University of Dayton
UDayton Global

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2020/2021

DESIGNED EXCLUSIVELY FOR THE STUDENTS

UDAYTON GLOBAL

Dayton, OH ("the Policyholder")
Group Number: ST1480SH

Fall New Policy Number: WI202OHLSHIP176-00
Fall New Effective: 8/1/2020 – 7/31/2021
Fall Returning Policy Number: WI2021OHSHIP176-01
Fall Returning Effective: 8/14/2020 – 7/13/2021
Spring Policy Number: WI2021OHSHIP176-02
Spring Annual Effective: 1/1/2020 – 12/31/2021
Summer Policy Number: WI2021OHSHIP176-03

UNDERWRITTEN BY:

Wellfleet Insurance Company | Fort Wayne, IN
("the Company")

ADMINISTERED B Y:

Wellfleet Group, LLC

WELLFLEET STUDENT

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Welcome Students…

We are pleased to provide you with this summary of the 2020 – 2021 Student Health Insurance Plan ("Plan"), which is fully compliant with the Affordable Care Act. "Benefits at a Glance" includes effective dates and costs of coverage, as well as other helpful information. For additional details about the Plan, please consult the Plan Certificate and other materials at **www.wellfleetstudent.com**. If you have questions about Enrollment into the Plan, please call University Health Plans at (800) 437-6448 **www.universityhealthplans.com/dayton**. For questions about medical benefits or claims, please call Wellfleet Student at (877) 657-5030, TTY 711.

Where to Find Help

For Questions About:	Please Contact:
Servicing Agent **Enrollment**	**University Health Plans** **15 Pacella Park Drive, Suite 130** **Randolph, MA 02368** **www.universityhealthplans.com/dayton** (800) 437-6448
Insurance Benefits **Claims Processing** **ID Cards** **Preferred Provider Listings**	**Wellfleet Group, LLC** **PO Box 15369** **Springfield, Massachusetts 01115-5369** **(877) 657-5030, TTY 711** **www.wellfleetstudent.com**
Preferred PPO Provider Listings **Cigna Claims**	**Wellfleet Student** **www.wellfleetstudent.com** or **www.cigna.com** **Send Cigna claims to:** **CIGNA** **PO Box 188061** **Chattanooga, TN 37422 – 8061** **Electronic Payor ID: 62308**
Prescription Drug Provider	**For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit www.wellfleetstudent.com** **Your plan includes Wellfleet Rx – offering over 40 generics at a $0 copay. Please ask your health care provider to review our formulary to see if these medications are right for you. Click here http://wellfleetrx.com/students/formularies/ for more information.**

Am I Eligible?

All eligible International students are required to have health insurance coverage and will be automatically enrolled in this health insurance plan and billed the plan costs for the health insurance plan. Eligible students do not have the option to waive coverage.

Insured Students who are enrolled in the Student Health Plan may also enroll their eligible dependents.

How Do I Enroll My Dependents?

To Enroll your eligible dependents:

- Go to **www.universityhealthplans.com/dayton**.
- Click the "Enroll" tab and proceed as directed to enroll in and purchase the student health insurance plan.

Refer to the dates below for the deadline to purchase dependent coverage.

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	Dependent Enrollment Deadline
Fall New Annual	8/1/2020	7/31/2021	9/30/2020
Fall Returning Annual	8/14/2020	7/31/2021	9/30/2020
Spring Annual	1/1/21	12/31/2021	2/28/2021
Summer Annual	5/1/2021	4/30/2021	06/30/2021

Plan Costs for International Students and their Dependents

	Fall New Annual	Fall Returning Annual	Spring Annual	Summer Annual
Student	$2,000	$2,000	$2,000	$2,000
Spouse	$2,000	$2,000	$2,000	$2,000
Each Child	$2,000	$2,000	$2,000	$2,000
3 or more Children	$6,000	$6,000	$6,000	$6,000

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

Preferred Provider Organization (PPO) Network

…providing access to quality health care at discounted costs!

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

UDayton Global Schedule of Benefits

This is only a brief description of coverage available under Certificate form OH SHIP CERT (2019). The Certificate will contain full details of coverage, coinsurance, limitations, exclusions, and termination provisions. If there are any conflicts between this document and the Certificate, the Certificate governs in all cases.

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

SCHEDULE OF BENEFITS

ELIGIBILITY

An eligible student must attend classes at the Policyholder's school for at least the first 31 days of the period for which he or she is enrolled, and/or pursuant to his or her visa requirements for the period for which coverage is elected.

Except in the case of withdrawal from school due to Sickness or Injury, any student who withdraws from the Policyholder's school during the first 31 days of the period for which he or she is enrolled shall not be covered under the insurance plan. A full refund of Premium will be made, minus the cost of any claim benefits paid by the Certificate. A student who graduates or withdraws after such 31 days of the period for which he or she is enrolled will remain covered under this Certificate for the term purchased and no refund will be allowed.

A student withdrawing due to a medical withdrawal due to a Sickness or Injury, must submit documentation or certification of the medical withdrawal to Us at least 30 days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable, or 30 days after the date of the medical leave from school. The student withdrawing due to a medical withdrawal due to a Sickness or Injury will remain covered under the Certificate for the term purchased and no refund will be allowed.

All International Students are required to have a J-1, F-1 or M-1 and their eligible Dependents (who are not U.S. citizens) are required to have a J-2, F-2 or M-2 Visa to be eligible for this insurance plan.

We maintain the right to investigate eligibility status and attendance records to verify that the Certificate eligibility requirements have been and continue to be met. If We discover that the Certificate eligibility requirements have not been met, Our only obligation is refund of premium less any claims paid.

