificate will contain full details of coverage, coinsurance, limitations, exclusions, and termination provisions. If there are any conflicts between this document and the Certificate, the Certificate governs in all cases.

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

SCHEDULE OF BENEFITS

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

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

Medical Deductible*	In-Network Provider	Individual:	$100
	Out-of-Network Provider	Individual:	$200

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

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

Out-of-Pocket Maximum:	In-Network Provider	Individual	$2,500
		Family	$5,000
	Out-of-Network Provider	Individual	$5,000
		Family	$10,000

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

Coinsurance Amounts:

In-Network Provider:	90% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below.
Out-of-Network Provider:	70% of the Usual and Customary Charge (U&C) for Covered Medical Expenses unless otherwise stated below.
Student Health Center	100% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below.

***Student Health Center Benefits:**
When Treatment is rendered at the Student Health Center, the Deductible and Copayments will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred.

Medical Benefit Payments for In-Network Providers and Out-of-Network Providers
The Certificate provides benefits based on the type of health care provider You and Your Covered Dependent selects. The 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 the type of service, as shown in the Schedule of Benefits.

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

THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:

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

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Inpatient Benefits		
Hospital Care Includes hospital room & board expenses and miscellaneous services and supplies. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Surgery: Pre-Certification Required Surgeon Services	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Anesthetist Assistant Surgeon	90% of the Negotiated Charge after Deductible for Covered Medical Expenses 90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses 70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Registered Nurse Services for private duty nursing while Confined	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Certification required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Maximum days per Policy Year	120	120
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
INPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
Inpatient Treatment for Mental Health Disorders, including Gender Dysphoria and Behavioral Health Treatment for Pervasive Developmental Disorder or Autism, and Substance Use Disorders. This includes inpatient Psychiatric and Residential Treatment Centers Pre-Certification Required 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.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Outpatient Benefits		
Outpatient Surgery: Pre-Certification required		
Surgeon Services	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Anesthetist	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Assistant Surgeon	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Surgery Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Office Visits For Mental Health and Substance Use Disorder benefit see below under Outpatient Mental Health and Substance Use Disorder	$10 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Specialist/Consultant Physician Services For Mental Health and Substance Use Disorder benefit see below under Outpatient Mental Health and Substance Use Disorder	$10 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telemedicine or Telehealth Services	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Cardiac Rehabilitation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitative Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Maximum Visits for each therapy per Policy Year for Physical Therapy, and Occupational Therapy	30	30
Maximum Visits per Policy Year for Speech Therapy	Unlimited	Unlimited
Habilitative Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitative Services Maximum Visits for each therapy per Policy Year for Physical Therapy, and Occupational Therapy	30	30
Emergency Services in an emergency department (includes Urgent Care for Emergency Medical Conditions).	$50 Copayment per visit then the plan pays 90% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Urgent Care Centers for non-life-threatening conditions	$10 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diagnostic Imaging Services Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Infusion Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Pre-Certification required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hospice Care Coverage	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
OUTPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
For the Treatment of Mental Health Disorders, including Gender Dysphoria and Behavioral Health Treatment for Pervasive Developmental Disorder or Autism, and Substance Use Disorders. <u>Outpatient Services, other than Office Visits.</u> Outpatient services includes, but not limited to the following: Intensive Outpatient Programs; Partial Hospitalization, Electronic Convulsive Therapy, Repetitive Transcranial Magnetic Stimulation (rTMS); Psychiatric and Neuro Psychiatric testing; and Gender Dysphoria surgery. See below for Office Visits In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits 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.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
<u>Outpatient Office Visits</u> (including but not limited to the following: physician visits, individual and group therapy, hormone therapy, medication management)	$10 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy or Student Health Center.		
TIER 1 (Including Enteral Formulas) For each fill up to a 30- day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$10 Copayment then the plan pays 100% of the Negotiated Charge for Covered medical Expenses Deductible Waived Copayment waived for Generic Contraceptives and brand-name contraceptives for which there are no therapeutic equivalent. Up to a 12-month supply of contraceptives may be dispensed with a single prescription order.	$10 Copayment then the plan pays 100% of the Actual charge after Deductible for Covered Medical Expenses Copayment waived for Generic Contraceptives and brand-name contraceptives for which there are no therapeutic equivalent. Up to a 12-month supply of contraceptives may be dispensed with a single prescription order.
More than a 30- day supply but less than a 61- day supply filled at a Retail pharmacy	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$20 Copayment then the plan pays 100% of Actual charge after Deductible for Covered Medical Expenses
More than a 60- day supply filled at a Retail pharmacy	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$30 Copayment then the plan pays 100% of Actual charge after Deductible for Covered Medical Expenses
TIER 2 (Including Enteral Formulas) For each fill up to a 30- day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$20 Copayment then the plan pays - 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$20 Copayment then the plan pays 100% of Actual charge after Deductible for Covered Medical Expenses
More than a 30- day supply but less than a 61- day supply filled at a Retail pharmacy	$40 Copayment then the plan pays - 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$40 Copayment then the plan pays 100% of Actual charge after Deductible for Covered Medical Expenses
More than a 60- day supply filled at a Retail pharmacy	$60 Copayment then the plan pays - 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$60 Copayment then the plan pays 100% of Actual charge after Deductible for Covered Medical Expenses

