DAVENPORT UNIVERSITY

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2021/2022

DESIGNED EXCLUSIVELY FOR THE STUDENTS

DAVENPORT UNIVERSITY – INTERNATIONAL STUDENTS

Grand Rapids, MI

("the Policyholder")

Policy Number: WI2122MISHIP117
Group Number: ST1493SH
Effective: 8/1/2021 – 7/31/2022

UNDERWRITTEN BY:

Wellfleet Insurance Company | Fort Wayne, IN

("the Company")

ADMINISTERED BY:

Wellfleet Group, LLC

WELLFLEET STUDENT

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Welcome Students…

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

Where to Find Help

For Questions About:	Please Contact:
Servicing Agent	**Gallagher Student Health** **500 Victory Road** **Quincy, MA 02171** **(888) 272-4951** **www.gallagherstudent.com/Davenport-int**
Enrollment **Insurance Benefits** **Claims Processing** **ID Cards** **Preferred Provider Listings**	**Wellfleet Group, LLC** **PO Box 15369** **Springfield, Massachusetts 01115-5369** **(877) 657-5030, TTY 711** **www.wellfleetstudent.com**
Preferred PPO Provider Listings	**Wellfleet Student** **www.wellfleetstudent.com**
Prescription Drug Provider	**For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit www.wellfleetstudent.com** **Your plan includes Wellfleet Rx – offering over 40 generics at a $0 copay. Please ask your health care provider to review our formulary to see if these medications are right for you. Click here http://wellfleetrx.com/students/formularies/ for more information.**

Am I Eligible?

All International Students on an F1 Visa are required to have health insurance and are automatically enrolled unless proof of comparable coverage is furnished.

How Do I Waive/Enroll?

To Waive:

- Go to www.gallagherstudent.com/davenport-int
- On the left toolbar, click 'Student Waive/Enroll'.
- Log in (if you haven't already) by following the instruction on the website.
- Click the 'I want to Waive/Enroll' button.
- Follow the instructions to complete the form.
- Save a copy of your reference number.

The deadline to waive coverage for Annual coverage is 9/21/2021.

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	Enrollment/Waiver Deadline
Annual	8/1/2021	7/31/2022	9/21/2021
Fall	8/1/2021	12/31/2021	9/21/2021
Winter Semester (New Students Only)	1/1/2022	7/31/2022	2/1/2022

Plan Costs for International Students

	Annual	Fall	Winter Semester (New Students Only)
Student	$2,040	$863	$1,177

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

Preferred Provider Organization (PPO) Network

…providing access to quality health care at discounted costs!

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

Davenport University International Students Schedule of Benefits

This is only a brief description of coverage available under Certificate form MI SHIP CERT (2020). The Certificate will contain full details of coverage, coinsurance, limitations, exclusions, and termination provisions. If there are any conflicts between this document and the Certificate, the Certificate governs in all cases.

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

SCHEDULE OF BENEFITS

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

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

Medical Deductible

Combined In-Network Provider and Out-of-Network Provider	Individual:	$100

Cost sharing You incur for Covered Medical Expenses that is applied to the Out-of-Network Deductible will 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 be applied to satisfy the Out-of-Network Provider Deductible.

Out-of-Pocket Maximum:

Combined In-Network Provider and Out-of-Network Provider	Individual:	$6,850

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.

*The combined amount will never exceed the federal maximum.

Coinsurance Amounts:

In-Network Provider:	100% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below.
Out-of-Network Provider:	80% of the Usual and Customary Charge (U&C) for Covered Medical Expenses unless otherwise stated below.

Medical Benefit Payments for In-Network Providers and Out-of-Network Providers

The Certificate provides benefits based on the type of health care provider You selects. The Certificate provides access to both In-Network Providers and Out-of-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by In-Network Providers versus Out-of-Network Providers, as shown in the Schedule of Benefits.

Dental and Vision Benefit Payments

For dental and vision benefits, You may choose any dental or vision provider.
For dental, different benefits may be payable based on the type of service, as shown in the Schedule of Benefits.