Eligibility requirements must be met each time premium is paid to continue Coverage.

If You or Your Dependent has performed an act that constitutes fraud; or You have made an intentional misrepresentation of material fact during Your enrollment under this insurance plan in order to obtain coverage for a service, coverage will be terminated immediately upon written notice of termination delivered by Us to You and/or Your Dependent, as applicable. If termination is a result of Your action, coverage will terminate for You and Your Dependents. If termination is a result of Your Dependent's action, coverage will terminate for Your Dependent.

Who is Eligible

Class	Description of Class(es)
1	All International Students of the Policyholder taking 1 or more credit hours.

Class 1: All students, as determined by the Policyholder, are eligible for coverage under the Policy. Eligible students are required to have health insurance coverage and will be automatically enrolled in the Student Health Insurance Plan and pay the applicable premium amount and do not have the option to waive coverage.

Dependents are eligible for coverage under this plan.

Your Dependent may become eligible for coverage under this Certificate only when You become eligible; or within 60 days of a Qualifying Life Event.

Refund of Premium: Premiums received by Us are fully earned upon receipt. Refund of Premium will be considered only:

1. If a student ceases to be eligible for the insurance and coverage is terminated prior to the next premium due date, a pro rata refund of Premium (less any claims paid) will be made for such person. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.
2. For any student who withdraws from school during the first 31 days of the period for which he or she is enrolled for a reason other than withdrawal due to Sickness or Injury. Such a student will not be covered under this Certificate and a full refund of the Premium will be made (less any claims paid) when written request is made within 90 days of withdrawal from school. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.
3. For an Insured Student entering the Armed Forces of any country. Such a student will not be covered under this Certificate as of the date of his/her entry into the service. A pro rata refund of Premium (less any claims paid) will be made upon written request received by Us within 90 days of withdrawal from school. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.
4. For an Insured International Student, Scholar, Visiting Faculty member departing school to return to his or her Home Country on a permanent basis. We will refund a pro rata refund of Premium (less any claims paid) when written request is received by Us within 60 days of such departure. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.

Pre-Certification Process

In-Network - Your In-Network Provider is responsible for obtaining any necessary Pre-certification before You receive the care. If Your In-Network Provider does not obtain the required Pre-Certification You will not be penalized. Please read below regarding review and notification.

Out-of-Network - You or Your Out-of-Network Provider are responsible for calling Us at the phone number found on the back of Your ID card and starting the Pre-Certification process. For Inpatient services the call must be made at least 5 working days prior to Hospital Confinement. For Outpatient services, the call must be made at least 5 working days prior to the start of the Outpatient service. In the case of an emergency, the call must take place as soon as reasonably possible.

The following Inpatient and Outpatient services or supplies require Pre-Certification:

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;
2. All Inpatient maternity care after the initial 48/96 hours;
3. All partial hospitalization in a Hospital, residential Treatment facility, or facility established primarily for the Treatment of substance abuse;
4. Home Health Care
5. Durable Medical Equipment over $500;
6. Surgery;
7. Sleep Management;
8. Transplant Services;
9. Diagnostic testing/radiology;
10. Chemotherapy/radiation;
11. Infusions/injectables;
12. Botox Injections;
13. Orthognathic Surgery
14. Genetic Testing, except for Bracca;
15. Orthotics/prosthetics;
16. Transcranial Magnetic Stimulation (TMS);
17. Physical Therapy (Outpatient) precertification required after the 12th visit by a Provider
18. Occupational Therapy (Outpatient) precertification required after the 12th visit by a Provider
19. Chiropractic Services (Outpatient) precertification required after the 12th visit by a Provider .

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.

Additionally, no authorization requirement will apply to obstetrical or gynecological care provided by In-Network Providers or Out-of-Network Providers.

Pre-Certification is not a guarantee that Benefits will be paid, this does not apply to electronic pre-certifications. We will not retrospectively deny if all criteria is met at the time the services are rendered.

Your Physician will be notified of Our decision as follows:

1. For elective (non-emergency) admissions to a health care facility, We will notify the Physician and the health care facility by telephone, secure electronic transmission process, and/or in writing of the number of Inpatient days, if any, approved;
2. For Confinement in a health care facility longer than the originally approved number of days, the treating Physician or the health care facility must contact Us before the last approved day. We will review the request for continued stay to determine Medical Necessity and notify the Physician or the health care facility of Our decision in writing, secure electronic transmission process, or by telephone;
3. For any other covered services requiring Pre-Certification, We will contact the Provider in writing, secure electronic transmission process, or by telephone regarding Our decision.

Our agent will make this determination within forty-eight (48) hours for an urgent request and four (4) business days for non-urgent requests following receipt of all necessary information for review. If additional information is needed to make a determination Our agent will notify Your Provider within 24 hours with the specific information that is required.

Notice of an Adverse Benefit Determination made by Our agent will be in writing or secure electronic transmission process and will include:

1. The reasons for the Adverse Benefit Determination including the clinical rationale, if any.
2. Instructions on how to initiate an appeal.
3. Notice of the availability, upon Your request or Your Authorized Representative, of the clinical review criteria relied upon to make the Adverse Benefit Determination. This notice will specify what, if any additional necessary information must be provided to, or obtained by, Our agent in order to render a decision on any requested appeal.

Retro Review is permitted for a claim that is submitted for a service where Pre-Certification was required but not obtained if the service in question meets all of the following criteria:

1. The service is directly related to another service for which Pre-Certification was obtained and already performed;
2. The new service was not known to be needed at the time the original Pre-Certification was performed;
3. The need for the new service was revealed at the time the original authorized service was performed.

