CONNECTICUT COLLEGE

# BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2023/2024

**DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:**

**CONNECTICUT COLLEGE**
**New London, CT**
**("the Policyholder")**

**Policy Number: WI2324CTSHIP52**

**Group Number: ST1030SH**

**Effective: 8/15/2023 - 8/14/2024**

**UNDERWRITTEN BY:**

Wellfleet Insurance Company | Fort Wayne, IN

("the Company")

**ADMINISTERED BY:**

Wellfleet Group, LLC

WELLFLEET STUDENT

## Welcome Students…

We are pleased to provide you with this summary of the 2023 – 2024 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 CT 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 at the website listed on the cover. In the case of a discrepancy between two versions of the Summary, the most recent will apply.

# Important Contact Information & Resources

## Contact Us

Wellfleet Group, LLC
PO Box 15369
Springfield, Massachusetts 01115-5369
**(877) 657-5030, TTY 711**

## Plan Administration

### Enrollment, Eligibility, & Waivers

Gallagher Student
500 Victory Road
Quincy, MA 02171
(877) 300-3541
www.gallagherstudent.com/conncoll

### Benefits, Claim Status, & ID Cards

Wellfleet Group, LLC
PO Box 15369
Springfield, Massachusetts 01115-5369
**(877) 657-5030, TTY 711**
**www.wellfleetstudent.com**
Monday–Thursday, 8:30 a.m. to 7:00 p.m.
Eastern Time
Friday, 9:00 a.m. to 5:00 p.m.
Eastern Time

### Claims

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

## PPO Network

Cigna Open Access Plus (OAP)
**www.mycigna.com**

## 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 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.

### Member Pharmacy Help

**(877) 640-7940**

## Student Health Center

CONNECTICUT COLLEGE
STUDENT HEALTH SERVICES
For appointments, call 860-439-2275
Or email: SHS@conncoll.edu

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

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# General Information

## Am I Eligible

**DOMESTIC**

All Full-Time Domestic Students, including students in Study Abroad programs are automatically enrolled in and billed for the Student Health Insurance Plan unless proof of comparable coverage is received by the published deadline.

**INTERNATIONAL**

All International Students are automatically enrolled in and billed for the Student Health Insurance Plan on a mandatory basis and cannot waive coverage.

**DEPENDENTS**

Dependents are not eligible.

## How Do I Waive?

**To Waive Coverage**

**Domestic students may complete the on-line waiver form by following these steps**:

1. Go to **www.gallagherstudent.com/conncoll**
2. Log in
3. Click on the 'Student Waive/Enroll' button. Select the 'I want to Waive' button. If you're waiving the insurance, have your current health insurance ID card ready as you will need this information in order to complete the waiver form.

**The deadline to waive for Annual coverage is 10/27/2023.**

## Effective Dates & Costs

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

| Coverage Period | Coverage Start Date | Coverage End Date | Waiver Deadline Date |
|---|---|---|---|
| **Annual** | 08/15/2023 | 08/14/2024 | 10/27/2023 |
| **Spring** | 01/01/2024 | 08/14/2024 | 02/16/2024 |

**Plan Costs for Domestic and International Students**

| | Annual | Spring |
|---|---|---|
| **Student*** | $ 2,646 | $1,641 |

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

## Plan Benefits

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

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

When You receive Emergency Services, or certain non-emergency Treatment or Urgent Crisis Center Services by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, or clinical laboratory, You are protected from Surprise Billing. Refer to the Preferred Provider Organization provision in the How The Plan Works And Description Of Benefits section for additional information.

