ST JOHN'S College

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2023/2024

DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

ST. JOHN'S COLLEGE

ANNAPOLIS, MD
("the Policyholder")

Policy Number: WI2324MDSHIP84

Group Number: ST1735SH

Effective: 8/1/2023 – 7/31/2024

UNDERWRITTEN BY:

Wellfleet Insurance Company | Fort Wayne, IN

("the Company")

ADMINISTERED BY:

Wellfleet Group, LLC

WELLFLEET STUDENT

Welcome Students…

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

"Benefits at a Glance" includes effective dates and costs of coverage, as well as other helpful information. For additional details about the Plan, please consult the Plan Certificate and other materials at **www.wellfleetstudent.com**.

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

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

Important Contact Information & Resources

Contact Us

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

Plan Administration

Benefits, Enrollment, Eligibility, & Waivers

University Health Plans, a Division of Risk Strategies
15 Pacella Park Drive, Suite 130
Randolph, MA 02368
www.universityhealthplans.com
Phone: 1 (833) 251-1136

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 PPO
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.wellfleetstudent.com**.

Your plan includes Wellfleet Rx – offering over 40 generics at a $0 copay. Please ask your health care provider to review our formulary to see if these medications are right for you. Click here http://wellfleetrx.com/students/formularies/ for more information.

Member Pharmacy Help

(877) 640-7940

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

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General Information

Am I Eligible

Domestic and Part-time Students

All Domestic Graduate, Undergraduate, and Part-time Students taking 3 or more credit hours, are required to purchase this Student Health Insurance Plan unless proof of comparable coverage is furnished. Eligible Students who fail to confirm enrollment or waive by the waiver deadline date will be automatically enrolled in this Student Health Insurance plan and the premium will be added their tuition fees.

International Students

All International Students are eligible for coverage on a mandatory basis and they will be automatically enrolled in the Student Health Plan and the premium will be added to their tuition fees. International Students are not eligible to waive the insurance.

Dependents

Dependents are eligible.

How Do I Waive/Enroll?

To Waive or Enroll

- Go to www.universityhealthplans.com.
- Search **St John's College**.
- Follow the directions for Waiver and proceed as directed. You must fill in all of the required information on the waiver form. If any information is missing, your waiver will not be accepted.
- Click submit and review the information being provided is accurate.
- When your online waiver form is successfully submitted you will receive a confirmation e-mail.

The deadline to waive coverage for Annual coverage is 07/29/2023.

To Purchase coverage and Enroll dependents:

- Go to www.universityhealthplans.com.
- Select **St John's College**.
- Follow the directions to Enroll and proceed as directed to purchase the student health insurance plan.

The deadline to enroll and purchase coverage for Annual coverage is 07/29/2023.

Effective Dates & Costs

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

Coverage Period	Coverage Start Date	Coverage End Date	Waiver Deadline Date/ Dependent Enrollment Deadline Date
Annual	8/1/2023	7/31/2024	7/29/2023
Fall	8/1/2023	12/31/2023	7/29/2023
Spring/Summer (New Students Only)	1/1/2024	7/31/2024	TBD

Plan Costs for Domestic and International Undergraduate Students and their Dependents

	Annual	Fall	Spring/Summer (New Students Only)
Student	$2,634	$1,104	$1,530
Spouse	$2,634	$1,104	$1,530
One Child	$2,634	$1,104	$1,530
Two or more Children	$5,268	$2,208	$3,060
Spouse + Two or more Children	$7,902	$3,312	$4,590

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

Plan Costs for Domestic and International Graduate Students and their Dependents

	Annual	Fall	Spring/Summer (New Students Only)
Student	$3,498	$1,462	$2,036
Spouse	$3,498	$1,462	$2,036
One Child	$3,498	$1,462	$2,036
Two or more Children	$6,996	$2,924	$4,072
Spouse + Two or more Children	$10,494	$4,386	$6,108

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

Plan Benefits

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

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

When You receive Emergency Services, or certain non-emergency Treatment 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.

