LEHIGH UNIVERSITY

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2024/2025

DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

LEHIGH UNIVERSITY

Bethlehem, PA
("the Policyholder")

Policy Number: WI2425PASHIP138

Group Number: ST0864SH

Effective: 08/15/2024 – 08/14/2025

UNDERWRITTEN BY:

Wellfleet Insurance Company | Fort Wayne, IN

("the Company")

ADMINISTERED BY:

Wellfleet Group, LLC

WELLFLEET STUDENT

Welcome Students…

We are pleased to provide you with this summary of the 2024 – 2025 Student Health Insurance Plan ("Plan"), which is fully compliant with the Affordable Care Act. This is only a brief description of the coverage(s) available under Certificate form PA SHIP Cert (2024). The Certificate will contain reductions, limitations, exclusions, and termination provisions. Full details of coverage are contained in the Certificate. If there are any conflicts between this document and the Certificate, the Certificate shall govern in all cases.

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

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

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

Important Contact Information & Resources

Contact Us

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

Plan Administration

Enrollment, Eligibility, & Waivers

Risk Strategies Education, University Health Plans
PO Box 818078
Cleveland, OH 44181
(833) 251-1713
www.universityhealthplans.com

Claim Status, & ID Cards

Wellfleet Group, LLC
PO Box 15369
Springfield, Massachusetts 01115-5369
(877) 657-5030, TTY 711
www.wellfleetstudent.com
Monday–Thursday, 8:30 a.m. to 7:00 p.m. Eastern Time
Friday, 9:00 a.m. to 5:00 p.m. Eastern Time

Claims

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

PPO Network

Cigna Open Access Plus (OAP)
www.mycigna.com

Pharmacy Benefits Manager

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

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

Member Pharmacy Help

(877) 640-7940

Student Health Center

Health & Wellness Center
Johnson Hall | 36 University Drive
Bethlehem, PA 18015
PH 610-758-3870
inluhc@lehigh.edu

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

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General Information

Am I Eligible?

Domestic and International students will be required to enroll in the Student Health Insurance Plan at registration, and the premium will be added to the student's tuition fees unless proof of comparable coverage is provided by completing the waiver.

Domestic Students

- Undergraduate matriculating students registered for five (5) or more credits;
- Undergraduate non-matriculating students (non-degree/General College Division) registered for twelve (12) or more credits;
- Graduate students enrolled in a degree seeking, on-campus based program and registered for nine (9) or more credits;
- Graduate students with certified-full time status registered for (1) or more credits.

International Students

- All Lehigh International Students on an F-1 or J-1 visa taking 1+ credits.

Dependents

Dependents are not eligible.

How Do I Waive/Enroll?

To Waive:

The charge for the annual premium will be included on the student's fall invoice once the student meets the minimum registration eligibility requirements. Those students who are insured under another policy may drop his/her coverage under this insurance plan and have the premium credited back to his/her university account by completing a waiver form by September 6th or within 10 days of becoming eligible if the minimum registration requirements are met after July 31st.

All Lehigh International Students on an F-1 or J-1 Visa are not permitted to drop coverage by submitting a waiver form unless you have parents or a spouse/domestic partner living and/or working in the U.S. and are covered under a family plan that's ACA-compliant, you are sponsored to study at Lehigh by your home country or U.S. government that provides you with an insurance plan, or you have dependents at Lehigh and have a private family insurance plan that's ACA-compliant

- An online waiver/enrollment form can be found at **www.universityhealthplans.com**
- International students should contact Lehigh's Office of International Students & Scholars (610) 758-4859 to verify if you qualify for a waiver.

The deadline to waive/enroll for Annual coverage is 09/06/2024.

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/Enrollment Deadline Date
Annual	08/15/2024	08/14/2025	09/06/2024
Spring	01/01/2025	08/14/2025	01/31/2025

Plan Costs for Undergraduate, Graduate and International Students

	Annual	Fall	Spring
Student	$2,509	$962	$1,557

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

Plan Benefits

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

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

When You receive Emergency Services, or Out-of-Network air Ambulance Services, or certain non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, You are protected from Surprise Billing. Refer to the Preferred Provider Organization provision in the How The Plan Works And Description Of Benefits section for additional information.

Student Health Center Referral

Where available, the student should first use the resources of the Student Health Center (SHC) where Treatment will be administered or a referral issued. Covered services that receive prior approval or referral will not be subject to the Deductible. A referral issued by the SHC must accompany the claim when submitted.

A SHC referral for outside care is not necessary ONLY under the following conditions:

1. For an Emergency Medical Condition. The student must return to the SHC for necessary follow-up care;
2. When the SHC is closed;
3. For medical care received when the student is more than 20 miles from campus;
4. For medical care obtained when a student is no longer able to use the SHC due to a change in student status.
5. For maternity care;
6. When service is rendered at another facility during break or vacation period.
7. Medical care is obtained by a student who is not eligible to use the SHC;
8. Mental Health Disorders.

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

The applicable Deductible(s); Coinsurance and Copayment(s) shall apply to all of the exceptions to the referral requirement shown above.

