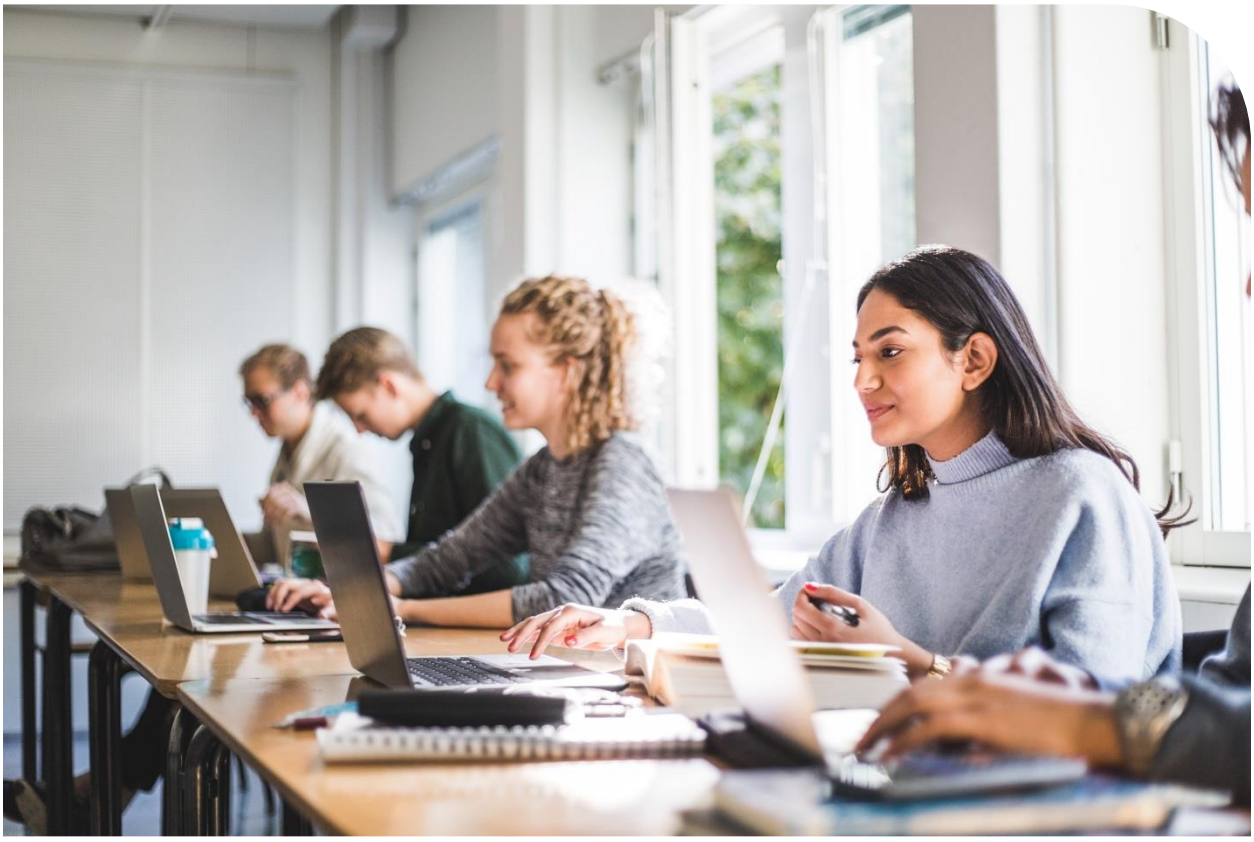
WELLFLEET STUDENT

True Choice Benefits at a Glance

HUSSON UNIVERSITY



Benefits at a Glance

Student Health Insurance Plan

Plan year 2024-2025

Designed exclusively for the students of:

Husson University
Bangor, ME
("the Policyholder")

Policy number: WI2425MESHIPTC02
Group number: ST0857TC
Effective: 8/1/2024 – 7/31/2025

Underwritten by:
Wellfleet Insurance Company
Fort Wayne, IN
("the Company")

Administered by:
Wellfleet Group, LLC

CSR-SHIP-APRIL-2024-20

Welcome Students…

We are pleased to provide you with this summary of the 2024 – 2025 Student Health Insurance Plan ("Plan"), which is fully compliant with the Affordable Care Act. This is only a brief description of the coverage(s) available under Certificate form ME RBP SHIP Cert (2023). The Certificate will contain reductions, limitations, exclusions, and termination provisions. Full details of coverage are contained in the Certificate. If there are any conflicts between this document and the Certificate, the Certificate shall govern in all cases.

