DREW

DREW UNIVERSITY / MADISON NJ

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2021/2022

DESIGNED EXCLUSIVELY FOR THE STUDENTS

DREW UNIVERSITY UNDERGRADUATE STUDENTS
Madison, NJ
("the Policyholder")

Policy Number: WI2122NJSHIP143
Group Number: ST0834SH
Effective: 8/15/2021 – 8/14/2022

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

ADMINISTERED BY:
Wellfleet Group, LLC

WELLFLEET STUDENT

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Welcome Students…

We are pleased to provide you with this summary of the 2021 – 2022 Student Health Insurance Plan ("Plan"), which is fully compliant with the Affordable Care Act. "Benefits at a Glance" includes effective dates and costs of coverage, as well as other helpful information. For additional details about the Plan, please consult the Plan Certificate and other materials at www.wellfleetstudent.com. If you have questions about Enrollment into the Plan, please call University Health Plans at (833) 251-1730. For questions about medical benefits or claims, please call Wellfleet Student at (877) 657-5030 TTY 711.

PENDING STATE APPROVAL

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

Where to Find Help

For Questions About:	Please Contact:
Servicing Agent **Enrollment**	**University Health Plans** *A Risk Strategies Company* 15 Pacella Park Drive Randolph, MA 02368 **www.universityhealthplans.com** **(833) 251-1730**
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 registered Full Time Students are required to have health insurance coverage, either through this Student Health Insurance Plan or through another individual or family plan. Students are automatically enrolled in the Student Health Insurance Plan unless proof of comparable coverage is provided by completing the waiver.

How Do I Waive?

In order to enroll in or waive the student health insurance you must log into Treehouse, and the form can be found in the My Account section under the Student tab, at **https://link.zixcentral.com/u/ead559bf/5Kt6Aq-A6hG8h1EEKXgf9A?u=https%3A%2F%2Fwww.drew.edu%2Fhome.**

The deadline to waive coverage for Annual coverage is 9/4/2021.

Effective Dates & Costs

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

Coverage Period	Coverage Start Date	Coverage End Date	Waiver Deadline
Annual	8/15/2021	8/14/2022	9/4/2021
Spring (New Students Only)	1/15/2022	8/14/2022	2/2/2022

Plan Costs for Undergraduate Students*

	Annual	Spring (New Students Only)
Student	$2,143	$1,244

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

Drew University Health Services

Students do not have to enroll in the student insurance plan in order to receive care at the Drew University Health Service.

On-campus services include:

- Alcohol / drug information
- Allergy shots
- Assessment and treatment of acute illnesses
- Diagnostic tests in on-site lab or outside lab
- Eating disorder care / information
- Gynecological care
- Health education programs
- Immunizations including flu shots
- International travel advisory/vaccines
- Management of chronic disease or disability
- Medications available on-site (discounted)
- Nutrition counseling
- Physical exams (discounted fees apply)
- Pregnancy testing
- Referrals to specialists as needed
- Sexually transmitted infection testing/treatment
- X-Ray and mammogram referral to local facility

Health Service Hours: (regular semesters)
Monday - Thursday 9 AM – 8 PM Friday 9 AM – 5 PM
Limited hours during January & summers

For more information about on-campus services contact:
Drew University Health Service
36 Madison Avenue
Madison, NJ 07940 (973) 408-3414 health@drew.edu
Or visit our website at www.drew.edu/health

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.

Drew University Undergraduate Students Schedule of Benefits

This is only a brief description of coverage available under Certificate form NJ 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

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

Out-of-Network Provider: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of the Usual and Customary Charge.

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

Cost sharing the Insured Person 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 the Insured Person incurs 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	$6,350
	Out-of-Network Provider	Individual	No maximum

Cost sharing the Insured Person incurs 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 the Insured Person incurs 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:	80% 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 Usual and Customary Charge (U&C) for Covered Medical Expenses unless otherwise stated below

***Student Health Center Benefits:**
When Treatment is rendered at the Student Health Center, benefits will be paid at 100% for Covered Medical Expenses incurred