Once the request and all necessary information is received, the claim will be reviewed for coverage and medical necessity. The new service will not be denied based solely on the face that a Pre-Certification approval was not received originally.

Failure by Our agent to make a determination within the time periods prescribed shall be deemed to be an Adverse Benefit Determination subject to an appeal.

If You have any questions about Your Pre-Certification status, you should contact Your Provider.

Urgent Care claims means a medical care or other service for a condition where application of the timeframe for making routine or non-life-threatening care determinations is either of the following:

a. Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state;
b. In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition,

would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

Urgent care requests can be submitted in writing or by a secure electronic transmission process (facsimile is not considered a secure electronic transmission).

Opioid dependency Treatment is considered an Urgent Care request in accordance with applicable state and federal laws.

Preventive Services:

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

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

Medical Deductible*	In-Network Provider	Individual:	$100
	Out-of-Network Provider	Individual:	$200

***Deductible** is waived if Covered Medical Expenses are incurred at the Student Health Center

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:	In-Network Provider	Individual	$2,500
		Family	$5,000
	Out-of-Network Provider	Individual	$5,000
		Family	$10,000

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 Amounts:

In-Network Provider:	90% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below.
Out-of-Network Provider:	70% of the Usual and Customary Charge (U&C) for Covered Medical Expenses unless otherwise stated below.
Student Health Center	100% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below.

***Student Health Center Benefits:**

When Treatment is rendered at the Student Health Center, the Deductible and Copayments will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred

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

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

Dental and Vision Benefit Payments

For dental and vision benefits, you may choose any dental or vision provider.

For dental, different benefits may be payable based on the type of service, as shown in the Schedule of Benefits.

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

THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL 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.**

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Inpatient Benefits		
Hospital Care Includes hospital room & board expenses and miscellaneous services and supplies. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined: Limited to 1 visit per day of Confinement per provider	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Surgery: Pre-Certification Required		
Surgeon Services	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Anesthetist	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Assistant Surgeon	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Physical Therapy while Confined (inpatient)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Certification required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Maximum days per Policy Year	120	120
Inpatient Rehabilitation Facility Expense Benefit including Physical Medicine and Day Rehabilitation Therapy services Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
INPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
Mental Health Disorder and Substance Use Disorder Benefit Including residential treatment facilities Pre-Certification Required In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-certification requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness. You can obtain information on opioid over-use, prevention programs, and case management tools available for high risk individuals by calling the toll free customer service number 877-657-5030 listed on the back of Your ID card.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Outpatient Benefits		
Outpatient Surgery: Pre-Certification required Surgeon Services Anesthetist Assistant Surgeon	 90% of the Negotiated Charge after Deductible for Covered Medical Expenses 90% of the Negotiated Charge after Deductible for Covered Medical Expenses 90% of the Negotiated Charge after Deductible for Covered Medical Expenses	 70% of Usual and Customary Charge after Deductible for Covered Medical Expenses 70% of Usual and Customary Charge after Deductible for Covered Medical Expenses 70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Surgery Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Office Visits	$10 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
Specialist/Consultant Physician Services	$10 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
Telemedicine or Telehealth Services	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Cardiac Rehabilitation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy and Inhalation Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maximum Visits for each therapy per Policy Year for Physical Therapy, Occupational Therapy and Inhalation Therapy	30	30
Maximum Visits per Policy Year for Speech Therapy	Unlimited	Unlimited
Habilitative Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required Habilitative Services are covered to the extent that they are Medically Necessary – including services for children (up to age 21) with a medical diagnosis of Autism Spectrum Disorder. Clinical Therapeutic intervention, including but not limited to Applied Behavior Analysis, These are separate limits and are not combined with therapy limits for other conditions.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitative Services Maximum Visits for each therapy per Policy Year for Physical Therapy, Occupational Therapy. These limits do not apply to the above limits for the condition of Autism.	30	30

Emergency Services	$50 Copayment per visit then the plan pays 90% of the Negotiated Charge after Deductible for Covered Medical Expenses	The cost-share is the same as in-network, however the benefit will be based on the greatest of the following three. • The median in-network rate; • The amount for the Emergency Service calculated using the same method We generally use to determine payments for Out-of-Network services but substituting the In-Network cost-sharing provisions for the Out-of-Network cost-sharing provisions; or • The amount that would be paid under Medicare for the Emergency Service.
Urgent Care Centers	$10 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diagnostic Imaging Services Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Including orally administered cancer drugs Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Infusion Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Home Health Care Expenses Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hospice Care Coverage	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Private Duty Nursing	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
OUTPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
Mental Health Disorder and Substance Use Disorder Benefit Pre-Certification Required except for office visits In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-Certification requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness. You can obtain information on opioid over-use, prevention programs, and case management tools available for high risk individuals by calling the toll free customer service number 877-657-5030 listed on the back of Your ID card.	$10 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
Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy or Student Health Center. **Retail Pharmacy Supply Limits -** We will pay for no more than a 30-day supply of the Prescription Drug purchased at a retail pharmacy. You are responsible for one (1) Cost Sharing amount for up to a 30-day supply.		