Key Plan Benefits

BENEFIT	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Policy Year Deductible* Individual *Medical Deductibles apply towards the Out-of-Pocket Maximum	$250	$600
Cost sharing You incur for Covered Medical Expenses that is applied to the Out-of-Network Deductible will not be applied to satisfy the In-Network Deductible. Cost sharing You incur for Covered Medical Expenses that is applied to the In-Network Deductible will not be applied to satisfy the Out-of-Network Provider Deductible.		
Out-of-Pocket Maximum Individual Family	$6,850* $13,700	$15,000** No Maximum
*This is the most You will incur during a Policy Year. After You incur this amount on Deductibles, Copayments, and Coinsurance, We will begin to pay 100% of the Negotiated Charge for Covered Medical Expenses incurred for Treatment provided by an In-Network Provider. This maximum will never include Premium, balance-billed charges or health care the Certificate does not cover. **This is the most You will incur during a Policy Year. After You incur this amount on Deductibles, Copayments, and Coinsurance, We will begin to pay 100% of the Usual and Customary Charge for Covered Medical Expenses incurred for Treatment provided by an Out-of-Network Provider. This maximum will never include Premium, balance-billed charges or health care the Certificate does not cover. 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)	60% of Usual & Customary (U&C) Charge

Preventive Services	100% of the (NC) for Covered Medical Expenses Deductible Waived	80% of (U&C) Charge for Covered Medical Expenses Deductible, Coinsurance, and any Copayment are not applicable No cost sharing shall apply to services provided by an Out-of-Network Provider for male sterilization.
Physician Office Visits including Specialist and Consultant visits ***Check below for additional copayments if applicable**	$25 Copayment per visit then the plan pays 100% of the (NC) for Covered Medical Expenses Deductible Waived	80% of (U&C) Charge after Deductible for Covered Medical Expenses
Emergency Services in an emergency department for Emergency Medical Conditions.	$150 Copayment after Deductible per visit then the plan pays 80% of the (NC) for Covered Medical Expenses 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 after Deductible per visit then the plan pays 80% of the (NC) for Covered Medical Expenses	$50 Copayment after Deductible per visit then the plan pays 60% of (U&C) Charge for Covered Medical Expenses

Schedule of Benefits

THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:

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

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK	OUT-OF-NETWORK
INPATIENT SERVICES		
Hospital Care Includes Hospital Room and Board Expenses and Hospital Miscellaneous Expenses. **For Hospitals regulated by the Maryland Health Services Cost**	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Review Commission (HSCRC), reimbursement for covered Hospital services is limited to the rate set by the HSCRC. **For all other Hospitals**, reimbursement for covered Hospital services will be subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Certification Recommended		
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 Pre-Certification Recommended	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 Pre-Certification Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
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, Speech Therapy, and Occupational 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 MISUSE DISORDER BENEFITS In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-certification requirements that apply to a Mental Health Disorder and Substance Misuse Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.		
Inpatient Mental Health Disorder and Substance Misuse Disorder Benefit Pre-Certification Recommended	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 Misuse Disorder Benefit Physician's Office Visits including, but not limited to, Physician visits; individual and group therapy; medication evaluation and management All Other Outpatient Services (refer to the outpatient Mental Health and Substance Misuse Disorder Benefit provision in the Certificate for information on covered services)	 $25 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	 80% of Usual and Customary 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: Pre-Certification Recommended Surgeon Services Anesthetist 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
Abortion Care Expense	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived, if applicable	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived, if applicable
Bariatric Surgery Pre-Certification Recommended	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 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 Recommended	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 Pre-Certification Recommended	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		
Home Health Care Expenses Pre-Certification Recommended	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	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telehealth Services	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Acupuncture Services (Medically Necessary Treatment only) Pre-Certification Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
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 Covered Injury or Covered Sickness per Policy Year	30	30
Tuberculosis screening (TB), Titers, QuantiFERON B tests including shots (other than covered under Preventive Services)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	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 after Deductible per visit then the plan pays 80% of the Negotiated Charge for Covered Medical Expenses Copayment waived if admitted	Paid the same as In-Network Provider subject to the Recognized Amount.