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

Dental and Vision Benefit Payments
For dental and vision benefits, the Insured Person 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 the Insured Person's area, consult the Provider Directory or call toll free 1-877-657-5030, 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 OTHER THAN MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS		
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	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	80% 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	80% 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 Anesthetist Assistant Surgeon	 80% of the Negotiated Charge after Deductible for Covered Medical Expenses 80% of the Negotiated Charge after Deductible for Covered Medical Expenses 80% 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
Physical Therapy while Confined (inpatient)	80% 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	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	80% 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 CONDITIONS AND SUBSTANCE USE DISORDERS BENEFITS FOR OUTPATIENT BENEFITS REFER TO THE OUTPATIENT MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS BENEFITS		
Mental Health Condition and Substance Use Disorder Benefit Includes Inpatient Hospital, Skilled Nursing Facility, and Inpatient Rehabilitation Facility services and supplies Pre-Certification Required	Same Terms and Conditions as apply to other medical or surgical benefits	Same Terms and Conditions as apply to other medical or surgical benefits

OUTPATIENT BENEFITS OTHER THAN MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS		
Outpatient Surgery: Pre-Certification required Surgeon Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Anesthetist	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Assistant Surgeon	80% of the Negotiated 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	80% 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	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Specialist/Consultant Physician Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telemedicine/Telehealth Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Cardiac Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	80% 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 Cognitive Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Habilitative Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Services (includes Ambulance and Urgent Care for emergency medical conditions).	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Urgent Care Centers for non-life-threatening conditions	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diagnostic Imaging Services Pre-Certification Required	80% 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	80% 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)	80% 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 Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	80% 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	80% 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	80% 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	80% 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 CONDITIONS AND SUBSTANCE USE DISORDERS BENEFITS FOR INPATIENT SERVICES SEE INPATIENT MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS BENEFITS		
Mental Health Condition and Substance Use Disorder Benefit Pre-Certification Required except for office visits Includes Office Visits and all other Outpatient services and supplies With regard to Autism and Developmental Disabilities, no visit limits apply to behavioral intervention services, speech, physical, occupational therapy and habilitative care. Refer to the Autism and Developmental Disabilities provision under Mandated Benefits.	Same Terms and Conditions as apply to other medical or surgical benefits	Same Terms and Conditions as apply to other medical or surgical benefits
OUTPATIENT PRESCRIPTION DRUGS		
No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy. Please note: Generic Prescription Drugs may appear in any tier of the Formulary posted on Our website www.wellfleetstudent.com . If a Generic Prescription Drug is in any tier other than Tier 1, the Tier 1 Copayment per 30 day supply will apply. Refer to the Formulary to determine which tier the Insured Person's prescription drug has been assigned.		
Prescription Drugs TIER 1 (Including Enteral 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. 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 Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$15 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$15 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	$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
More than a 60 day supply filled at a Retail pharmacy	$45 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$45 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses

Prescription Drugs TIER 2 (Including Enteral 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. 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 Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$30 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	$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
More than a 60 day supply filled at a Retail pharmacy	$90 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$90 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses
Prescription Drugs TIER 3 (Including Enteral 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. 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 Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$50 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	$100 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$100 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	$150 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$150 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses

Prescription Drugs **Zero Cost Generics**		
Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of the Negotiated Charge for Covered Medical Expenses 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 Pharmacy Prescription Drug Fill	
Other Benefits		
Allergy Testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible 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 Usual and Customary Charge.
Non-Emergency Ambulance Service ground and/or air, water transportation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Bariatric Surgery Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Covered Clinical Trials	Same as any other Covered Sickness	
Durable Medical Equipment Pre-Certification Required	80% 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.	Covered the same as any other Sickness	Covered the same as any other Sickness
Dialysis Treatment	80% 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.	80% 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	80% 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	80% 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)	See the Pediatric Dental Care Benefit description in the Certificate for further information.	
Preventive Services	100% of Usual and Customary Charge	
Restorative Services	100% of Usual and Customary Charge	
Endodontic Services	50% of Usual and Customary Charge	
Periodontic Services	50% of Usual and Customary Charge	
Prosthodontic Services	50% of Usual and Customary Charge	
Oral and Maxillofacial Surgical Services	50% of Usual and Customary Charge	
Orthodontic Services	50% of Usual and Customary Charge	
Adjunctive General 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.		