TIER 1 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$10 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$10 Copayment then the plan pays 100% of Actual charge after Deductible for Covered Medical Expenses
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$20 Copayment then the plan pays 100% of Actual charge after Deductible for Covered Medical Expenses
More than a 60 day supply filled at a Retail pharmacy	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$30 Copayment then the plan pays 100% of Actual charge after Deductible for Covered Medical Expenses
TIER 2 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$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 after Deductible for Covered Medical Expenses
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 after Deductible for Covered Medical Expenses
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 after Deductible for Covered Medical Expenses

TIER 3 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail Pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$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 after Deductible for Covered Medical Expenses
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 after Deductible for Covered Medical Expenses
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 after Deductible for Covered Medical Expenses
Zero Cost Generics		
In addition to ACA Preventive Care medications, certain Generic Drugs are covered at no cost to you. These zero cost generics can be identified in the Formulary posted on Our website www.wellfleetstudent.com	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	100% of Actual charge for Covered Medical Expenses Deductible Waived
Specialty Prescription Drugs		
Specialty Prescription Drugs For each fill up to a 30 day supply	$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 after Deductible for Covered Medical Expenses
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 Deductible Waived	$80 Copayment then the plan pays 100% of Actual charge after Deductible for Covered Medical Expenses

More than a 60 day supply	$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 after Deductible for Covered Medical Expenses
Tobacco Cessation		
Tobacco cessation prescription and over-the-counter drugs will be covered for two 90-day treatment regimens only. Any additional prescription drug treatment regimens will be subject to the cost sharing below. For details on the current list of tobacco cessation prescription drugs and OTC drugs covered with no cost sharing during the two 90-day treatment regimens allowed, visit www.wellfleetstudent.com or call (877) 657-5030, TTY 711 .	100%	
Tobacco Cessation		
Tobacco cessation prescription drugs beyond the coverage above. Additional regiments of over-the-counter drugs are excluded.	$10 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$10 Copayment then the plan pays 100% of Actual charge after Deductible for Covered Medical Expenses
Orally administered anti-cancer prescription drugs (including specialty drugs)		
Benefit	Greater of: • Chemotherapy Benefit; or • Home Infusion Therapy Benefit	
Diabetic Supplies (for Prescription supplies purchased at a pharmacy)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Other Benefits		
Allergy Testing	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Allergy Injections/Treatment	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Ambulance Service ground and/or air, water, fixed wing and rotary wing air transportation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider
Covered Cancer Clinical Trials	Same as any other Covered Sickness	
Durable Medical Equipment Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diabetic services and supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
Enteral Formulas and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Prosthetic and Orthotic Devices Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Reconstructive Surgery Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)	**IN-NETWORK or OUT-OF-NETWORK PROVIDER**
Type A services: Diagnostic and Preventive care	100% of Usual and Customary Charge
Type B services: Basic Restorative Care	80% of Usual and Customary Charge
Type C services: Major Restorative care	50% of Usual and Customary Charge
Orthodontic services	50% of Usual and Customary Charge
Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	

PREVENTIVE AND DIAGNOSTIC SERVICES (TYPE A)
Diagnostic and Treatment Services:
Periodic oral evaluation- Limited to 1 every 6 months
Limited oral evaluation- problem focused- Limited to 1 every 6 months
Comprehensive oral evaluation- Limited to 1 every 6 months
Comprehensive periodontal evaluation- Limited to 1 every 6 months
Intraoral-complete series (including bitewings) 1 every 60 (sixty) months film
Intraoral- periapical first
Intraoral- periapical - each additional film
Intraoral- occlusal film
Bitewing- single film 1 set every 6 months
Bitewings -two films 1 set every 6 months
Bitewings - four films 1 set every 6 months
Vertical bitewings-7 to 8 films 1 set every 6 months
Panoramic film-1 film every 60 (sixty) months
Cephalometric x-ray
Oral/ Facial Photographic Images
Diagnostic Models
Preventative Services:
Prophylaxis-Child- Limited to 1 every 6 months
Topical application of fluoride (excluding prophylaxis)--Limited to 2 every 12 months
Topical application of fluoride (excluding prophylaxis)- 2 every 12 months
Topical fluoride varnish- 2 in 12 months
Sealant- per tooth- unrestored permanent molars - 1 sealant per tooth every 36 months
Preventative resin restorations in a moderate to high caries risk patient- permanent tooth- 1 sealant per tooth every 36 months
Space maintainer-fixed -unilateral
Space maintainer-fixed- bilateral
Space maintainer-removable-unilateral
Space maintainer-removable-bilateral
Re-cementation of space maintainer
Additional Procedures covered as Preventive and Diagnostic:
Palliative treatment of dental pain- minor procedure
BASIC RESTORATIVE SERVICES (TYPE B)
Minor Restorative Services:
Amalgam- one surface, primary or permanent
Amalgam- two surfaces, primary or permanent
Amalgam- three surfaces, primary or permanent

Amalgam- four or more surfaces, primary or permanent
Resin-based composite - one surface, anterior
Resin-based composite -two surfaces, anterior
Resin-based composite -three surfaces, anterior
Resin-based composite- four or more surfaces or involving incisal angle (anterior)
Re-cement inlay
Re-cement crown
Prefabricated stainless-steel crown· primary tooth - Limited to I per tooth in 60 months
Prefabricated stainless-steel crown - permanent tooth - Limited to I per tooth in 60 months
Protective Restoration
Pin retention per tooth, in addition to restoration
Endodontic Services:
Therapeutic pulpotomy (excluding final restoration)- *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.*
Partial pulpotomy for apexogenesis- permanent tooth with incomplete root development *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a pan of the root canal procedure and benefits are not payable separately.*
Pulpal therapy (resorbable filling)- anterior, primary tooth (excluding final restoration)
Pulpal therapy (resorbable filling)- posterior, primary tooth (excluding final restoration). Incomplete endodontic treatment when treatment is discontinued.
Periodontal Services:
Periodontal scaling and root planing-four or more teeth per quadrant- Limited to 1 every 24 months
Periodontal scaling and root planing-one to three teeth, per quadrant- Limited to 1 every 24 months
Periodontal maintenance- 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy.
Prosthodontic Services:
Adjust complete denture-maxillary
Adjust complete denture-mandibular
Adjust partial denture-maxillary
Adjust partial denture-mandibular
Repair broken complete denture base
Replace missing or broken teeth complete denture (each tooth)
Repair resin denture base
Repair cast framework
Repair or replace broken clasp
Replace broken teeth- per tooth
Add tooth to existing partial denture
Add clasp to existing partial denture
Rebase complete maxillary denture- Limited to 1 in a 36-month period 6 months after the initial installation
Rebase maxillary partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
Rebase mandibular partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
Reline complete maxillary denture -Limited to 1 in a 36-month Period 6 months after the initial installation
Reline complete mandibular denture -Limited to l in a 36-month period 6 months after the initial installation
Reline maxillary partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
Reline mandibular partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
Reline complete maxillary denture (laboratory) -Limited to 1 in a 36-month period 6 months after the initial
Reline complete mandibular denture (laboratory)- Limited to 1 in a 36-month period 6 months after the initial
Reline maxillary partial denture (laboratory)·Limited to 1 in a 36-month period 6 months after the initial installation
Reline mandibular partial denture (laboratory) Rebase/Reline- Limited to 1 in a 36-month period 6 months after the initial installation
Tissue conditioning (maxillary)
Tissue conditioning (mandibular)
Re-cement fixed partial denture
Fixed partial denture repair, by report
Oral Surgery:

Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
Removal of impacted tooth - soft tissue
Removal of impacted tooth- partially bony
Removal of impacted tooth - completely bony
Removal of impacted tooth - completely bony with unusual surgical complications
Surgical removal of residual tooth roots (cutting procedure)
Coronectomy- intentional partial tooth removal
Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
Surgical access of an unerupted tooth
Alveoloplasty in conjunction with extractions - per quadrant
Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
Alveoloplasty not in conjunction with extractions- per quadrant
Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
Removal of exostosis
Incision and drainage of abscess intraoral soft tissue
Suture of recent small wounds up to *5* cm
Excision of pericoronal gingiva
MAJOR SERVICES (TYPE C)
Major Restorative Services:
Detailed and extensive oral evaluation- problem focused, by report
Inlay- metallic- one surface- An alternate benefit will be provided
Inlay- metallic- two surfaces -An alternate benefit will be provided
Inlay- metallic-three surfaces -An alternate benefit will be provided
Onlay- metallic- two surfaces- Limited to 1 per tooth every 60 months
Onlay - metallic- three surfaces- Limited to 1 per tooth every 60 months
Onlay - metallic- four or more surfaces- Limited to 1 per tooth every 60 months
Crown- porcelain/ceramic substrate- Limited to 1 per tooth every 60 months
Crown- porcelain fused to high noble metal- Limited to 1 per tooth every 60 months
Crown- porcelain fused to predominately base metal-Limited to 1 per tooth every 60 months
Crown- porcelain fused to noble metal-Limited to 1 per tooth every 60 months
Crown - 3/4 cast high noble metal- Limited to 1 per tooth every 60 months
Crown - 3/4 cast predominately base metal- Limited to 1 per tooth every 60 months
Crown - 3/4 porcelain/ceramic- Limited to 1 per tooth every 60 months
Crown - full cast high noble metal- Limited to 1 per tooth every 60 months
Crown- full cast predominately base metal-Limited to 1 per tooth every 60 months
Crown - full cast noble metal- Limited to I per tooth every 60 months
Crown-titanium- Limited to 1 per tooth every 60 months
Core buildup, including any pins- Limited to 1 per tooth every 60 months
Prefabricated post and core, in addition to crown- Limited to 1 per tooth every 60 months
Crown repair, by report
Endodontic Services:
Anterior root canal (excluding final restoration)
Bicuspid root canal (excluding final restoration)
Molar root canal (excluding final restoration)
Retreatment of previous root canal therapy-anterior
Retreatment of previous root canal therapy-bicuspid
Retreatment of previous root canal therapy-molar
Apexification/recalcification- initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
Apexification/recalcification- interim medication replacement (apical closure/calcific repair of perforations, root
Apexification/recalcification- final visit (includes completed root canal therapy, apical closure/calcific repair of
Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp)
Apicoectomy/periradicular surgery- anterior
Apicoectomy/periradicular surgery- bicuspid (first root)
Apicoectomy/periradicular surgery -molar (first root)