"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**.

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

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

Important Contact Information & Resources

Contact Us

Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369
(877) 657-5035, TTY 711

Plan Administration

Enrollment, Eligibility, & Waivers

Cross Insurance
150 Mill Street, Suite 4
Lewiston, ME 04240
www.crossinsurance.com
1-800-537-6444

Benefits, Claim Status, & ID Cards

Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369
(877) 657-5035, TTY 711
CustomerService@wellfleetinsurance.com
www.wellfleetstudent.com

Monday–Thursday, 8:30 a.m. to 7:00 p.m. Eastern Time

Friday, 9:00 a.m. to 5:00 p.m.Eastern Time

Choose the "Help" button in the Wellfleet Student app to talk with our Customer Service team.

Claims

Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369

Pharmacy Benefits Manager

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 healthcare provider to review our formulary to see if these medications are right for you. Click here http://wellfleetrx.com/students/formularies/ for more information.

Member Pharmacy Help

(877) 640-7940

True Choice Provider Information

Under Wellfleet True Choice Plan, members can seek care from **any healthcare provider**. Simply show your Wellfleet ID card. **For additional assistance call toll free at** 1-877-657-5035.

Teladoc®

Your plan includes virtual access to board-certified physicians for Behavioral Health Services by phone, video, or app.

- Scheduled mental health services – 7 days a week
  Register at
  https://www.teladoc.com/wellfleetstudent/

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

Table of Contents

General Information

Am I Eligible

All full-time graduate students enrolled in 6 or more credit hours, and all undergraduate students enrolled in 9 or more credits are eligible.

Students areasked to either elect coverage under the Husson University SHIP or to request a waiver to opt out of insurance.

Note: The Student Health Insurance Plan is not available to fully online programs or non-Bangor Campuses.

Dependents are not eligible.

How Do I Waive/Enroll?

To Waive:

- Go to www.wellfleetstudent.com.
- Search **Husson University**
- Click the waiver tab and proceed as directed. You must fill in all of the required information on the waiver form. If any information is missing, your waiver will not be accepted.
- Click submit and review the information being provided is accurate.
- When your online waiver form is successfully submitted you will receive a confirmation e-mail.

The deadline to waive coverage for Annual coverage is 09/10/2024.

Effective Dates & Costs

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

Coverage Period	Coverage Start Date	Coverage End Date	Waiver Deadline Date/ Dependent Enrollment Deadline Date
Annual	08/01/2024	07/31/2025	09/10/2024
Spring/Summer	01/01/2025	07/31/2025	01/28/2025

Plan Costs for Students

	Annual	Spring/Summer
Student*	$,3,585	$2,084

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

Plan Benefits

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

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

Balance Billing - This plan wor pays claims based on the Maximum Allowance. Some Physicians and Hospitals will accept the Maximum Allowance as payment in full. Other Physicians and Hospitals may bill You for the difference between the Maximum Allowance and the Actual Charges. This is known as balance billing. Balance billing is legal in many states, and We have no control over Physicians and Hospitals that engage in balance billing practices.

Key Plan Benefits

BENEFIT	BENEFIT AMOUNT PAYABLE
Policy Year Deductible Individual	$250
Out-of-Pocket Maximum Individual	$6,500
Coinsurance	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Preventive Services	Benefits are paid at 100% of the Maximum Allowance.
Physician Office Visits including Specialist and Consultant visits *Check below for additional copayments if applicable	$25 Copayment per visit then the plan pays 100% of the Maximum Allowance for Covered Medical Expenses Deductible Waived
Emergency Services in an emergency department for Emergency Medical Conditions.	$100 Copayment per visit after Deductible then the plan pays 75% of the Maximum Allowance for Covered Medical Expenses Copayment waived if admitted .
Urgent Care for non-life-threatening conditions	$25 Copayment per visit then the plan pays 100% of the Maximum Allowance for Covered Medical Expenses Deductible Waived