TIER 3 (Including Enteral Formulas) For each fill up to a 30- day supply filled at a Retail Pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$40 Copayment then the plan pays - 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$40 Copayment then the plan pays 100% of Actual charge after Deductible for Covered Medical Expenses
More than a 30- day supply but less than a 61- day supply filled at a Retail pharmacy	$80 Copayment then the plan pays - 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$80 Copayment then the plan pays 100% of Actual charge after Deductible for Covered Medical Expenses
More than a 60- day supply filled at a Retail pharmacy	$120 Copayment then the plan pays - 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$120 Copayment then the plan pays 100% of Actual charge after Deductible for Covered Medical Expenses
Zero Cost Generics		
Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	100% of Actual charge for Covered Medical Expenses Deductible Waived
Specialty Prescription Drugs		
Specialty Prescription Drugs For each fill up to a 30- day supply Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	$40 Copayment then the plan pays - 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$40 Copayment then the plan pays 100% of Actual charge after Deductible for Covered Medical Expenses
More than a 30- day supply but less than a 61- day supply]	$80 Copayment then the plan pays - 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$80 Copayment then the plan pays 100% of Actual charge after Deductible for Covered Medical Expenses

More than a 60- day supply	$120 Copayment then the plan pays - 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$120 Copayment then the plan pays 100% of Actual charge after Deductible for Covered Medical Expenses
Orally administered anti-cancer prescription drugs (including specialty drugs)	Same as any other Prescription Drug. The total amount of copayments and coinsurance an Insured must pay will not exceed $250 for an individual prescription of up to a 30-day supply.	
Diabetic Supplies (for Prescription supplies purchased at a pharmacy)		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill	
Other Benefits		
Allergy Testing	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Allergy Injections/Treatment	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	90% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Non-Emergency Ambulance Service ground and/or air, water transportation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Bariatric Surgery Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Cancer Clinical Trials	Same as any other Covered Sickness	
Durable Medical Equipment Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diabetic services and supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Maternity Benefit	Same as any other Covered Sickness	
Enteral Formulas and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Prosthetic and Orthotic Devices Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Reconstructive Surgery Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19) Diagnostic and preventive care (Type A services) Limited to 1 dental exams every 6 months. *The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care*: Basic Restorative Care (Type B Services) Major Restorative Care (Type C Services) Orthodontic Services (Medically Necessary) Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	See Benefit for limitations 100% of Usual and Customary Charge 80% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge	

Dental benefits are subject to the medical plan's **deductibles** and **maximum out-of-pocket limits** as explained on the schedule of benefits.