Apicoectomy/periradicular surgery (each additional root)
Root amputation- per root
Hemisection (including any root removal)- not including root canal therapy
Periodontal Services:
Gingivectomy or gingivoplasty- four or more teeth-Limited to 1 every 36 months
Gingivectomy or gingivoplasty-one to three teeth
Gingival flap procedure, four or more teeth-Limited to 1 every 36 months
Clinical crown lengthening-hard tissue
Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant-
Pedicle soft tissue graft procedure
Free soft tissue graft procedure (including donor site surgery)
Subepithelial connective tissue graft procedures (including donor site surgery)
Full mouth debridement to enable comprehensive evaluation and diagnosis
Prosthodontic Services:
Complete denture - maxillary-Limited to 1 every 60 months
Complete denture- mandibular-Limited to 1 every 60 months
Immediate denture- maxillary-Limited to 1 every 60 months
Immediate denture- mandibular-Limited to 1 every 60 months
Maxillary partial denture- resin base (including any conventional clasps, rests and teeth)- Limited to 1 every 60
Mandibular partial denture- resin base (including any conventional clasps, rests and teeth)-Limited to 1 every 60
Maxillary partial denture- cast metal framework with resin denture base (including any conventional clasps, rests
Mandibular partial denture- cast metal framework with resin denture base (including any conventional clasps, rests
Removable unilateral partial denture-one-piece cast metal (including clasps and teeth)-Limited to 1 every 60 months
Endosteal Implant- 1 every 60 months
Surgical Placement of Interim Implant Body- 1 every 60 months
Eposteal Implant- 1 every 60 months
Transosteal Implant. Including Hardware- 1 every 60 months
Implant supported complete denture
Implant supported partial denture
Connecting Bar-implant or abutment supported- 1 every 60 months
Prefabricated Abutment- 1 every 60 months
Abutment supported porcelain ceramic crown - 1 every 60 months
Abutment supported porcelain fused to high noble metal- 1 every 60 months
Abutment supported porcelain fused to predominately base metal crown- 1 every 60 months
Abutment supported porcelain fused to noble metal crown 1 every 60 months
Abutment supported cast high noble metal crown - 1 every 60 months
Abutment supported cast predominately base metal crown – 1 every 60 months
Abutment supported Cast noble metal crown 1 every 60 months
Implant supported porcelain/ceramic crown- 1 every 60 months
Implant supported porcelain fused to high metal crown - 1 every 60 months
Implant supported metal crown- 1 every 60 months
Abutment supported retainer for porcelain/ceramic fixed partial denture- 1 every 60 months
Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months
Abutment supported retainer for porcelain fused to noble metal fixed partial denture- 1 every 60 months
Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months
Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months
Abutment supported retainer for cast noble metal fixed partial denture- 1 every 60 months
Implant supported retainer for ceramic fixed Partial denture- 1 every 60 months
Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
Implant supported retainer for cast metal fixed partial denture - 1 every 60 months
Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months
Implant/abutment supported fixed partial denture for partially edentulous arch- 1 every 60 months
Implant Maintenance Procedures -1 every 60 months
Repair Implant Prosthesis -1 every 60 months
Replacement of Semi-Precision or Precision Attachment- 1 every 60 months
Repair Implant Abutment -1 every 60 months

Implant Removal-1 every 60 months
Implant Index -1 every 60 months
Pontic-cast high noble metal- Limited to 1 every 60 months
Pontic-cast predominately base metal -Limited to 1 every 60 months
Pontic-cast noble metal- Limited to 1 every 60 months
Pontic-titanium-Limited to 1 every 60 months
Pontic -porcelain fused to high noble metal-Limited to 1 every 60 months
Pontic-porcelain fused to predominately base metal-Limited to 1 every 60 months
Pontic-porcelain fused to noble metal Limited to 1 every 60 months
Pontic-porcelain/ceramic-Limited to 1 every 60 months
Inlay/on lay- porcelain/ceramic-Limited to 1 every 60 months
Inlay-metallic-two surfaces-Limited to 1 every 60 months
Inlay- metallic-three or more surfaces- Limited to 1 every 60 months
Onlay- metallic- three surfaces- 1 every 60 months
Onlay- metallic- four or more surfaces -1 every 60 months
Retainer -cast metal for resin bonded fixed prosthesis -1 every 60 months
Retainer- porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months
Crown- porcelain/ceramic- 1 every 60 months
Crown -porcelain fused to high noble metal - 1 every 60 months
Crown- porcelain fused to predominately base metal- 1 every 60 months
Crown- porcelain fused to noble metal - 1 every 60 months
Crown -3/4 cast high noble metal - 1 every 60 months
Crown- 314 cast predominately base metal • 1 every 60 months
Crown 3/4 cast noble metal 1 every 60 months
Crown - 3/4 porcelain/ceramic- 1 every 60 months
Crown • full cast high noble metal- 1 every 60 months
Crown -full cast predominately base metal- 1 every 60 months
Crown full cast noble metal 1 every 60 months
Core build up for retainer including any pins 1 every 60 months
Occlusal guard, by report- 1 in 12 months
GENERAL SERVICES (TYPE C)
Anesthesia Services:
Deep sedation/general anesthesia- first 30 minutes
Deep sedation/general anesthesia- each additional 15 minutes
Intravenous Sedation:
Intravenous conscious sedation/analgesia- first 30 minutes
Intravenous conscious sedation/analgesia each additional 15 minutes
Consultations:
Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)
Medications:
Therapeutic drug injection, by report
Post-Surgical Services:
Treatment of complications (post-surgical) unusual circumstances, by report
MEDICALLY NECESSARY ORTHODONTIA SERVICES (TYPE D)
Orthodontic Services -covered for persons with severe and handicapping malocclusion
Limited orthodontic treatment of the primary dentition
Limited orthodontic treatment of the transitional dentition
Limited orthodontic treatment of the adolescent dentition
Interceptive orthodontic treatment of the primary dentition
Interceptive orthodontic treatment of the transitional dentition
Comprehensive orthodontic treatment of the transitional dentition
Comprehensive orthodontic treatment of the adolescent dentition
Removable appliance therapy
Periodic orthodontic treatment visits (as part of contract)
Orthodontic retention (removal of appliances, construction and placement of retainer(s)

Pediatric Vision Care Benefit (including low vision services) (to the end of the month in which the Insured Person turns age 19) Limited to 1 visit(s) 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.	**IN-NETWORK or OUT-OF-NETWORK PROVIDER** 100% of Usual and Customary Charge after Deductible for Covered Medical Expenses per Policy Year	
Accidental Injury Dental Treatment	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Pre-Certification Required	$10 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Organ Transplant Surgery Donor's search for bone marrow/stem cell transplants limited to $30,000 per Transplant Maximum benefit payable for travel and lodging expenses for any one transplant $10,000 Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Treatment for Temporomandibular (TMJ) or Craniomandibular Joint (CMJ) Disorder and Craniomandibular Jaw Disorder	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Child Health Supervision Services, when Dependent Coverage is part of this Certificate.	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
ADDITIONAL BENEFITS		
Bariatric Surgery Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infertility Treatment Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Medical Evacuation Expense	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived Subject to $50,000 maximum per Policy Year	
Repatriation Expense	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived Subject to $25,000-Unlimited	
Non-emergency Care While Traveling Outside of the United States	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses for Medically Necessary treatment when You are traveling outside of the United States. Subject to $10,000 maximum per Policy Year	
Registered Nurse Services for private duty nursing while Confined	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Student Health Center Expense	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	
Shots and Injections unless considered Preventive Services	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Tuberculosis screening, Titers, Quantiferon B tests including shots (other than covered under preventive services)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Principal Sum $10,000