Schedule of Benefits

THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:

1. **THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
3. **UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE WILL ALWAYS APPLY.**
4. **UNLESS SPECIFIED BELOW, ANY APPLICABLE COPAYMENTS ARE APPLIED AFTER DEDUCTIBLE IS MET.**

BENEFITS FOR COVERED INJURY/SICKNESS	BENEFIT AMOUNT PAYABLE
INPATIENT SERVICES	
Hospital Care Includes Hospital Room and Board Expenses and Hospital Miscellaneous Expenses. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Certification Required	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Preadmission Testing	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Physician's Visits while Confined	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Certification Required	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER BENEFITS In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-certification requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.	
Inpatient Mental Health Disorder and Substance Use Disorder Benefit Pre-Certification Required	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Outpatient Mental Health Disorder and Substance Use Disorder Benefit Physician's Office Visits including, but not limited to, Physician visits; individual and group therapy; medication management	$25 Copayment per visit then the plan pays 100% of the Maximum Allowance for Covered Medical Expenses Deductible Waived

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	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
PROFESSIONAL AND OUTPATIENT SERVICES	
Surgical Expenses	
Inpatient and Outpatient Surgery includes: Pre-Certification Required Surgeon Services Anesthetist Assistant Surgeon	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Outpatient Surgical Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Abortion Expense	100% of the Maximum Allowance Deductible Waived, if applicable
Bariatric Surgery Pre-Certification Required	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Organ Transplant Surgery travel and lodging expenses a maximum of $2,000 per Policy Year or$250 per day, whichever is less while at the transplant facility. Pre-Certification Required	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Human Leukocyte Antigen Testing	Paid at 100% of Maximum Allowance. Deductible Waived. Subject to once per lifetime for Antigen testing laboratory fees
Reconstructive Surgery Pre-Certification Required	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Other Professional Services	
Gender Affirming Treatment Benefit Pre-Certification Required	75% of the Maximum Allowance after Deductible for Covered Medical Expenses

Home Health Care Expenses Pre-Certification required	75%of the Maximum Allowance after Deductible for Covered Medical Expenses
Hospice Care Coverage	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Office Visits	
Physician's Office Visits including Specialists/Consultants	$25 Copayment per visit then the plan pays 100% of the Maximum Allowance for Covered Medical Expenses Deductible Waived
Telemedicine or Telehealth Services	$25 Copayment per visit then the plan pays 100% of the Maximum Allowance for Covered Medical Expenses Deductible Waived
Acupuncture Services (Medically Necessary Treatment only)	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Acupuncture Services Maximum visits per Policy Year	30
Allergy Testing and Treatment, including injections	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Chiropractic Care Benefit	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Maximum visits per Policy Year	40
Tuberculosis screening (TB), Titers, QuantiFERON B tests including shots (other than covered under Preventive Services)	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
EMERGENCY SERVICES, AMBULANCE AND NON-EMERGENCY SERVICES	
Emergency Services in an emergency department for Emergency Medical Conditions.	$100 Copayment per visit after deductible then the plan pays 75% of the Maximum Allowance for Covered Medical Expenses Copayment waived if admitted
Urgent Care Centers for non-life-threatening conditions	$25 Copayment per visit then the plan pays 100% of the Maximum Allowance for Covered Medical Expenses Deductible Waived
Emergency Ambulance Service ground and/or air, water transportation	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Non-Emergency Ambulance Expenses ground and/or air (fixed wing) transportation Pre-Certification Required for non-emergency air Ambulance (fixed wing)	75% of the Maximum Allowance after Deductible for Covered Medical Expenses

DIAGNOSTIC LABORATORY, TESTING AND IMAGING SERVICES	
Diagnostic Imaging Services Pre-Certification Required	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Certification Required	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
REHABILITATION AND HABILITATION THERAPIES	
Cardiac Rehabilitation	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Cardiac Rehabilitation Maximum Visits per Policy Year	60
Pulmonary Rehabilitation	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation Maximum Visits per Policy Year	60
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Rehabilitation Therapy Maximum Visits for each therapy per Policy Year for Physical Therapy, and Occupational Therapy and Speech Therapy Combined with Habilitation Services Therapy The Maximum Visits do not apply to Rehabilitation Therapy for a Mental Health Disorder or Substance Use Disorder.	30
Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy	75% of the Maximum Allowance after Deductible for Covered Medical Expenses