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
- 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 Prefabriated 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 apexogensis
- 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 Occlusial analysis
- D9951 Occlusial adjustment - limited
- D9952 Occlusial 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 desentive 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 reline 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

<table>
<tr><td colspan="3">• D8999 Unspecified orthodontic treatment, by report
D8692 Replacement of lost or broken retainer (once per arch)</td></tr>
<tr><td>Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19)

Routine Eye Exams, eyeglasses and/or contact lenses

Optional lenses and treatment

Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.</td><td colspan="2">100% of Usual and Customary Charge after Deductible for Covered Medical Expenses per Policy Year</td></tr>
<tr><td colspan="3">Pediatric Vision Care benefits are subject to the medical plan's deductibles and maximum out-of-pocket
• Pediatric comprehensive low vision evaluations performed by a legally qualified ophthalmologist or optometrist - limited to one vision evaluation every five (5) years; 4 follow up visits in any five year period
• Office Visits to ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
• Eyeglass frames, prescription lenses, including glass or plastic lenses, all lenses power (single, bifocal, trifocal, lenticular), fashion and gradient tinting, ultraviolet protective coating, oversized and glass grey #3 prescription sunglass lenses – limited to one set per plan year
• Prescription contact lenses (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery), limited as follows:
○ Daily disposables: up to 1-year supply
○ Extended Wear disposable: Up to 1-year supply
○ Non-disposable – Up one set per plan year
• Optical Devices – limited to one optical device per plan year

Limitations: We will cover either prescription lenses for eyeglass frames or prescription contact lenses but not both.</td></tr>
<tr><td>Acupuncture Services Expense Benefit (Medically Necessary Treatment) only</td><td>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</td><td>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</td></tr>
<tr><td>Accidental Injury Dental Treatment for Insured Persons over age 18</td><td>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</td><td>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</td></tr>
<tr><td>Chiropractic Care Benefit
Pre-Certification Required</td><td>$10 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses</td><td>80% of Usual and Customary Charge after Deductible for Covered Medical Expenses</td></tr>
<tr><td>Gender Dysphoria Treatment Expenses</td><td colspan="2">See benefits for Mental Health Disorder and Substance Use Disorder</td></tr>
<tr><td>Infertility Treatment
Pre-Certification Required</td><td>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</td><td>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</td></tr>
</table>

Organ Transplant Surgery Pre-Certification Required	Same as any other Covered Sickness	
Shots and Injections unless considered Preventive Services	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Surgical Services Directly Affecting the Upper or Lower Jawbone Benefit	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Tuberculosis (TB) screening, Titers, Quantiferon B tests including shots (other than covered under preventive services)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Student Health Center/Infirmary Expense Benefit	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	
Sports Accident Expense - incurred as the result of the play or practice of club sports	Same as any other Covered Injury	Same as any other Covered Injury
Non-emergency Care While Traveling Outside of the United States	70% of Actual Charge after Deductible for Covered Medical Expenses Subject to $10,000 maximum per Policy Year	
Medical Evacuation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $50,000 maximum per Policy Year	
Repatriation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $25,000 maximum per Policy Year	
Mandated Benefits		
AIDS Vaccine	Same as any other Preventive Service	80% of Usual and Customary Charge for Covered Medical Expenses
Alzheimer's Disease	Same as any other Covered Sickness	
Behavioral Health Treatment for Pervasive Developmental Disorder or Autism	See benefits for Mental Health Disorder and Substance Use Disorder	
Breast Cancer Screening	Same as any other Preventive Service	
Cancer Screening	Same as any other Preventive Service	
Cervical Cancer Screening Benefit	Same as any other Preventive Service	
Contraceptive Methods - Up to a 12-month supply of contraceptives may be dispensed with a single prescription order.	Same as any other Covered Sickness, unless considered a Preventive Service	
Dental Anesthesia	Same as any other Covered Sickness	
Diethylstilbestrol (DES) Coverage	Same as any other Covered Sickness	

HIV Testing	Same as any other Preventive Service
Lead Screening (for Children)	Same as any other Preventive Service
Mammography	Same as any other Preventive Service
Mastectomy Benefit	Same as any other Covered Sickness
Organ Donation Services	Same as any other Covered Sickness
Organ Transplant	Same as any other Covered Sickness
Osteoporosis	Same as any other Preventive Service
Pain Management Medication for Terminally Ill	Same as any other Prescription Drug
Pediatric Asthma Services	Same as any other Covered Sickness
Pediatric Preventive Services	Same as any other Preventive Service
California Prenatal Screening Program	No cost sharing
Prostate Cancer Screening	Same as any other Preventive Service
Special Shoe Benefit	Same as any other Covered Sickness
Prenatal Diagnosis of Genetic Disorders of Fetus	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 the Certificate.