Preferred Provider Organization:

To locate an In-Network Provider in Your area, consult Your Provider Directory or call toll free 877-657-5030, TTY 711 or visit Our website at **www.wellfleetstudent.com**

THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BETHOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;

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

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Inpatient Benefits		
Hospital Care Includes hospital room & board expenses and miscellaneous services and supplies. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined: Limited to 1 visit per day of Confinement per provider	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Surgery: Pre-Certification Required		
Surgeon Services	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Anesthetist	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Assistant Surgeon	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Registered Nurse Services for private duty nursing while Confined	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient) Maximum Visits per Policy Year	60	60
Skilled Nursing Facility Benefit Pre-Certification required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Skilled Nursing Facility Benefit Maximum days per Policy Year	45	45
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
INPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
Mental Health Disorder and Substance Use Disorder Benefit Pre-Certification Required In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-certification requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Benefits		
Outpatient Surgery: Pre-Certification required		
Surgeon Services	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Anesthetist	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Assistant Surgeon	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Surgery Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Office Visits	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	$30 Copayment per visit then the plan pays 100% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Specialist/Consultant Physician Services	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	$30 Copayment per visit then the plan pays 100% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telemedicine Services	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Cardiac Rehabilitation	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	$30 Copayment per visit then the plan pays 100% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Cardiac Rehabilitation and Pulmonary Rehabilitation Maximum Visits per Policy Year Combined	30	30
Pulmonary Rehabilitation	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	$30 Copayment per visit then the plan pays 100% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation and Cardiac Rehabilitation Maximum Visits per Policy Year Combined	30	30
Rehabilitation Therapy including, Physical Therapy, Occupational Therapy, and Chiropractic Care Pre-Certification Required	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	$30 Copayment per visit then the plan pays 100% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maximum Visits per Policy Year for Physical Therapy, Occupational Therapy and Chiropractic Care Combined	30	30
Maximum Visits per Policy Year for Speech Therapy	30	30
Habilitative Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	$30 Copayment per visit then the plan pays 100% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitative Services Maximum Visits per Policy Year for Physical Therapy, and Occupational Therapy Combined	30-Unlimited	30-Unlimited

Maximum Visits per Policy Year for Speech Therapy	30	30
Emergency Services in an emergency department (includes Urgent Care for Emergency Medical Conditions)	$50 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses 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	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	$30 Copayment per visit then the plan pays 100% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diagnostic Imaging Services Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Pre-Certification required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hospice Care Coverage Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maximum Hospice Care days per Policy Year	45	45

OUTPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
Mental Health Disorder and Substance Use Disorder Benefit Pre-Certification Required except for office visits		
Physician's Office Visits including, but not limited to, physician visits; individual and group therapy; medication management	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	$30 Copayment per visit then the plan pays 100% of Usual and Customary Charge after Deductible for Covered Medical Expenses
All Other Outpatient Services including, but not limited to, Intensive Outpatient Programs (IOP); partial hospitalization; Electronic Convulsive Therapy (ECT); Repetitive Transcranial Magnetic Stimulation (rTMS); psychiatric and neuropsych testing 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.	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy.		
TIER 1 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$10 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered

More than a 60 day supply filled at a Retail pharmacy	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
TIER 2 (Including Enteral Formulas) For each fill up to a 30- day supply filled at a Retail pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$15 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 60 day supply filled at a Retail pharmacy	$45 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
TIER 3 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail Pharmacy 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	Not Covered
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 60 day supply filled at a Retail pharmacy	$90 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
Zero Cost Generics		
	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered

Specialty Prescription Drugs		
Specialty Prescription Drugs For each fill up to a 30 day supply	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 30 day supply but less than a 61 day supply	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 60 day supply	$90 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
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 or Mail Order Pharmacy Prescription Drug Fill	
Other Benefits		
Allergy Testing	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% 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 Service ground and/or air, water transportation	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Weight Loss Services Benefit, includes one (1) Bariatric Surgery per lifetime Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Covered Clinical Trials	Same as any other Covered Sickness	
Durable Medical Equipment Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Diabetic services and supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
Enteral Formulas and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Prosthetic Devices Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19) Preventive Dental Care Limited to 2 dental exams every 12 months The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care: Emergency Dental Routine Dental Care Endodontic Services Prosthodontic Services Periodontic Services Medically Necessary Orthodontic Care 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 Pediatric Dental Care Benefit description in the Certificate for further information. 100% of Usual and Customary Charge 80% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge	

Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19) Limited to 1 visit(s) per benefit period per Policy Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses or if Medically Necessary) 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 after Deductible for Covered Medical Expenses per Policy Year	
Adult Vision Care (age 19 and older) Routine Eye Exam once every 12 months 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	
Chiropractic Care Benefit Pre-Certification Required	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	$30 Copayment per visit then the plan pays 100% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Maximum visits per Policy Year combined with occupational therapy and physical therapy for Rehabilitation	30	30
Infertility Treatment Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge 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	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Tuberculosis screening, Titers, Quantiferon B tests including shots (other than covered under preventive services)	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Non-emergency Care While Traveling Outside of the United States	80% of Actual Charge after Deductible for Covered Medical Expenses Subject to $10,000 maximum per Policy Year
Medical Evacuation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $50,000 maximum per Policy Year
Repatriation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $25,000 maximum per Policy Year
Mandated Benefits	
Autism Spectrum Disorder	Same as any other Covered Sickness, except that no visit limitation will apply to speech therapy, Physical Therapy and/or occupational therapy
Breast Reconstructive Surgery	Same as any other Covered Sickness, subject to the limitations described in the Benefit
Must Offer Benefits	
Breast Cancer Diagnostic Services, Breast Cancer Outpatient Treatment Services, and Breast Cancer Rehabilitative Services; and Coverage for Breast Cancer Screening Mammography	Same as any other Covered Sickness, unless considered a Preventive Service, subject to the limitations described in the Benefit

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Principal Sum $10,000

Loss must occur within 365 days of the date of a covered Accident.

Only one benefit will be payable under this provision, that providing the largest benefit, when more than one (1) loss occurs as the result of any one (1) Accident. This benefit is payable in addition to any other benefits payable under the Certificate.

Pre-Certification

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

Exclusions and Limitations

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

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

1. **International Students Only -** Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible
2. Treatment, service or supply which is not Medically Necessary for the diagnosis, care or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended or approved by the Student Health Center or by Your attending Physician or dentist.
3. Medical services rendered by a provider employed for or contracted with the Policyholder, including team physicians or trainers, except as specifically provided in the Schedule of Benefits or as part of the Student Health Center benefits provided by this plan.
4. Professional services rendered by an Immediate Family Member or anyone who lives with You.
5. Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary because of Injury, infection or disease.
6. Infertility treatment (male or female)-this includes but is not limited to:
    - Procreative counseling;
    - Premarital examinations;
    - Genetic counseling and genetic testing;
    - Impotence, organic or otherwise;
    - Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
    - In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
    - Costs for an ovum donor or donor sperm;
    - Sperm storage costs;
    - Cryopreservation and storage of embryos;
    - Ovulation induction and monitoring;
    - Artificial insemination;
    - Hysteroscopy;
    - Laparoscopy;
    - Laparotomy;
    - Ovulation predictor kits;
    - Reversal of tubal ligations;
    - Reversal of vasectomies;
    - Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
    - Cloning; or
    - Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.
7. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
8. Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services covered by Student Health Fees.
9. Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
10. 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.
11. 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.
12. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate or club sports for which benefits are paid under another Sports Accident policy issued to

the Policyholder; or for which coverage is provided by the National Collegiate Athletic Association (NCAA), National Association of Intercollegiate Athletic (NAIA) or any other sports association

13. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
14. 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.
15. Services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
16. Expenses payable under any prior policy which was in force for the person making the claim.
17. 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.
18. 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.
19. Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
20. Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
21. Surgery for removal of excess skin or fat.
22. Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
23. Expenses for radial keratotomy.
24. Adult Vision unless specifically provided in the Certificate.
25. 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.
26. Charges for hearing exams, hearing screening, hearing aids and the fitting or repair or replacement of hearing aids or cochlear implants except as specifically provided in the Certificate.
27. Racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles) or other hazardous sport or hobby.
28. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma. This exclusion does not apply to medically necessary plastic surgery for blepharoplasty of upper lids, breast reduction, surgical treatment of male gynecomastia, panniculectomy, and sleep apnea treatments including rhinoplasty and septorhinoplasty
29. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric and Adult Dental Care Benefit.
30. Extraction of impacted wisdom teeth or dental abscesses.
31. Dental treatment to repair teeth due to a Covered accidental Injury.
32. Custodial Care service and supplies.
33. Charges for hot or cold packs for personal use.
34. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
35. Services of private duty Nurse except as provided in the Certificate.
36. Expenses that are not recommended and approved by a Physician.
37. 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.
38. Cosmetic procedures related to Gender Reassignment including but not limited to, face lift, facial bone reduction, lip enhancement or reduction, reduction thyroid chondroplasty, hair removal, voice modification surgery, skin resurfacing, chin implants, nose implants.
39. Sleep Disorders, except for the diagnosis and treatment of obstructive sleep apnea.
40. Treatment of Acne unless Medically Necessary.
41. Experimental or Investigational drugs, devices, treatments or procedures unless otherwise covered under Covered Clinical Trials or covered under clinical trials (routine patient costs). See the Other Benefits section for more information.
42. Under the Prescription Drug Benefit shown in the Schedule of Benefits:
    - any drug or medicine which does not, by federal or state law, require a prescription order, i.e. over-

the-counter drugs, even if a prescription is written, except as specifically provided under Preventive Services or in the Prescription Drug Benefit section of the Certificate. Insulin and OTC preventive medications required under ACA are exempt from this exclusion;

- drugs with over-the-counter equivalents except as specifically provided under Preventive Services;
- allergy sera and extracts administered via injection;
- any drug or medicine for the purpose of weight control;
- sexual enhancements drugs;
- vitamins, and minerals, except as specifically provided under Preventive Services;
- food supplements, dietary supplements; except as specifically provided in the Certificate;
- cosmetic drugs or medicines, including but not limited to, products that improve the appearance of wrinkles or other skin blemishes;
- refills in excess of the number specified or dispensed after 1 year of date of the prescription;
- drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
- any drug or medicine purchased after coverage under the Certificate terminates;
- any drug or medicine consumed or administered at the place where it is dispensed;
- if the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
- bulk chemicals;
- non-insulin syringes, surgical supplies, durable medical equipment/medical devices, except as specifically provided in the Prescription Drug Benefit section of the Certificate;
- repackaged products;
- blood components except factors;
- immunology products.

43. Non-chemical addictions.
44. Non-physical, occupational, speech therapies (art, dance, etc.).
45. Modifications made to dwellings.
46. General fitness, exercise programs.
47. Hypnosis.
48. Rolfing.
49. Biofeedback.

Value Added Services

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

VISION DISCOUNT PROGRAM

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

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

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

24 HOUR NURSELINE

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

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

Appropriate care may include self-care at home, a call to a physician, or a visit to the emergency room.
Calls are answered 24 hours a day, 365 days a year by experienced registered nurses who have been specifically trained to handle telephone health inquiries.
This program is not a substitute for doctor visits or emergency response systems. The *Nurseline* does not answer health plan benefit questions. Health benefit questions should be referred to the Plan Administrator. The *24 Hour Nurseline* toll free number will be on the ID card.

(800) 634-7629

CareConnect
Integrated Behavioral Health from Wellfleet Student

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

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