Habilitation Services Maximum Visits for each therapy per Policy Year for Physical Therapy, and Occupational Therapy and Speech Therapy Combined with Rehabilitation Therapy The Maximum Visits do not apply to Habilitation Services for a Mental Health Disorder or Substance Use Disorder.	30
OTHER SERVICES AND SUPPLIES	
Covered Clinical Trials	Same as any other Covered Sickness
Diabetic Services and Supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Dialysis Treatment	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Durable Medical Equipment Pre-Certification Required	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Enteral Formulas and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Hearing Aids One hearing aid per affected ear every 36 months	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Infertility /Fertility Preservation Treatment Benefits Pre-Certification Required	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness
Prosthetic and Orthotic Devices Pre-Certification Required	75% of the Maximum Allowance after Deductible for Covered Medical Expenses

Prosthetic Devices (Arm and Leg) Pre-Certification Required	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Accidental Injury Dental Treatment	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Sickness Dental Expense Benefit	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Anesthesia and Facility Charges for Dental Procedures	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Dental Care for Cancer Patients	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Sports Accident Expense Benefit - incurred as the result of the play or practice of Intercollegiate sports or club sports Pre-Certification not Required	75% of the Maximum Allowance after Deductible for Covered Medical Expenses
Non-emergency Care While Traveling Outside of the United States	55% of Actual Charge for Covered Medical Expenses Subject to $10,000 maximum per Policy Year
Medical Evacuation Expense	100% of Actual Charge for Covered Medical Expenses Subject to $50,000 maximum per Policy Year. Deductible Waived
Repatriation Expense	100% of Actual Charge for Covered Medical Expenses Subject to $25,000 maximum per Policy Year. Deductible Waived
MANDATED BENEFITS	
Breast Reduction/Varicose Vein Surgery	Same as any other Covered Sickness
Children's Early Intervention	Same as any other Covered Sickness
Prostate Cancer Screening	Same as any other Covered Sickness, unless considered a Preventive Service
Diagnostic Breast Examination	100% of the Maximum Allowance. If applicable, Deductible waived
Pasteurized Donated Human Breast Milk	Same as any other Covered Sickness

Infant Formula	Same as any other Covered Sickness
Accidental Death and Dismemberment	
Principal Sum	$10,000
Loss must occur within 365 days of the date of a covered Accident.	
Only one benefit will be payable under this provision, that providing the largest benefit, when more than one (1) Loss occurs as the result of any one (1) Accident. This benefit is payable in addition to any other benefits payable under this Certificate.	

Exclusions and Limitations

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

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

General Exclusions

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

- Expenses incurred after:
  - The date insurance terminates as to an Insured Person, except as specified in the extension of benefits provision; and
  - The end of the Policy Year specified in the Policy.
- Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
- You are:
  - committing or attempting to commit a felony,
  - engaged in an illegal occupation, or
  - participating in a riot.
- Custodial Care service and supplies.
- Charges for hot or cold packs for personal use.
- Services of private duty Nurse except as provided in the Certificate.
- Expenses that are not recommended and approved by a Physician.
- Experimental or Investigative drugs, devices, Treatments or procedures unless otherwise covered under Covered Clinical Trials. See the Other Benefits section for more information.
- Routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal or artificial organs or tissues.
- Loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
- Non-chemical addictions.
- Non-physical, occupational, speech therapies (such as art, dance, drama, horticulture, music, writing, etc.).
- Modifications made to dwellings.
- General fitness, exercise programs.
- Hypnosis.
- Rolfing.
- Biofeedback.
- Sleep Disorders, except for a sleep study performed in the Insured Person's home, the diagnosis, and Treatment of obstructive sleep apnea.
- Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary because of Injury, infection or disease.

Activities Related

- Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.

Racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles).

Weight Management/Reduction

- Weight management. Weight reduction. Nutrition programs. This does not apply to nutritional counseling, or any screening or assessment specifically provided under the Preventive Services benefit, or otherwise

specifically covered under the Certificate.
- Treatment for obesity except surgery for morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat.