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

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

Pre-Certification

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

Exclusions and Limitations

OHIO STATE SPECIFIC BENEFIT EXCLUSIONS

Skilled Nursing Facility Benefit

Exclusions under this benefit include**:**

a. Custodial Care service and supplies, and
b. Confinement for Custodial Care or residential care.

Inpatient Rehabilitation Facility Expense Benefit, including Physical Medicine and Day Rehabilitation Program

Non covered services for Physical Medicine and Inpatient Rehabilitation include, but are not limited to**:**

a. Admission to a Hospital mainly for physical therapy;
b. Long term rehabilitation in an Inpatient setting.

Outpatient Physical therapy

Non covered services include but are not limited to:

a. maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness;
b. repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients);
c. range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities;
d. general exercise programs;
e. diathermy, ultrasound and heat treatments for pulmonary conditions;
f. diapause;
g. work hardening.

Outpatient Occupational therapy

Non covered services include but are not limited to:

a. supplies (looms, ceramic tiles, leather, utensils);
b. therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again;
c. general exercises to promote overall fitness and flexibility;
d. therapy to improve motivation; suction therapy for newborns (feeding machines);
e. soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial;
f. adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

Home Health Care Expenses

Non covered services under this benefit includes Custodial Care service and supplies.

Hospice Care Coverage

Non-Covered Services for Hospice Care include but are not limited to:

a. Services provided by volunteers
b. Housekeeping services

Prescription Drugs

Non covered drugs under this Prescription Drug benefit for any drug or medicine:

a. Prescription Drugs dispensed by any Mail Service program other than the PBM's mail Service, unless prohibited by law, except as required for Preventive Care Services and unless covered elsewhere in this certificate.
b. Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product, except as required for Preventive Care Services.
c. Off label use, except as otherwise prohibited by law.
d. Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
e. Drugs not approved by the FDA.
f. Charges for the administration of any Drug.
g. Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.
h. Any Drug which is primarily for weight loss.
i. Drugs not requiring a prescription by federal law (including Drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
j. Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
k. Fertility Drugs, unless covered elsewhere in this certificate.
l. Oral immunizations, and biologicals, although they are federal legend Drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter Drugs, devices or products, they are not Covered Services, unless such over the counter methods are prescribed by a Physician, except as specifically provided under Preventive Services.
m. Drugs in quantities which exceed the limits established by the Plan.
n. Compound Drugs unless there is at least one ingredient that requires a prescription.
o. Treatment of Onchomycosis (toenail fungus).
p. Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter except for Preventive Services.
q. Brand-Name Prescription Drugs with generic equivalents, except as specifically provided under Preventive Services.

Ambulance Service

Non-covered Services for Ambulance include but are not limited to:

a. A Physician's office or clinic;
b. A Morgue or Funeral Home.

Durable Medical Equipment (DME)

Non covered services for DME items include but are not limited to:

a. Air Conditioners
b. Ice bags/cold pack pump
c. Raised toilet sear
d. Rental of equipment if the Member is in a Facility that is expected to provide such equipment
e. Trans lift chairs
f. Treadmill exerciser
g. Tub chair used in shower.

Maternity Benefit

Non-covered Service for Maternity Benefit include but are not limited to services that are duplicated when provided by both a certified Nurse-midwife and a Physician.

Prosthetic Devices

Non covered services for Prosthetic appliance include but are not limited to:

a. Dentures, replacing teeth or structures directly supporting teeth
b. Dental appliances
c. Such non-rigid appliance as elastic stockings, garter belts, arch supports and corsets
d. Artificial heart implants
e. Wigs (except as described above following cancer treatment).
f. Penile prosthesis in men suffering impotency resulting from disease or injury.

Orthotic Devices

Non covered services for Orthotic devices include but not limited to:

a. Orthopedic shoes (except therapeutic shoes for diabetics)
b. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace
c. Standard elastic stockings, garter belts, and other supplies not specially made and fitted
d. Garter belts or similar devices.

Accidental Injury Dental Treatment

Non covered services under this benefit include but not limited to:

a. orthodontic braces and orthodontic appliances.
b. routine dental care and treatment.

Chiropractic Care Benefit

Non covered service for Chiropractic Care include but not limited to:
This benefit does not cover charges incurred for:

a. Acupuncture,
b. heat Treatment,
c. diathermy,
d. massage, in any form, except to the extent provided in the Schedule of Benefits

Organ Transplant Surgery

Non covered services for Organ Transplant Surgery include, but not limited to:

a. Routine harvesting and storage of stem cells from newborn cord blood;
b. The purchase price of any organ or tissue;
c. Donor services if the recipient is not an Insured Person under this plan;
d. Services for or related to the transplantation of animal or artificial organs or tissues;
e. The transplant services of a non-Insured Person acting as a donor for an Insured Person if the non-Insured Person's expenses will be Covered under another health plan or program.

