QUEENS UNIVERSITY of CHARLOTTE

# BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2025/2026

**DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:**

## QUEENS UNIVERSITY OF CHARLOTTE

**Charlotte, NC**
**("the Policyholder")**

**Policy Number: WI2526NCSHIP215**

**Group Number: ST2230SH**

**Effective: 08/01/2025 – 07/31/2026**

## 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 2025 – 2026 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 NC SHIP Cert (2025). 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.

**PENDING STATE APPROVAL**

**The Plan described in "Benefits at a Glance" is awaiting approval by the North Carolina Department of Insurance. If the Plan is changed during the approval process, a revision of this document will be provided. This is not an insurance policy and your receipt of this document does not constitute the issuance or delivery of a policy of insurance.**

# 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 Health
500 Victory Road
Quincy, MA 02171
(833) 468-9571
www.gallagherstudent.com/queens

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

## PPO Network

Cigna

Cigna
**www.mycigna.com**

## Pharmacy Benefits Manager

For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit **www.wellfleetrx.com/students**.

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**

## Telehealth Service

Your plan includes access to virtual healthcare advice by phone, video, or app.

- Scheduled mental health services – 7 days a week

Register at
https://www.teladoc.com/wellfleetstudent/

- In addition, your plan includes virtual physical therapy and other musculoskeletal services from Hinge Health
- Register at https://hinge.health/wellfleet

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

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# General Information

## Am I Eligible

### Domestic & International Students

All full-time traditional Domestic Undergraduate Students taking 12 credit hours or more, and all International Students, Athletes (including Graduate Athletes) and Students in the BSN and ABSN Nursing Program taking 1 credit hour or more are automatically enrolled in this Insurance Plan at registration, and the premium will be added to the Student's tuition fees, unless proof of comparable coverage is furnished and a waiver is approved.

### Dependents

Dependents are not eligible.

## How Do I Waive?

**To Waive:**

- Go to www.gallagherstudent.com/queens.
- Follow the login instructions.
- Click on the "Waive" button under "Plan Summary."
- You will need your health insurance information.
- **Please Note:** Waivers are required to be completed for each plan year.

**Note:** Your insurance information is required to complete the waiver form; you do not need to upload documents at the time of initial submission. You will receive an email notification if additional documents are needed.

**The deadline to waive for Annual coverage is 09/06/2025.**

## 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** | 08/01/2025 | 07/31/2026 | 09/05/2025 |
| **Fall** | 08/01/2025 | 12/31/2025 | 09/05/2025 |
| **Spring/Summer** | 01/01/2026 | 07/31/2026 | 01/16/2026 |
| **Summer** | 05/09/2026 | 07/31/2026 | 05/26/2026 |

**Plan Costs for Students**

| | Annual | Fall | Spring/Summer | Summer |
|---|---|---|---|---|
| **Student*** | $2,164 | $907 | $1,256 | $498 |

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

## Plan Benefits

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

When You receive Emergency Services, or Out-of-Network air Ambulance Services, or certain non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, 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.

**Pre-Certification Requirement:**
What types of Inpatient and Outpatient services or supplies require Pre-Certification?
Pre-Certification is required for the following:

1. All Inpatient admissions, including length of stay, to a Hospital, Skilled Nursing Facility, a facility established primarily for the Treatment of a Substance Use Disorder, or a residential Treatment facility, surgical procedures;
2. All Inpatient maternity care after the initial 48/96 hours;
3. Home Health Care;
4. Durable Medical Equipment over $500 per item;
5. Outpatient Surgical Procedures;
6. Transplant Services;
7. Diagnostic Testing and Radiology Services listed at www.wellfleetstudent.com/providers/. See Prior Authorization Requirements section;
8. Complex Imaging;
9. Biomarker Testing;
10. Chemotherapy/Radiation;
11. Infusions/Injectables;
12. Botox Injections;

13. Genetic Testing, except for BRCA;
14. Orthotics/Prosthetics;
15. Non-emergency Air Ambulance (fixed wing)
16. Outpatient Private Duty Nursing.

Pre-Certification is not required for an Emergency Medical Condition, or Urgent Care, or Hospital Confinement for the initial 48/96 hours of maternity care.