## Key Plan Benefits

| BENEFIT | IN-NETWORK PROVIDER | OUT-OF-NETWORK PROVIDER |
|---|---|---|
| **Policy Year Deductible Individual** | $250 | $500 |
| 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 Individual**<br>***Combined In-Network and Out-of-Network** | $6,350 | |
| Cost sharing You incur for Covered Medical Expenses that is applied to the Out-of-Network Provider Out-of-Pocket Maximum will 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 be applied to satisfy the Out-of-Network Provider Out-of-Pocket Maximum.<br><br>*The combined amount will never exceed the federal maximum. | | |
| **Coinsurance** | 80% of the Negotiated Charge (NC) for Covered Medical Expenses | 50% of the Usual and Customary (U&C) Charge for Covered Medical Expenses |
| **Preventive Services** | 100% of the (NC)<br><br>Deductible Waived | 50% of the (U&C) Charge<br><br>Deductible, Coinsurance and any Copayment are applicable |
| **Physician Office Visits including specialist and consultant visits**<br>***Check below for additional copayments if applicable** | $40 Copayment per visit then the plan pays 100% of the (NC) for Covered Medical Expenses<br><br>Deductible Waived | 50% of (U&C) Charge after Deductible for Covered Medical Expenses |
| **Emergency Services in an emergency department for Emergency Medical Conditions.** | $175 Copayment per visit after Deductible then the plan pays 100% of the (NC) for Covered Medical Expenses<br><br>Copayment waived if admitted | Paid the same as In-Network Provider subject to (U&C) Charge. |
| **Urgent Care for non-life-threatening conditions** | 80% of the (NC) after Deductible for Covered Medical Expenses | 50% of (U&C) Charge after Deductible for Covered Medical Expenses |

## Schedule of Benefits

**THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:**

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

| BENEFITS FOR COVERED INJURY/SICKNESS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **INPATIENT SERVICES** | | |
| Hospital Care<br>Includes Hospital Room and Board Expenses and Hospital Miscellaneous Expenses.<br><br>Subject to Semi-Private room rate unless intensive care unit is required.<br><br>Room and Board includes intensive care.<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Preadmission Testing | Cost sharing based on facility where service is rendered | |
| Physician's Visits while Confined | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Skilled Nursing Facility Benefit<br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Inpatient Rehabilitation Facility Expense Benefit<br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Inpatient Rehabilitation Facility Expense Benefit<br>Maximum days per Policy Year | 90 | 90 |
| Registered Nurse Services for private duty nursing while Confined | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Physical Therapy while Confined (inpatient) | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |

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| **MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER BENEFITS**<br>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**<br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **Outpatient Mental Health Disorder and Substance Use Disorder Benefit**<br><br>Physician's Office Visits including, but not limited to, Physician visits; individual and group therapy; medication management<br><br>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 | <br><br>$40 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived<br><br>80% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | <br><br>80% of Usual and Customary Charge after Deductible for Covered Medical Expenses<br><br><br><br>80% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **Mental Health Wellness Exams**<br>limited to 2 exams per Policy Year<br>Pre-Certification is not required | Paid at 100% of the Negotiated Charge<br>Deductible Waived if applicable | Paid at 100% of Usual and Customary Charge<br>Deductible waived if applicable |
| **PROFESSIONAL AND OUTPATIENT SERVICES** | | |
| ***Surgical Expenses*** | | |
| **Inpatient Surgery includes:**<br>Pre-Certification Required<br>Surgeon Services<br>Anesthetist<br>Assistant Surgeon | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **Outpatient Surgery includes**:<br>Pre-Certification Required<br>For Surgeon Services, Assistant Surgeon, and Anesthetist charges. This also includes outpatient miscellaneous– expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma charges. | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |

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| Organ Transplant Surgery<br>travel and lodging expenses limited to:<br><br>Lodging 10 nights<br>up to the average standard room rate (assumes double occupancy).<br><br>Meals- 2 meals per person a day up to a 10 day maximum while at the transplant facility.<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Bone Marrow Testing Benefit | Based on site of service not to exceed 20% of Actual charge for Covered Medical Expenses<br><br>Deductible Waived | Based on site of service not to exceed 20% of Actual charge for Covered Medical Expenses<br><br>Deductible Waived |
| Reconstructive Surgery<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| ***Other Professional Services*** | | |
| Gender Affirming Treatment Benefit<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Home Health Care Expenses<br>Pre-Certification Required<br><br>This benefit is not subject to the plan Deductible. | 80% of the Negotiated Charge for Covered Medical Expenses | 80% of Usual and Customary Charge for Covered Medical Expenses |
| Hospice Care Coverage | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Maximum Hospice Care days per Policy Year | 60 | 60 |
| Maximum Social Services visits per lifetime | 6 visits | 6 visits |
| Maximum Bereavement visits per lifetime | 2 visits | 2 visits |
| **Office Visits** | | |
| Physician's Office Visits including Specialists/Consultants | $40 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |

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| Telemedicine or Telehealth Services | $40 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Allergy Testing and Treatment, including injections performed at a Physician's, or specialists office | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Chiropractic Care Benefit | $40 Copayment per visit after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Chiropractic Care Benefit Maximum visits per Policy Year | 30 | 30 |
| Tuberculosis screening (TB), Titers, QuantiFERON B tests including shots (other than covered under Preventive Services) | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **EMERGENCY SERVICES, AMBULANCE AND NON-EMERGENCY SERVICES** | | |
| Emergency Services in an emergency department for Emergency Medical Conditions. | $175 Copayment per visit after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Copayment waived if admitted | Paid the same as In-Network Provider subject to Usual and Customary Charge. |
| Urgent Care Centers for non-life-threatening conditions | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Emergency Ambulance Service ground and/or air, water transportation | 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | Paid the same as In-Network Provider subject to Usual and Customary Charge. |
| Non-Emergency Ambulance Expenses ground and/or air (fixed wing)transportation<br><br>Pre-Certification Required for non-emergency air Ambulance (fixed wing) | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **DIAGNOSTIC LABORATORY, TESTING AND IMAGING SERVICES** | | |
| Diagnostic Imaging Services Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| CT Scan, MRI and/or PET Scans Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Laboratory Procedures (Outpatient) | 80% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |

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| Chemotherapy and Radiation Therapy<br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Infusion Therapy<br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **REHABILITATION AND HABILITATION THERAPIES** | | |
| Cardiac Rehabilitation | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Pulmonary Rehabilitation | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge 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<br><br>The Maximum Visits do not apply to Rehabilitation Therapy for a Mental Health Disorder or Substance Use Disorder. | 40 | 40 |
| Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge 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<br><br>The Maximum Visits do not apply to Habilitation Services for a Mental Health Disorder or Substance Use Disorder. | 40 | 40 |
| **OTHER SERVICES AND SUPPLIES** | | |
| Covered Clinical Trials | Same as any other Covered Sickness | |
| Diabetic Services and Supplies (including equipment and training)<br><br>Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit. | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |

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|---|---|---|
| Dialysis Treatment | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Durable Medical Equipment<br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Enteral Formulas and Nutritional Supplements<br><br>(Treatment of Inherited Metabolic Diseases including cystic fibrosis and Medically Necessary Specialized Formulas)<br><br>See the Prescription Drug section of this Schedule when purchased at a pharmacy. | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Hearing Aids<br>Limited to 1 pair of hearing aids per 24 month period | Paid the same as Durable Medical Equipment | |
| Infertility Treatment<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Maternity Benefit | Same as any other Covered Sickness | |
| Prosthetic and Orthotic Devices<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Lyme Disease | Same as any other Covered Sickness subject to the limits described in the benefit | |
| Mobile Field Hospital | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Student Health Center/Infirmary Expense Benefit | $10 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | |
| Sports Accident Expense Benefit - incurred as the result of the play or practice of club sports | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Non-emergency Care While Traveling Outside of the United States | 50% of Actual Charge after Deductible for Covered Medical Expenses<br>Subject to $10,000 maximum per Policy Year | |
| Medical Evacuation Expense | 100% of Actual Charge for Covered Medical Expenses<br>Deductible Waived | |
| Repatriation Expense | 100% of Actual Charge for Covered Medical Expenses<br>Deductible Waived | |