Urgent Care Centers for non-life-threatening conditions	$50 Copayment after Deductible per visit then the plan pays 80% of the Negotiated Charge for Covered Medical Expenses	$50 Copayment after Deductible per visit then the plan pays 60% of Usual and Customary Charge for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to the Recognized Amount.
Non-Emergency Ambulance Expenses ground and/or air (fixed wing) transportation Pre-Certification Recommended for non-emergency air Ambulance (fixed wing)	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, TESTING AND IMAGING SERVICES		
Diagnostic Imaging/Testing Services Pre-Certification Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Certification Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Laboratory Procedures/Tests (Outpatient)	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 Pre-Certification Recommended	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 Pre-Certification Recommended	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 Covered Injury or Covered Sickness per Policy Year for Physical Therapy, Occupational Therapy and Speech Therapy The Maximum Visits do not apply to Rehabilitation Therapy for a Mental Health Disorder or Substance Misuse Disorder.	30	30
Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy There is no age limit except for certain Habilitation Services. Refer to the Habilitation Services provision in the Certificate for additional information.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitation Services Maximum Visits for each therapy per Covered Injury or Covered Sickness per Policy Year for Physical Therapy, and Occupational Therapy and Speech Therapy Combined with Rehabilitation Therapy The Maximum Visits do not apply to Habilitation Services for Mental Health Disorder or Substance Misuse Disorder. In addition, the Maximum Visits do not apply to Habilitation Services for Insured Persons age 19 and under.	30	30
OTHER SERVICES AND SUPPLIES		
Covered Clinical Trials	Same as any other Covered Sickness	
Diabetic Services and Supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	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 Pre-Certification Recommended	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Elemental Formulas, Medical Foods, and Nutritional Supplements 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 Limited to 1 hearing aid per impaired ear per 36 month period	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 Pre-Certification Recommended • Infertility Services • Standard Fertility Preservation Procedures	80% of the Negotiated Charge after Deductible for Covered Medical Expenses 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary 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 Pre-Certification Recommended	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Student Health Center/Infirmary Expense Benefit	$25 Copayment per visit then the plan pays 100% Usual and Customary for Covered Medical Expenses Deductible Waived	
Non-emergency Care While Traveling Outside of the United States	60% of Actual Charge after Deductible for Covered Medical Expenses Subject to $10,000 maximum per Policy year	
Medical Treatment Received in Home Country (International Students and their Dependents Only)	60% of Actual Charge after Deductible for Covered Medical Expenses	
Medical Evacuation Expense (International Students, and Domestic Students)	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $50,000 maximum per Policy Year	
Repatriation Expense (International Students, and Domestic Students)	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $25,000 maximum per Policy Year	
PEDIATRIC DENTAL AND VISION CARE		
Pediatric Dental Care Benefit (through the end of the month in which the Insured Person turns age 19)	See the Pediatric Dental Care Schedule description in the Certificate for further information.	

Preventive Dental Care – items or services that have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"). For more information visit: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations Type A Services - Diagnostic and Preventive Care: • Preventive Dental Care not otherwise considered a Preventive Service • Diagnostic Care Type B Services – Basic Restorative Care Type C Services – Major Restorative Care Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of Usual and Customary Charge for Covered Medical Expenses 100% of Usual and Customary Charge for Covered Medical Expenses 80% of Usual and Customary Charge for Covered Medical Expenses 60% of Usual and Customary Charge for Covered Medical Expenses 60% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived	
Pediatric Vision Care Benefit (through the end of the month in which the Insured Person turns age 19) Limited to 1 vision examination per Policy Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived	
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
Treatment for Temporomandibular Joint (TMJ) Disorders (age 19 and older)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
General Anesthesia for Dental Care	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
PRESCRIPTION DRUGS		
Prescription Drugs Retail Pharmacy We will not impose a Copayment or Coinsurance requirement for a covered Prescription Drug or device that exceeds the retail price of the Prescription Drug or device. No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy. Your benefit is limited to a 30 day supply. Coverage for more than a 30 day supply only applies if the smallest package size exceeds a 30 day supply. See "Retail Pharmacy Supply Limits" section for more information. All fills of a Maintenance Prescription Drug will be available up to a 90-day supply.		
TIER 1 (Including Elemental Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. You can request a Prescription Drug reimbursement claim form by calling the number on Your ID Card. 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 Elemental Formula, Medical Foods, and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$20 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$40 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses 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 Deductible Waived	$60 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
TIER 2 (Including Elemental Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. You can request a Prescription Drug reimbursement claim form by calling the number on Your ID Card. 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 Elemental Formula, Medical Foods, and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$40 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses 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 Deductible Waived	$80 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses 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 Deductible Waived	$120 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
TIER 3 (Including Elemental Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. You can request a Prescription Drug reimbursement claim form by calling the number on Your ID Card. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	$65 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$65 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived

See the Elemental Formula, Medical Foods, 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	$130 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$130 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Retail pharmacy	$195 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$195 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
Specialty Prescription Drugs		
Out-of-Network Provider benefits are provided on a reimbursement basis. You can request a Prescription Drug reimbursement claim form by calling the number on Your ID Card. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	$100 Copayment for each fill up to a 30-day supply then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$100 Copayment for each fill up to a 30-day supply then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
Specialty Prescription Drugs with Copayment Assistance Program Copayment Assistance Program - Prior Authorization May Be Required: Amounts You pay out-of-pocket for covered Specialty Prescription Drugs will not exceed the applicable Tier's cost share per 30 day supply and will be applied towards the Deductible (if applicable) and Out-of-Pocket Maximum. Copayment Assistance may be available to You for certain Specialty Prescription Drugs when Your prescription is filled at a participating network pharmacy. Visit www.wellfleetstudent.com for the applicable Specialty Prescription Drugs. Copayment Assistance dollars paid by the drug manufacturer for covered Specialty Prescription Drugs will not be applied towards the Deductible (if applicable) or Out-of-Pocket Maximum. Any amounts paid by You for a covered Specialty Prescription Drug after Copayment Assistance will be applied to the deductible (if applicable) and Out-of-Pocket Maximum. For details, contact the Copayment Assistance Program at 636-271-5280.		
For each fill up to a 30 day supply.	75% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
Prescription Mail Order Drugs We will not impose a Copayment or Coinsurance requirement for a covered Prescription Drug or device that exceeds the retail price of the Prescription Drug or device. No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy		
TIER 1 For each fill up to a 30 day supply filled at a Mail Order pharmacy	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$20 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived

Out-of-Network Provider benefits are provided on a reimbursement basis. You can request a Prescription Drug reimbursement claim form by calling the number on Your ID Card. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.		
More than a 30 day supply but less than a 61 day supply filled at a Mail Order pharmacy	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$40 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Mail Order pharmacy	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$60 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
TIER 2 For each fill up to a 30 day supply filled at a Mail Order pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. You can request a Prescription Drug reimbursement claim form by calling the number on Your ID Card. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$40 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Mail Order pharmacy	$80 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$80 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Mail Order pharmacy	$120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$120 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
TIER 3 For each fill up to a 30 day supply filled at a Mail Order pharmacy	$65 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	$65 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses

Out-of-Network Provider benefits are provided on a reimbursement basis. You can request a Prescription Drug reimbursement claim form by calling the number on Your ID Card. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	Deductible Waived	Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Mail Order pharmacy	$130 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$130 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Mail Order pharmacy	$195 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$195 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived
Zero Cost Drugs		
Out-of-Network Provider benefits are provided on a reimbursement basis. You can request a Prescription Drug reimbursement claim form by calling the number on Your ID Card. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	100% of Actual Charge for Covered Medical Expenses Deductible Waived
Orally administered anti-cancer Prescription Drugs (including Specialty Drugs)		
Benefit	Greater of: • Chemotherapy Benefit; or • Infusion Therapy Benefit	
Diabetic Supplies (for prescription supplies purchased at a pharmacy)		
Benefit	Paid the same as any other Retail or Mail Order Pharmacy Prescription Drug Fill, except that Insured Person's out-of-pocket costs for covered prescription insulin will not exceed $30 per 30-day supply regardless of the amount or type of insulin that is needed to fill the Insured Person's prescription; and no cost share shall apply to blood glucose test strips.	
Prescription Drugs to treat Diabetes, HIV or AIDS		
Benefit	Paid the same as any other Retail or Mail Order Pharmacy Prescription Drug Fill, except that the Insured Person's cost share shall not exceed $150 for up to a 30-day supply for Prescription Drugs prescribed to treat diabetes, HIV, or AIDS.	
MANDATED BENEFITS		
Breast Cancer Screening	Same as any other Preventive Service, except covered services provided by an Out-of-Network Provider are not subject to the Deductible, if applicable	

Lymphedema Diagnosis, Evaluation, and Treatment	Same as any other Covered Sickness	
Nutritional Counseling	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Patient Centered Medical Home Expense Benefit Pre-Certification Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pediatric Autoimmune Neuropsychiatric Disorders	Same as any other Covered Sickness	
Prostate Cancer Screening	Same as any other Preventive Service, except covered services provided by an Out-of-Network Provider are not subject to the Deductible, if applicable	
Wellness Program Benefits	Up to $200 per six (6) month period; and up to an additional $100 per six (6) month period for each Dependent	
Accidental Death and Dismemberment		
Principal Sum	$10,000	
Loss must occur within 365 days of the date of a covered Accident. Only one benefit will be payable under this provision, that providing the largest benefit, when more than one (1) Loss occurs as the result of any one (1) Accident. This benefit is payable in addition to any other benefits payable under this Certificate.		