Family Planning
- Infertility Treatment (male or female)-this includes but is not limited to:
  - Procreative counseling;
  - Premarital examinations;
  - Genetic counseling and genetic testing;
  - Impotence, organic or otherwise;
  - Costs for an ovum donor or donor sperm;
  - Ovulation predictor kits;
  - Reversal of tubal ligations;
  - Reversal of vasectomies;
  - Costs for and relating to surrogate motherhood (maternity services are covered for Insured Persons acting as surrogate mothers);
  - Cloning; or
  - Medical and surgical procedures that are Experimental or Investigative, unless Our denial is overturned by an External Appeal Agent.

Hearing
- Charges for hearing exams, hearing screening, or cochlear implants except as specifically provided in the Certificate.

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

ADDITIONAL BENEFITS
PEDIATRIC DENTAL SERVICES
SCHEDULE OF BENEFITS

PEDIATRIC DENTAL	
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)	See the Dental Care Schedule of Benefits below and Pediatric Dental Care Benefits description for further information.
Type A – Basic Services Preventive Dental Care Limited to 1 dental exam every 6 months	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived
The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care:	
Type B – Intermediate Services	70% of Usual and Customary Charge for Covered Medical Expenses
Type C – Major Services	50% of Usual and Customary Charge for Covered Medical Expenses
Type D: Medically Necessary Orthodontic Services	50% of Usual and Customary Charge for Covered Medical Expenses
General Services	50% of Usual and Customary Charge for Covered Medical Expenses
Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	Deductible Waived

Dental Care Schedule of Benefits

Type A – Basic Services

<u>Diagnostic and Treatment Services</u>
Periodic oral evaluation - Limited to 1 every 6 months
Limited oral evaluation - problem focused - Limited to 1 every 6 months
Comprehensive oral evaluation - Limited to 1 every 6 months
Comprehensive periodontal evaluation - Limited to 1 every 6 months
Intraoral – complete set of radiographic images including bitewings - 1 every 60 (sixty) months
Intraoral - periapical radiographic image
Intraoral - additional periapical image
Intraoral - occlusal radiographic image
Extraoral – Each Additional Radiographic Image
Bitewing - single image Adult - 1 set every calendar year/Children - 1 set every 6 months
Bitewings - two images - Adult - 1 set every calendar year/Children - 1 set every 6 months

Bitewings - four images - Adult - 1 set every calendar year/Children - 1 set every 6 months
Vertical bitewings – 7 to 8 images – Adult - 1 set every calendar year/Children - 1 set every 6 months
Panoramic radiographic image – 1 image every 60 (sixty) months
Cephalometric radiographic image
2D Oral / Facial Photographic Images-obtained intraorally and extraorally
3D photographic image
Interpretation of Diagnostic Image
Lab test
Collect & Prep Genetic Sample-1 per lifetime
Genetic Test-Specimen Analysis-1 per lifetime
Diagnostic Models

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

Additional Procedures Covered as Basic Services
Palliative treatment of dental pain – minor procedure
Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)
Consultation With Medical Professional
Office Visit- after regularly scheduled hours

Type B – Intermediate Services

Minor Restorative Services
Amalgam - one surface, primary or permanent
Amalgam - two surfaces, primary or permanent
Amalgam - three surfaces, primary or permanent

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

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

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

Prosthodontic Services
Adjust complete denture – maxillary
Adjust complete denture – mandibular
Adjust partial denture – maxillary
Adjust partial denture - mandibular

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

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

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

Type C – Major Services

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

Endodontic Services
Anterior root canal (excluding final restoration)

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

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

Full mouth debridement to enable comprehensive evaluation and diagnosis– Limited to 1 per lifetime

Prosthodontic Services

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

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

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

Type D – Medically Necessary Orthodontic Services

Orthodontia Services

Limited orthodontic treatment of the primary dentition
Limited orthodontic treatment of the transitional dentition
Limited orthodontic treatment of the adolescent dentition
Limited orthodontic treatment of the adult dentition