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

## Key Plan Benefits

| BENEFIT | IN-NETWORK PROVIDER | OUT-OF-NETWORK PROVIDER |
|---|---|---|
| **Policy Year Deductible*<br>Individual<br>*Medical Deductible is waived if Covered Medical Expenses are incurred at the Student Health Center** | $350 | $750 |
| 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<br>Individual** | $6,000 | $12,000 |
| Cost sharing You incur for Covered Medical Expenses that is applied to the Out-of-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the In-Network Provider Out-of-Pocket Maximum and cost sharing You incur for Covered Medical Expenses that is applied to the In-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the Out-of-Network Provider Out-of-Pocket Maximum. | | |
| **Coinsurance** | 80% of the Negotiated Charge (NC) after Deductible for Covered Medical Expenses | 60% of Usual & Customary (U&C) Charge after Deductible for Covered Medical Expenses |
| **Preventive Services** | 100% of the (NC)<br>Deductible Waived | 70% of (U&C) Charge<br>Deductible, Coinsurance, and any Copayment are applicable |
| **Physician's Office Visits including Specialists/Consultants<br>*Check below for additional copayments if applicable** | $35 Copayment per visit then the plan pays 100% of the (NC) for Covered Medical Expenses<br><br>Deductible Waived | 70% of (U&C) Charge after Deductible for Covered Medical Expenses |
| **Emergency Services in an emergency department for Emergency Medical Conditions.** | $150 Copayment per visit then the plan pays 100% of the (NC) for Covered Medical Expenses<br><br>Deductible Waived<br>Copayment waived if admitted | Paid the same as In-Network Provider subject to (U&C) Charge. |
| **Urgent Care Centers for non-life-threatening conditions** | $50 Copayment per visit then the plan pays 100% of the (NC) for Covered Medical Expenses<br><br>Deductible Waived | $50 Copayment per visit then the plan pays 100% of (U&C) Charge for Covered Medical Expenses<br><br>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. 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.

**NOTICE: YOUR ACTUAL EXPENSES FOR COVERED SERVICES MAY EXCEED THE STATED APPLICABLE COINSURANCE PERCENTAGE OR COPAYMENT AMOUNT BECAUSE THE ACTUAL PROVIDER CHARGES MAY NOT BE USED TO DETERMINE THIS PLAN AND YOUR PAYMENT OBLIGATIONS.**

| 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 | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Preadmission Testing | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Physician's Visits while Confined | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Skilled Nursing Facility Benefit<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Inpatient Rehabilitation Facility Expense Benefit<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |

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|---|---|---|
| Registered Nurse Services for private duty nursing while Confined | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% 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 | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **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, 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. Day or visit limits do not apply to Mental Health Disorder and Substance Use Disorder Benefits. | | |
| **Inpatient Mental Health Disorder and Substance Use Disorder Benefits**<br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **Outpatient Mental Health Disorder and Substance Use Disorder Benefits** | | |
| Physician's Office Visits including, but not limited to, Physician visits; individual and group therapy; medication management<br><br>(For Treatment rendered at the Student Health Center/Infirmary, refer to the Student Health Center/Infirmary Expense Benefit section of this Schedule of Benefits for benefit information.) | $35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 70% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| All Other Outpatient Services<br>(All Other Outpatient Services does not include Emergency Services in an emergency department, Urgent Care Centers, and Emergency Ambulance Service and Prescription Drugs. Refer to the Emergency Services, Ambulance and Non-Emergency Services, and Prescription Drugs sections of this Schedule of Benefits for benefit information.)<br><br>Pre-Certification may be required for certain All Other Outpatient Services. To see if Pre-Certification is required, refer to the Pre-Certification Requirement listing and specific benefit listed in this Schedule of Benefits. | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |

| PROFESSIONAL AND OUTPATIENT SERVICES | | |
|---|---|---|
| ***Surgical Expenses*** | | |
| **Inpatient and Outpatient Surgery includes:**<br>Pre-Certification Required for Surgery only<br>Surgeon Services<br>Anesthetist<br>Assistant Surgeon | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge 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 | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Bariatric Surgery<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Organ Transplant Surgery<br>- Transplant surgery and donor search expenses<br>- Travel and lodging expenses while at the transplant facility.<br>- Donor travel and lodging and meal expenses while at the transplant facility<br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Reconstructive Surgery<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| ***Other Professional Services*** | | |
| Gender Affirming Services Benefit<br>Pre-Certification Required for gender affirming surgery | Same as any other Mental Health Disorder | |
| Home Health Care Expenses<br>Pre-Certification required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Hospice Care Coverage | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **Office Visits** | | |
| Physician's Office Visits including Specialists/Consultants | $35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 70% of Usual and Customary Charge after Deductible for Covered Medical Expenses |