Pre-Certification

Pre-Certification is required for inpatient hospital, surgery and selected outpatient services. Pre-Certification is not required for an Emergency Medical Condition or for a Life Threatening Condition or Urgent Care or Hospital Confinement for the initial 48 hours following vaginal delivery/96 hours following cesarean section of maternity care. Additionally, no authorization requirement will apply to obstetrical or gynecological care provided by In-Network Providers.

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 within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible.
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;
    - Sperm storage costs;
    - Cryopreservation and storage of embryos;
    - Ovulation induction and monitoring;
    - Artificial insemination;
    - Hysteroscopy;
    - Laparoscopy;
    - Laparotomy;
    - Ovulation predictor kits;
    - Reversal of tubal ligations;
    - Reversal of vasectomies;
    - Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
    - Cloning; or
    - Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.
7. Expenses paid by Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medi-Cal.
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 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 certified Nurse-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. 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.
16. Treatment for obesity except surgery for morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat.
17. Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
18. Expenses for radial keratotomy.
19. Adult Vision unless specifically provided in the Certificate.
20. 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.

21. Charges for hearing screening, hearing aids and the fitting or repair or replacement of hearing aids or cochlear implants except as specifically provided in the Certificate.
22. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma, or for gender dysphoria.
23. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
24. Extraction of impacted wisdom teeth or dental abscesses.
25. You are:
    - committing or attempting to commit a felony,
    - engaged in an illegal occupation, or
    - participating in a riot.
26. Custodial Care service and supplies.
27. Charges for hot or cold packs for personal use.
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.
31. 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.
32. Sleep Disorders, unless medically necessary, except for the diagnosis and treatment of obstructive sleep apnea.
33. Treatment of Acne unless Medically Necessary.
34. Experimental or Investigational drugs, devices, treatments or procedures unless otherwise covered under Covered Clinical Trials or covered under clinical trials (routine patient costs). See the Other Benefits section for more information.
35. Under the Prescription Drug Benefit shown in the Schedule of Benefits:
    - 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 the 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;
    - sexual enhancements drugs;
    - 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;
36. Non-chemical addictions.
37. Non-physical, occupational, speech therapies (art, dance, etc.).
38. Modifications made to dwellings.
39. General fitness, exercise programs.
40. Hypnosis.
41. Rolfing.
42. Biofeedback.

Value Added Services

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

VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:

www.wellfleetstudent.com

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

Wellfleet Student provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Wellfleet Student at (877) 657-5030, TTY 711. **If you are traveling and need assistance in North America, call the Assistance Center toll-free at: (877) 305-1966 *or* if you are in a foreign country, call collect at: (715) 295-9311**. When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

24 HOUR NURSELINE

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

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

Appropriate care may include self-care at home, a call to a physician, or a visit to the emergency room.

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

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

(800) 634-7629

CareConnect

Integrated Behavioral Health from Wellfleet Student

With CareConnect from Wellfleet Student, students have 24/7 access to professional assistance to help manage personal concerns, emotional issues, transition and adjustment concerns, academic stress, career development, and the demands of daily and family obligations.

Members in need of assistance simply call the behavioral health hotline on their ID card, **(888) 857-5462**, or via the Wellfleet Student mobile app for immediate access to a masters-level mental health professional. Students are run through a clinical assessment to determine if CareConnect counseling, health center referral, or other treatment is necessary. To access mobile features, students simply download their school's app in their device's app store.