Pediatric Vision Care Benefit (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.	100% of Usual and Customary Charge after Deductible for Covered Medical Expenses	
Adult Vision Care (age 19 and older) Routine Eye Exam once every 12 months Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses	
Accidental Injury Dental Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Sickness Dental Expense for Insured Person's over age 18	80% 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	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Gender Reassignment Benefit Pre-Certification Required	80% 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	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Organ Transplant Surgery travel and lodging expenses a maximum of $500 per Policy Year or $250 per day, whichever is less Pre-Certification Required	80% 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 Joint (TMJ) Disorders	80% 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)	80% 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/Infirmary Expense	100% of the Usual and Customary Charge for Covered Medical Expenses	
Medical Treatment Received in Home Country (International Students Only)	70% of actual charge after Deductible for Covered Medical Expenses	
Non-emergency Care While Traveling Outside of the United States	70% of actual charge after Deductible for Covered Medical Expenses Subject to $10,000 maximum per Policy Year	
Medical Evacuation Expense	100% of actual charge for Covered Medical Expenses Deductible Waived Subject to $50,000 maximum per Policy Year	
Repatriation Expense	100% of actual charge for Covered Medical Expenses Deductible Waived Subject to $25,000 maximum per Policy Year	
Mandated Benefits		
Fertility Preservation Services	Same as any other Sickness, subject to the limitations described in the Benefit	
Anesthesia and Hospitalization for Dental Services	Same as any other Sickness, subject to the limitations described in the Benefit	
Audiology and Speech Language Pathology Benefit	Same as any other Sickness, subject to the limitations described in the Benefit	
Autism or Other Developmental Disability	Same terms and conditions as apply to other medical or surgical benefits, subject to the limitations described in the Benefit	
Cancer Treatment; Bone Marrow Transplants	Same as any other Sickness, subject to the limitations described in the Benefit	
Cervical Cancer Screening	Same as any other Sickness, unless considered a Preventive Service	
Colorectal Cancer Screening	Same as any other Sickness, unless considered a Preventive Service	
Female Contraceptives	Same as any other Sickness, unless considered a Preventive Service	
Health Wellness Examinations	Same as any other Sickness, unless considered a Preventive Service. Digital tomosynthesis for women 40 years and over are considered a Preventive Service.	
Hemophilia Treatment	Same as any other Sickness, subject to the limitations described in the Benefit	
Mammography Coverage	Same as any other Sickness, unless considered a Preventive Service	
Mastectomy and Reconstructive Breast Surgery Benefit	Same as any other Sickness, subject to the limitations described in the Benefit	
Newborn Hearing Loss Screening	Same as any other Sickness, unless considered a Preventive Service	
Prostate Cancer Screening	Same as any other Sickness, unless considered a Preventive Service	
Second and Third Surgical Opinions	Same as any other Sickness, subject to the limitations described in the Benefit	
Sickle Cell Anemia Coverage	Same as any other Sickness, subject to the limitations described in the Benefit	
Treatment of Wilm's Tumor	Same as any other Sickness, subject to the limitations described in the Benefit	

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Principal Sum $10,000

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

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

Pre-Certification

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

Exclusions and Limitations

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

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

1. **International Students Only -**expenses incurred within the Insured Person's Home Country or country of regular domicile, that exceed the benefit amount shown in the Schedule of Benefits.
2. Treatment, service or supply which is not Medically Necessary for the diagnosis, care or Treatment of the Sickness or Injury involved. This does not apply to Preventive Services including diagnosis, care or Treatment prescribed, recommended or approved by the Student Health Center or by the Insured Person's Physician or dentist.
3. Medical services rendered by a provider employed for or contracted with the Policyholder, including team Physicians or trainers, except as specifically provided in the Schedule of Benefits or as part of the Student Health Center benefits provided by this plan.
4. Professional services rendered by an Immediate Family Member or anyone who lives with the Insured Person.
5. Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary because of Injury, infection or disease.
6. Infertility Treatment (male or female)-this includes but is not limited to:
   - Procreative counseling;
   - Premarital examinations;
   - Genetic counseling and genetic testing;
   - Impotence, organic or otherwise;
   - Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
   - Costs for an ovum donor or donor sperm;
   - Sperm storage costs;
   - Cryopreservation and storage of embryos;
   - Ovulation induction and monitoring;
   - Artificial insemination;
   - Hysteroscopy;
   - Laparoscopy;
   - Laparotomy;
   - Ovulation predictor kits;

- Reversal of tubal ligations;
- Reversal of vasectomies;
- Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
- Cloning; or
- Medical and surgical procedures that are Experimental/Investigative, unless Our denial is overturned by an external appeal agent.

7. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
8. Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance.
9. Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
10. Services or supplies received as a result of a war or an act of war, if the Sickness or Injury occurs while the Insured Person is serving in the military, naval or air forces of any country, combination of countries or international organization and Sickness or Injury suffered as a result of special hazards incident to such service if the Sickness or Injury occurs while the Insured Person is serving in such forces and is outside the home area.
11. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate or club sports for which benefits are paid under another Sports Accident policy issued to the Policyholder; or for which coverage is provided by the National Collegiate Athletic Association (NCAA), National Association of Intercollegiate Athletic (NAIA) or any other sports association.
12. Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which the Insured Person is required to pay.
13. Services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
14. Expenses payable under any prior policy which was in force for the person making the claim.
15. Expenses incurred after:
    - The date insurance terminates as to an Insured Person, except as specified in the extension of benefits provision; and
    - The end of the Policy Year specified in the Policy.
16. Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
17. Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
18. Weight management. Weight reduction. Nutrition programs. This does not apply to nutritional counseling or any screening or assessment specifically provided under the Preventive Services benefit, or otherwise specifically covered under the Certificate.
19. Treatment for obesity except Bariatric Surgery. Surgery for removal of excess skin or fat.
20. Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
21. Charges for Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness
22. Expenses for radial keratotomy or Lasik surgery.
23. Adult Vision unless specifically provided in the Certificate.
24. Charges for office visit exam for the fitting of prescription contact lenses, duplicate spare eyeglasses, lenses or frames, non-prescription lenses or contact lenses that are for cosmetic purposes.
25. Charges for hearing exams, and the fitting or repair or replacement of hearing aids or cochlear implants except as specifically provided in the Certificate.
26. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, trauma, congenital defects or birth abnormalities.
27. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
28. Services or supplies necessary because the Insured Person engaged, or tried to engage, in an illegal occupation or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony. Exception*:* This exclusion does not apply to injuries that result from an act of domestic violence or to injuries that result from a medical condition.
29. Elective abortions.

30. Custodial Care service and supplies.
31. Charges for hot or cold packs for personal use.
32. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
33. Services of private duty Nurse except as provided in the Certificate.
34. Expenses that are not recommended and approved by a Physician.
35. Routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal or artificial organs or tissues.
36. Sleep Disorders, except for the diagnosis and Treatment of obstructive sleep apnea.
37. Treatment of acne unless Medically Necessary.
38. Experimental/Investigative drugs, devices, Treatments or procedures unless otherwise covered under Covered Clinical Trials or covered under clinical trials (routine patient costs). See the Other Benefits section for more information.
39. Under the Prescription Drug Benefit shown in the Schedule of Benefits:
    - any drug or medicine which does not, by federal or state law, require a prescription order, except as specifically provided under Preventive Services or in the Prescription Drug Benefit section of the Certificate;
    - Allergens and allergy serums;
    - any drug or medicine for the purpose of weight control;
    - sexual enhancements drugs;
    - Vitamins except as specifically provided under Preventive Services and legend drug vitamins;
    - cosmetic drugs when used for cosmetic purposes. This exclusion is not applicable to Insured Persons with a medically diagnosed congenital defect or birth abnormality who have been covered under the group policy from the moment of birth;
    - refills in excess of the number specified, or refilled too soon, or in excess of therapeutic limits or dispensed after 1 year of date of the prescription;
    - drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental/Investigative Drugs;
    - if the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental/Investigative for any reason;
    - compounded drugs that do not contain at least one ingredient that requires a prescription;
    - charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war;
    - non-insulin syringes, and other therapeutic devices or appliances except as specifically provided in the Prescription Drug Benefit section of the Certificate;
    - biological sera, blood, or blood plasma, unless they can be self-administered;
    - Charges for prescriptions drugs needed due to conditions caused, directly or indirectly, by taking part in a riot or other civil disorder;
40. Self-administered services such as: biofeedback, patient-controlled analgesia on an outpatient basis, related diagnostic testing, self-care and self-help training.

The following exclusions apply to the Accidental Death and Dismemberment Benefit:

1. Loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
2. Injury sustained as the result of the Insured Person's operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.
3. Racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles) or other hazardous sport or hobby.

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.