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| Telemedicine or Telehealth Services Benefit | $35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 70% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Telemedicine or Telehealth Services Program<br><br>Behavioral Health<br><br><br><br>Musculoskeletal | $0 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived<br><br>$0 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | |
| Allergy Testing and Treatment, including injections | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Chiropractic Care Benefit | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Chiropractic Care Benefit Maximum visits per Policy Year | 30 | 30 |
| Shots and Injections unless considered Preventive Services | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| 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 | 60% 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. | $150 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived<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 | $50 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | $50 Copayment per visit then the plan pays 100% of Usual and Customary Charge for Covered Medical Expenses<br><br>Deductible Waived |
| Emergency Ambulance Service ground and/or air, water transportation | 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | Paid the same as In-Network Provider subject to Usual and Customary Charge. |

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| 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 | Ground Ambulance transportation: 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses<br><br>Air Ambulance transportation: Paid the same as In-Network Provider subject to Usual and Customary Charge |
| **DIAGNOSTIC LABORATORY, RADIOLOGY, TESTING AND IMAGING SERVICES** | | |
| Diagnostic Complex Imaging Services<br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Diagnostic Laboratory Radiological Services and Testing (Outpatient)<br><br>Pre-Certification may be required. See Prior Authorization Requirements section listed at www.wellfleetstudent.com/providers/. | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Chemotherapy and Radiation Therapy<br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% 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 | 60% 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 | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Pulmonary Rehabilitation | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% 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 | 60% 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 | 30 | 30 |
| Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |

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|---|---|---|
| Habilitation Services<br>Maximum Visits for each therapy per Policy Year for Physical Therapy, and Occupational Therapy and Speech Therapy Combined with Rehabilitation Therapy | 30 | 30 |
| **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 | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Dialysis Treatment | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% 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 | 80% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Enteral Formulas and Nutritional Supplements<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 | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Hearing Aids<br><br>Limited to one (1) hearing aid per impaired ear, and replacement hearing aids once every 36 months | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Infertility Treatment Benefit<br><br>Infertility Treatment limited to 3 Treatments per Insured Person per lifetime<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% 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 | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Outpatient Private Duty Nursing<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |

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|---|---|---|
| Sexual Dysfunction Services | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Student Health Center/Infirmary Expense Benefit | 100% of the Negotiated Charge for Covered Medical Expenses<br>Deductible Waived | |
| Sports Accident Expense Benefit - incurred as the result of the play or practice of Intercollegiate sports or club sports<br>Up to $7,500 per Accident<br><br>Pre-Certification not Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Non-emergency Care While Traveling Outside of the United States | 60% 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<br>Subject to $50,000 maximum per Policy Year | |
| Repatriation Expense | 100% of Actual Charge for Covered Medical Expenses<br>Deductible Waived<br>Subject to $25,000 maximum per Policy Year | |
| **PEDIATRIC DENTAL AND VISION CARE** | | |
| Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)<br><br>Type A – Basic Services<br>Preventive Dental Care Limited to 1 dental exam every 6 months<br><br>The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care:<br><br>Type B – Intermediate Services<br><br>Type C – Major Services<br><br>Type D:<br>• Medically Necessary Orthodontic Services<br>• General Services<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. | See the Dental Care Schedule of Benefit below and Pediatric Dental Care Benefits provision in the Certificate for further information.<br><br>50% of Usual and Customary Charge for Covered Medical Expenses<br><br>50% of Usual and Customary Charge for Covered Medical Expenses<br><br>50% of Usual and Customary Charge for Covered Medical Expenses<br><br>50% of Usual and Customary Charge for Covered Medical Expenses<br><br>Deductible Waived | |

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|---|---|---|
| Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19)<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. | $20 Copayment per visit then the plan pays 100% of Usual and Customary Charge for Covered Medical Expenses<br><br>Deductible Waived | |
| Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19) - Low Vision Evaluation | 100% 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 | 80% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Sickness Dental Expense Benefit | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Treatments of Bones and Joints of the Jaw, Face, or Head Benefit | Same as any other Covered Sickness | |
| Anesthesia and Hospitalization for Dental Procedures Benefit | Same as any other Covered Sickness | |
| **PRESCRIPTION DRUGS** | | |
| **Prescription Drugs Retail Pharmacy**<br>No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy or Student Health Center.<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>Generic Prescription Drug (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. | $20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | $20 Copayment then the plan pays 100% 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 | $40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | $40 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| More than a 60 day supply filled at a Retail pharmacy | $60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | $60 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| TIER 2<br>Preferred Prescription Drug (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 | $40 Copayment then the plan pays 100% 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 | $80 Copayment then the plan pays 100% 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 | $120 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| TIER 3<br>Non-Preferred Prescription Drug (Including Enteral Formulas)<br>For each fill up to a 30 day supply filled at a Retail Pharmacy | $70 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | $70 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |

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| 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. | | |
| More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy | $140 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | $140 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| More than a 60 day supply filled at a Retail pharmacy | $210 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | $210 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| **Specialty Prescription Drugs** | | |
| TIER 1<br>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. | $20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | $20 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| More than a 30 day supply but less than a 61 day supply | $40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | $40 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| More than a 60 day supply | $60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | $60 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |

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| TIER 2<br>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 | $40 Copayment then the plan pays 100% 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 | $80 Copayment then the plan pays 100% 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 | $120 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| TIER 3<br>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. | $70 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | $70 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| More than a 30 day supply but less than a 61 day supply | $140 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | $140 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses<br><br>Deductible Waived |
| More than a 60 day supply | $210 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | $210 Copayment then the plan pays 100% 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 |

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| **Orally administered anti-cancer Prescription Drugs (including Specialty Drugs)** | |
| Benefit | If the cost share for the Prescription Drug's Tier is greater than the Chemotherapy Benefit or Infusion Therapy Benefit, the cost share will be calculated as follows: 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 |
| **MANDATED BENEFITS** | |
| Colorectal Cancer Screening Benefit | Same as any other Preventive Service |
| Diagnosis and Treatment of Lymphedema | Same as any other Covered Sickness |
| Mammography | Same as any other Covered Sickness, unless considered a Preventive Service<br>Deductible does not apply if applicable |
| Cervical Cancer Screening | Same as any other Covered Sickness, unless considered a Preventive Service<br>Deductible does not apply if applicable |
| Osteoporosis Coverage/Bone Mass Measurement Benefit | Same as any other Preventive Service |
| Ovarian Cancer Surveillance Tests | Same as any other Preventive Service |
| Prostate Cancer Benefit | Same as any other Preventive Service |
| **Accidental Death and Dismemberment** | |
| Principal Sum | $10,000<br><br>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 -** Covered Medical Expenses received within Your Home Country or country of origin that are covered under Your governmental or national health plan.
- 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, except tax supported institutions 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 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.
- Services or supplies for the Treatment of an occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or Workers' Compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
- Expenses covered under any 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 when provided by a close relative or a member of Your household except as provided in the Certificate.
- Expenses that are not recommended and approved by a Physician.
- Experimental or Investigational drugs, devices, Treatments or procedures.
- 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.
- Outpatient non-physical, occupational, speech therapies (art, dance, etc.).
- Modifications made to dwellings.
- General fitness, exercise programs.
- Hypnosis.
- Rolfing.
- Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
- Sleep Disorders, the diagnosis, and Treatment of obstructive sleep apnea, including testing performed in a home or outpatient setting.
- 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 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 in excess of $7,500 per Intercollegiate or club sports Accident.
- 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) except as provided under the Infertility Treatment benefit-this includes but is not limited to:
  - 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 eggs or embryos;
  - Ovulation induction and monitoring;
  - Ovulation predictor kits;
  - Reversal of tubal ligations;
  - Reversal of vasectomies;
  - Costs for and relating to surrogate motherhood if the individual is not an Insured Person under the Certificate;
  - Cloning; or
  - Medical and surgical procedures that are Experimental or Investigative, unless Our denial is overturned by an External Appeal Agent.
- Elective abortions, except when the pregnancy is the result of rape or incest or if the mother's life is in danger in accordance with state law.

**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 except as provided under the Pediatric Vision Care Benefit, 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 screening, or cochlear implants.

**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;
- 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.

# 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

# 24/7 Nurseline

Students who enroll and maintain medical coverage in this insurance plan have **free** access to the 24/7 Nurseline by calling (800) 634-7629. This 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
- an office or telehealth visit with a healthcare provider
- Or a visit to an urgent care center or emergency room.

Calls are answered 24/7/365 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.

# Contracted Providers for Telemedicine/Telehealth

**The right care when you need it most**
Your Wellfleet health plan gives you access to virtual healthcare by phone, video, or app.

**Teladoc** gives you access to board-certified physicians for **Mental Health (at no additional cost to you)** 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).

**Hinge Health** gives you access to licensed physical therapists and health coaches for personalized musculoskeletal services including **virtual physical therapy** to help alleviate pain concerns.

Whether you are at school, home, or traveling, Hinge Health can assist in providing exercise therapy wherever and whenever you need treatment at **no additional cost to you**.

Register your account today and start your exercise therapy at https://hinge.health/wellfleet.

CareConnect
BY WELLFLEET

## 24/7 Telehealth Counseling for Mental Health

CareConnect is an integrated behavioral health program offering students easy access to licensed mental health clinicians 24/7/365 via telephone (888) 857-5462 and website access to expert mental health and emotional wellbeing resources.

The CareConnect hotline is available at **no additional cost to you**, and you also have free access to courses, articles, and short videos that support mental health and wellbeing by visiting https://careconnect.mysupportportal.com/welcome.