Travel Expenses

Non-Covered Services for transportation and lodging include, but are not limited to:

a. Child care;
b. Mileage within the medical transplant facility city;
c. Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us;
d. Frequent Flyer miles;
e. Coupons, Vouchers, or Travel tickets;
f. Prepayments or deposits;
g. Services for a condition that is not directly related or a direct result of the transplant;
h. Telephone calls;
i. Laundry;
j. Postage;
k. Entertainment;
l. Interim visits to a medical care facility while waiting for the actual transplant procedure;
m. Travel expenses for donor companion/caregiver;
n. Return visits for the donor for a Treatment of condition found during the evaluation.

EXCLUSIONS AND LIMITATIONS

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

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

1. Which are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.
2. Received from an individual or entity that is not a Provider, as defined in this Certificate, or recognized by Us.
3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, subject to the internal and external review process. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.
4. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to an Insured Person, then this Exclusion does not apply. This exclusion applies if the Insured Person receives the benefits in whole or in part. This exclusion also applies whether or not the Insured Person claims the benefits or compensation.
5. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
6. For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
7. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
8. For court ordered testing or care unless Medically Necessary.
9. For which an Insured Person has no legal obligation to pay in the absence of this or like coverage.
10. For the following:
    - Physician or Other Practitioners' charges for consulting with Insured Persons by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Insured Person except as otherwise described in this Certificate.
    - Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with Providers not directly responsible for an Insured Person's care.
    - Charges that are not documented in Provider records.

- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

11. Received from a dental or medical department maintained by or on behalf of a School, mutual benefit association, labor union, trust or similar person or group, or as part of the Student Health Center benefits provided by this plan.
12. Prescribed, ordered or referred by or received from a member of an Insured Person's immediate family, including an Insured Person's spouse, child, brother, sister, parent, in-law, or self.
13. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
14. For missed or canceled appointments.
15. For mileage, lodging and meals costs, and other Insured Person travel related expenses, except as specifically stated as a Covered Service.
16. For which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if an Insured Person had applied for Parts A, B and/or D, except, as specified elsewhere in this Certificate or as otherwise prohibited by federal law, as addressed in the section titled "Medicare" in General Provisions. For the purposes of the calculation of benefits, if the Insured Person has not enrolled in Medicare Part B, We will calculate benefits as if they had enrolled.
17. Charges in excess of Our Maximum Usual and Reasonable.
18. Incurred prior to an Insured Person's Effective Date.
19. Incurred after the termination date of this coverage except as specified elsewhere in this Certificate.
20. For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve an Insured Person's appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of an Insured Person's skin or to change the size, shape or appearance of facial or body features (such as an Insured Person's nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Insured Person was covered by another carrier/self-funded plan prior to coverage under this Certificate. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.
21. For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves an Insured Person's present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
22. For the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, (except for Mental Health Disorder and Substance Use Disorder treatment), treatment center, halfway house, or school because an Insured Person's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
    - Care provided or billed by a residential facility (except for Mental Health Disorder and Substance Use Disorder treatment), including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
    - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

- Wilderness camps.

23. For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.
    - applying skin creams in order to maintain skin tone.
    - other services that are performed when there is not a localized illness, injury or symptom involving the foot.
24. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; Tartaglia; metatarsalgia; hyperkeratosis.
25. Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
26. For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous plan, and it applies if the surgery was performed while the Insured Person was covered by a previous carrier/self-funded plan prior to coverage under this Certificate. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.
27. For marital counseling.
28. For hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Certificate.
29. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
30. For services to reverse voluntarily induced sterility.
31. For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;
    - Safety helmets for Insured Persons with neuromuscular diseases; or
    - Sports helmets.
32. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
33. For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or as otherwise described in this Certificate.
34. For care received in an emergency room which is not Emergency Care, except as specified in this Certificate. This includes, but is not limited to suture removal in an emergency room.
35. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
36. For self-help training and other forms of non-medical self-care, except as otherwise provided in this Certificate.
37. For examinations relating to research screenings.
38. For stand-by charges of a Physician.
39. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes except as required under Preventive Services.

40. For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.
41. For Manipulation Therapy services rendered in the home as part of Home Care Services.
42. Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
43. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
44. For any services or supplies provided to a person not covered under the Certificate in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
45. For surgical treatment of gynecomastia.
46. For treatment of hyperhidrosis (excessive sweating).
47. Complications directly related to a service or treatment that is a non- Covered Service under this Certificate because it was determined by Us to be Experimental/Investigational or non- Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non- Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non- Medically Necessary service.
48. For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply, except as required for Preventive Care Services. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
49. Treatment of telangiectatic dermal veins (spider veins) by any method.
50. Reconstructive services except as specifically stated in the **Covered Services** section of this Certificate, or as required by law.
51. Nutritional and/or dietary supplements, except as provided in this Certificate or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.
52. **International Students Only -** Eligible expenses within the Insured Person's Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which the Insured Person could be eligible.
53. Dental Implants, except for the benefit covered under the Pediatric Dental benefit, unless covered elsewhere in this Certificate.
54. Human Growth Hormone for children born small for gestational age.
55. Prescriptions, fitting, or purchase of eyeglasses or contact lenses, except for benefits provided under Pediatric Vision, and except in the case of Injury or as otherwise provided and unless covered elsewhere in this Certificate.
56. Vision correction surgery, Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision (including LASIK, radial keratotomy or keratomileusis), except as provided herein or when due to a disease process. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery for treatment of cataract or aphakia, contact lenses or glasses following lens implantation.

Value Added Services

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

VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:

www.wellfleetstudent.com

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

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

24 HOUR NURSELINE

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

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

Appropriate care may include self-care at home, a call to a physician, or a visit to the emergency room.

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

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

(800) 634-7629

CareConnect

Integrated Behavioral Health from Wellfleet Student

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

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