| PEDIATRIC AND ADULT DENTAL AND VISION CARE | |
|---|---|
| Pediatric Dental Care Benefit (thru age 26 subject to the termination date provision) | See the Pediatric Dental Care Benefit description in the Certificate for further information. |
| Preventive Dental Care<br>Limited to 2 dental exams every 12 months | 100% of Usual and Customary Charge for Covered Medical Expenses |
| The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care: | |
| Emergency Dental | 50% of Usual and Customary Charge for Covered Medical Expenses |
| Routine Dental Care | 50% of Usual and Customary Charge for Covered Medical Expenses |
| Endodontic Services | 50% of Usual and Customary Charge for Covered Medical Expenses |
| Prosthodontic Services | 50% of Usual and Customary Charge for Covered Medical Expenses |
| Periodontic Services | 50% of Usual and Customary Charge for Covered Medical Expenses |
| Medically Necessary Orthodontic Care | 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. | |
| Pediatric Vision Care Benefit (thru age 26 subject to the termination date provision)<br><br>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<br><br>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 after Deductible for Covered Medical Expenses |

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|---|---|---|
| Adult Vision Care<br>(age 26 and older)<br>Routine Eye Examination once every 12 months<br><br>Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions | 80% of Usual and Customary Charge after Deductible for Covered Medical Expenses | |
| Adult Vision Care<br>Annual retina exam for an existing condition of the eye, such as glaucoma or diabetic retinopathy.<br><br>Subject to the limits described in the benefit. | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **MISCELLANEOUS DENTAL SERVICES** | | |
| Accidental Injury Dental Treatment | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Sickness Dental Expense Benefit | 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | 100% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Treatment for Temporomandibular Joint (TMJ) Disorders | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Hospital Dental Services Benefit | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **PRESCRIPTION DRUGS** | | |
| **Prescription Drugs Retail Pharmacy**<br>No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy.<br><br>Your benefit is limited to a 30-day supply. Coverage for more than a 30-day supply only applies if the smallest package size exceeds a 30-day supply. See “Retail Pharmacy Supply Limits” section for more information. | | |
| TIER 1<br>(Including Enteral Formulas)<br>For each fill up to a 30-day supply filled at a Retail pharmacy<br><br>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.<br><br>See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy. | $5 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |

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|---|---|---|
| More than a 30-day supply but less than a 61-day supply filled at a Retail pharmacy | $10 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| More than a 60-day supply filled at a Retail pharmacy | $15 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| TIER 2<br>(Including Enteral Formulas)<br>For each fill up to a 30-day supply filled at a Retail pharmacy<br><br>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.<br><br>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<br><br>Deductible Waived | 50% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| More than a 30-day supply but less than a 61-day supply filled at a Retail pharmacy | $80 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| More than a 60-day supply filled at a Retail pharmacy | $120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| TIER 3<br>(Including Enteral Formulas)<br>For each fill up to a 30-day supply filled at a Retail Pharmacy<br><br>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<br><br>Deductible Waived | 50% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |

| | | |
|---|---|---|
| See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy. | | |
| More than a 30-day supply but less than a 61-day supply filled at a Retail pharmacy | $80 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| More than a 60-day supply filled at a Retail pharmacy | $120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| **Specialty Prescription Drugs** | | |
| For each fill up to a 30-day supply<br><br>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<br><br>Deductible Waived | 50% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| 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<br><br>Deductible Waived | 50% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| More than a 60-day supply | $120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Actual Charge for Covered Medical Expenses<br><br>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<br><br>Deductible Waived | 100% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| **Orally administered anti-cancer Prescription Drugs (including Specialty Drugs)** | | |
| Benefit | Greater of:<br>• Chemotherapy Benefit; or<br>• 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 shall not exceed the amounts below and the deductible is waived:<br>• Covered insulin drugs will not exceed $25 per each 30-day supply;<br>• Covered non-insulin drugs will not exceed $25 per each 30-day supply; and<br>• Covered diabetes devices or diabetic ketoacidosis devices will not cumulatively exceed $100 per 30-day supply regardless of the number of devices dispensed in a 30-day period, so long as the devices can be prescribed and dispensed in a 30-day supply.<br>The out-of-pocket caps described above only apply when:<br>• Prescribed to the Insured by a prescribing practitioner; or<br>• Prescribed and dispensed by a pharmacist once during a policy year | |
| **MANDATED BENEFITS** | | |
| Colorectal Cancer Screening | Same as any other Preventive Service | |
| Craniofacial Disorders Benefit | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Epidermolysis Bullosa Treatment Benefit | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Mammography, Breast and Ovarian Cancer Screening | Paid at 100% of the Negotiated Charge<br><br>Deductible Waived if applicable | Paid at 100% of Usual and Customary Charge<br><br>Deductible Waived if applicable |
| Pain Management Benefit | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Prostate Cancer Screening and Treatment | Same as any other Covered Sickness, unless considered a Preventive Service | |
| **Accidental Death and Dismemberment** | | |
| Principal Sum | $10,000 | |
| Loss must occur within 365 days of the date of a covered Accident.<br><br>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 the Student Health Center or 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 or as part of the Student Health Center benefits provided by this plan.
- Professional services rendered by an Immediate Family Member or anyone who lives with You.
- Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services covered by Student Health Fees.
- Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
- Treatment, services, supplies or facilities in a Hospital owned or operated by national government or any of its agencies, except when a charge is made which You are required to pay or by a Veteran's Administration.
- 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, subject to applicable law.
- 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.
- Participation in a riot, civil disorder or a felony, except when Injury occurs when the Insured Person has an elevated blood alcohol content or when under the influence of intoxicating liquor or any drug or both. Participation means to voluntarily take a part or share with others assembled together in some activity. Riot means a violent public disturbance of the peace by a number of persons assembled together.
- Custodial Care service and supplies, except when provided in connection with Extended Day Treatment Programs.
- 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 (art, dance, etc.).
- Modifications made to dwellings.
- General fitness, exercise programs.
- Hypnosis.
- Rolfing.
- Biofeedback.
- Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
- Sleep Disorders, except for 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.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate sports for which benefits are paid under another Sports Accident policy issued to the Policyholder; or for which coverage is provided by the National Collegiate Athletic Association (NCAA), National Association of Intercollegiate Athletic (NAIA) or any other sports association.
- 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. Surgery for removal of excess skin or fat.

**Family Planning**

- Infertility Treatment (male or female)-this includes but is not limited to (except as otherwise specifically covered under this Certificate):
  - 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;
  - Costs for an ovum donor or donor sperm;
  - Sperm storage costs;
  - Cryopreservation and storage of embryos;
  - 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 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.
- Elective abortions.

**Vision**
- Expenses for radial keratotomy.
- Adult Vision unless specifically provided in the Certificate.
- Charges for office visit exam for the fitting of prescription contact lenses, duplicate spare eyeglasses, lenses or frames, non-prescription lenses or contact lenses that are for cosmetic purposes.

**Dental**
- Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.

**Hearing**
- Charges for hearing exams, hearing screening, and the fitting or repair or replacement of hearing aids 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.

**Prescription Drugs**
- Any drug or medicine which does not, by federal or state law, require a prescription order, i.e., over-the-counter drugs, even if a prescription is written, except as specifically provided under Preventive Services or in the Prescription Drug Benefit section of this Certificate. Insulin and OTC preventive medications required under ACA are exempt from this exclusion;
- Drugs with over-the-counter equivalents except as specifically provided under Preventive Services;
- Allergy sera and extracts administered via injection;
- Vitamins, and minerals, except as specifically provided under Preventive Services;
- Food supplements, dietary supplements; except as specifically provided in the Certificate;
- Cosmetic drugs or medicines including, but not limited to, products that improve the appearance of wrinkles or other skin blemishes;
- Refills in excess of the number specified or dispensed after 1 year of date of the prescription;
- Drugs labeled, “Caution – limited by federal law to Investigational use” or Experimental Drugs;
- Any drug or medicine purchased after coverage under the Certificate terminates;
- Any drug or medicine consumed or administered at the place where it is dispensed;
- If the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
- 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 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.

# VISION DISCOUNT PROGRAM

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

# EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

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

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

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

## How to Access Services

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

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

Please provide the following information when you call:

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

# 24 Hour Nurseline

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

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

Appropriate care may include:

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

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

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

CareConnect
Integrated Behavioral Health from Wellfleet Student

## 24/7 Behavioral Telehealth and Nurseline Access

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

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