Exclusions and Limitations

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

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

General Exclusions

- Services that are not Medically Necessary and Elective Surgery or Elective Treatment.
- Services performed or prescribed under the direction of a person who is not a health care practitioner.
- Services that are beyond the scope of practice of the health care practitioner performing the service.
- Services to the extent they are covered by any government unit, except for veterans in Veterans' Administration or armed forces facilities for services received for which the recipient is liable;
- Services for which an Insured Person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan.
- Personal care services and domiciliary care services.
- Services rendered by a health care practitioner who is an Insured Person's Spouse, mother, father, daughter, son, brother, or sister.
- Experimental services.
- Services incurred before the Effective Date of coverage for an Insured Person.

- Services incurred after an Insured Person's Termination Date of coverage, including any Extension of Benefits.
- Services for injuries or diseases related to an Insured Person's job to the extent the Insured Person is required to be covered by a workers' compensation law.
- Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.
- Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment.
- Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form, except as provided in the Telehealth Services benefit.
- Inpatient admissions primarily for diagnostic studies.
- Except for Emergency Services, services received while the Insured Person is outside the United States, except as otherwise covered under the Non-Emergency Care While Traveling Outside of the United States or Home County Coverage Benefit.
- Immunizations related to foreign travel.
- Services that duplicate benefits provided under federal, State, or local laws, regulations, or programs;
- Non-replacement fees for blood and blood products.
- Wigs or cranial prosthesis except as provided for hair prosthesis for Insured Persons whose hair loss results from chemotherapy or radiation Treatment for cancer.
- Weekend admission charges, except for emergencies and maternity.
- Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements.
- Services for conditions that State or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution.
- Physical examinations required for obtaining or continuing employment, insurance, or government licensing.
- Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.
- Private Hospital room.
- Payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines was provided as a result of a prohibited referral.

In addition, for International Students Only, the following are not covered services:

- Expenses incurred within the Insured Person's Home Country or country of regular domicile.

Weight Management/Reduction

- Medical or surgical Treatment or regimen for reducing or controlling weight, unless otherwise specified in the covered services for Bariatric Surgery.
- Lifestyle improvements, including nutrition counseling, or physical fitness programs, except as provided under the Nutrition Counseling and Wellness Benefits.

Family Planning

- Ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.
- Services to reverse a voluntary sterilization procedure.
- Services for sterilization or reverse sterilization for a Dependent minor, except for FDA approved sterilization procedures for women with reproductive capacity as required under the Affordable Care Act.
- Treatment of sexual dysfunction not related to organic disease.

Vision

- The purchase, examination, or fitting of eyeglasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for use in the treatment of a disease or injury. This exclusion does not apply to the Pediatric Vision Care Benefit.
- Practitioner, Hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.

Dental

- Unless otherwise specified in covered services for Pediatric Dental Care Benefits, dental work or Treatment which includes Hospital or professional care in connection with:
  - The operation or Treatment for the fitting or wearing of dentures,
  - Orthodontic care or malocclusion,
  - Operations on or for Treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or Treatment of Injury to Sound, Natural Teeth due to an Accident if the Treatment is received within 6 months of the Accident; and
  - Dental implants;
- Accidents occurring while and as a result of chewing, except as provided in the Pediatric Dental Care Benefit.
- Temporomandibular joint syndrome (TMJ) Treatment and Treatment for craniomandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if Medically Necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or Injury.

Hearing

- The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, except as required as a covered service under Hearing Aids.

Cosmetic

- Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies.

Foot Care

- 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.
- Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be Medically Necessary.

Organ Transplants:

- Except for covered Ambulance Services, travel, whether or not recommended by a health care practitioner, except for the cost of air transportation for the recipient and a companion (or two companions if recipient is under the age of 18) to and from the site of a covered Organ Transplant.
- Nonhuman organs and their implantation.
- Services for, or related to, the removal of an organ from an Insured Person for purposes of transplantation into another person, unless the:
  - Transplant recipient is covered under the plan and is undergoing a covered transplant, and
  - Services are not payable by another carrier.

VALUE ADDED SERVICES

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

VISION DISCOUNT PROGRAM

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

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

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

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

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

How to Access Services

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

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

Please provide the following information when you call:

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

24 Hour Nurseline

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

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

Appropriate care may include:

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

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

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

CareConnect
Integrated Behavioral Health from Wellfleet Student

24/7 Behavioral Telehealth and Nurseline Access

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

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