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

Type D – General Services

Anesthesia Services
Deep sedation/general anesthesia-first 15 minutes
Deep sedation/general anesthesia - each 15 minute increment
Intravenous Sedation
Intravenous moderate (conscious) sedation/analgesia-first 15 minutes
Intravenous moderate (conscious) sedation/analgesia-each 15 minute increment
Medications
Therapeutic drug injection, by report
Infiltration of a sustained release therapeutic drug-single or multiple sites
Post Surgical Services
Treatment of complications (post-surgical) unusual circumstances, by report

Pediatric Dental Benefits

EXCLUSIONS

- Any expenses in excess of the Usual and Customary Charge.
- Adult Dental Care
- Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric and Adult Dental Care Benefit.
- Services and treatment resulting from Your failure to comply with professionally prescribed treatment;
- Any charges for failure to keep a scheduled appointment;
- Any service charges for personalization or characterization of prosthetic dental appliances;
- Office infection control charges;
- Duplicate, provisional and temporary devices, appliances, and services;
- Plaque control programs, oral hygiene instruction, and dietary instructions;
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
- Gold foil restorations;
- Charges by the provider for completing dental forms;
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;
- Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Sealants for teeth other than permanent molars;

- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Replacement of dentures that have been lost, stolen or misplaced;
- Medically Necessary orthodontic services provided to a Covered Person who has not met any applicable waiting period requirement.
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliances;
- Fabrication of athletic mouth guard;
- Internal bleaching;
- Nitrous oxide;
- Oral sedation;
- Topical medicament center
- Bone grafts when done in connection with extractions, apicoetomies or non-covered/non eligible implants.
- Treatment and periodically adjusted);
- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

PEDIATRIC VISION SERVICES

SCHEDULE OF BENEFITS

PEDIATRIC VISION	
Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19) Limited to 1 vision examination per Policy Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived

Pediatric Vision Benefits

EXCLUSIONS

- Expenses for radial keratotomy.
- Any expenses in excess of the Usual and Customary Charge;
- Adult Vision Care.
- 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.

PRESCRIPTION DRUG EXPENSE BENEFIT

SCHEDULE OF BENEFITS

PRESCRIPTION DRUGS		
Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy. Your benefit is limited to a 30 day supply. Coverage for more than a 30 day supply only applies if the smallest package size exceeds a 30 day supply. See "Retail Pharmacy Supply Limits" section for more information.		
BENEFITS FOR COVERED INJURY/SICKNESS	**IN-NETWORK**	**OUT-OF-NETWORK**
TIER 1 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$20 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
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.	$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 for Covered Medical Expenses Deductible Waived

TIER 3 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail Pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$60 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
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.	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$60 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
Prescription Mail Order Drugs		
TIER 1 For each fill up to a 30 day supply filled at a Mail Order 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.	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$20 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
TIER 2 For each fill up to a 30 day supply filled at a Mail Order pharmacy	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	$30 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses

Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	Deductible Waived	Deductible Waived
TIER 3 For each fill up to a 30 day supply filled at a Mail Order 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.	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$60 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
Zero Cost Drugs		
Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	100% of Actual Charge for Covered Medical Expenses Deductible Waived
Orally administered anti-cancer Prescription Drugs (including Specialty Drugs)		
Benefit	Greater of: • Chemotherapy Benefit; or • Infusion Therapy Benefit	
Diabetic Supplies (for prescription supplies purchased at a pharmacy)		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill except, that the Insured Person's out-of-pocket costs for covered prescription insulin drugs will not exceed $30 per 30-day supply regardless of the amount or type of insulin that is needed to fill the Insured Person's prescription.	

EXCLUSIONS AND LIMITATIONS

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

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.

Telehealth Service

Teladoc Health® gives you 24/7 access to board-certified physicians for Behavioral Health services. Whether you are at school, home, or traveling, Teladoc can diagnose and treat most minor medical conditions wherever and whenever you need treatment.

Register your account today and request a visit at https://www.teladochealth.com/benefits/wellfleetstudent or call (800)-Teladoc (835-2362).

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) 657-5035, TTY 711.

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

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

How to Access Services

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

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

Please provide the following information when you call:

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

24 Hour Nurseline

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

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

Appropriate care may include:

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

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

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

CareConnect
Integrated Behavioral Health from Wellfleet Student

24/7 Behavioral Telehealth and Nurseline Access

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

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