Key Plan Benefits

BENEFIT	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Policy Year Deductible* Individual ***Medical Deductible is waived if Covered Medical Expenses are incurred at the Student Health Center. ***For Covered Medical Expenses, the Medical Deductible is waived when You are referred by the Student Health Center.	$50	$50
Cost sharing You incur for Covered Medical Expenses that is applied to the Out-of-Network Deductible will not be applied to satisfy the In-Network Deductible. Cost sharing You incur for Covered Medical Expenses that is applied to the In-Network Deductible will not be applied to satisfy the Out-of-Network Provider Deductible.		
Out-of-Pocket Maximum Individual	$4,000	No Maximum
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	95% of the Negotiated Charge (NC)	85% of Usual & Customary (U&C) Charge
Preventive Services	100% of the (NC) for Covered Medical Expenses Deductible Waived	85% of (U&C) Charge after Deductible for Covered Medical Expenses Deductible, Coinsurance, and any Copayment are applicable
Physician's Office Visits Including Specialists/Consultants	95% of the (NC) after Deductible for Covered Medical Expenses	85% of (U&C) Charge after Deductible for Covered Medical Expenses
Emergency Services in an emergency department for Emergency Medical Conditions.	95% of the (NC) after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to (U&C) Charge.
Urgent Care Centers for non-life-threatening conditions	95% of the (NC) after Deductible for Covered Medical Expenses	85% of (U&C) Charge after Deductible for Covered Medical Expenses

Schedule of Benefits

THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:

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

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK	OUT-OF-NETWORK
INPATIENT SERVICES		
Hospital Care Includes Hospital Room and Board Expenses and Hospital Miscellaneous Expenses. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Certification Required	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Certification Required	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Registered Nurse Services for private duty nursing while Confined	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Physical Therapy while Confined (inpatient)	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER BENEFITS In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-certification requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.		
Inpatient Mental Health Disorder and Substance Use Disorder Benefit Pre-Certification Required	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Mental Health Disorder and Substance Use Disorder Benefit Including Autism Spectrum Disorders Physician's Office Visits including, but not limited to, Physician visits; individual and group therapy; medication management All Other Outpatient Services including, but not limited to, Intensive Outpatient Programs (IOP); partial hospitalization; Electronic Convulsive Therapy (ECT); Repetitive Transcranial Magnetic Stimulation (rTMS); Psychiatric and Neuro Psychiatric testing	95% of the Negotiated Charge after Deductible for Covered Medical Expenses 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses 85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
PROFESSIONAL AND OUTPATIENT SERVICES		
Surgical Expenses		
Inpatient and Outpatient Surgery includes: Pre-Certification Required Surgeon Services Anesthetist Assistant Surgeon	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Surgical Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Abortion Expense	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Organ Transplant Surgery travel and lodging expenses a maximum of $2,000 per Policy Year or $250 per day, whichever is less while at the transplant facility. Pre-Certification Required	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Reconstructive Surgery Pre-Certification Required	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Other Professional Services		
Gender Affirming Treatment Benefit Pre-Certification Required	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Pre-Certification Required	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Maximum visits per Policy Year	60	60
Hospice Care Coverage	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Office Visits		
Physician's Office Visits including Specialists/Consultants	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telemedicine or Telehealth Services	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telemedicine or Telehealth Services by a contracted Provider (Behavioral Health)	$0 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	
Allergy Testing and Treatment, including injections	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Maximum visits per Policy Year	30	30

Shots and Injections unless considered Preventive Services	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Tuberculosis screening (TB), Titers, QuantiFERON B tests including shots (other than covered under Preventive Services)	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
EMERGENCY SERVICES, AMBULANCE AND NON-EMERGENCY SERVICES		
Emergency Services in an emergency department for Emergency Medical Conditions.	95% 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	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	95% 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 Expenses ground and/or air (fixed wing) transportation Pre-Certification Required for non-emergency air Ambulance (fixed wing)	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	Ground Ambulance transportation: 85% of Usual and Customary Charge after Deductible for Covered Medical Expenses Air Ambulance transportation: Paid the same as In-Network Provider subject to Usual and Customary Charge
DIAGNOSTIC LABORATORY, TESTING AND IMAGING SERVICES		
Diagnostic Imaging Services Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses

REHABILITATION AND HABILITATION THERAPIES		
Cardiac Rehabilitation	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy Maximum Visits for each therapy per Policy Year for Physical Therapy, and Occupational Therapy and Speech Therapy Combined with Habilitation Services Therapy The Maximum Visits do not apply to Rehabilitation Therapy for a Mental Health Disorder or Substance Use Disorder.	30	30
Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitation Services Maximum Visits for each therapy per Policy Year for Physical Therapy, and Occupational Therapy and Speech Therapy Combined with Rehabilitation Therapy The Maximum Visits do not apply to Habilitation Services for a Mental Health Disorder or Substance Use Disorder.	30	30
OTHER SERVICES AND SUPPLIES		
Covered Clinical Trials	Same as any other Covered Sickness	
Diabetic Services and Supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Dialysis Treatment	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Durable Medical Equipment Pre-Certification Required	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Enteral Formulas (Deductible, if applicable, does not apply to Enteral Formulas) and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infertility Treatment Pre-Certification Required	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
Prosthetic and Orthotic Devices Pre-Certification Required	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Student Health Center/Infirmary Expense Benefit	100% of the Usual and Customary Charge for Covered Medical Expenses Deductible Waived	
Sports Accident Expense Benefit - incurred as the result of the play or practice of Intercollegiate sports Up to $2,000 per Accident or club sports Pre-Certification not Required	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Non-emergency Care While Traveling Outside of the United States	85% of Actual Charge after Deductible for Covered Medical Expenses	
Medical Evacuation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived	
Repatriation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived	
PEDIATRIC AND ADULT DENTAL AND VISION CARE		
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19) Preventive Dental Care Limited to 2 dental exams every 12 months	See the Pediatric Dental Care Benefit description in the Certificate for further information. 100% of Usual and Customary Charge for Covered Medical Expenses	

The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care: Emergency Dental Routine Dental Care Endodontic Services Prosthodontic Services Periodontic Services Medically Necessary Orthodontic Care Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses	
Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19) Limited to 1 vision examination per Policy Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of Usual and Customary Charge after Deductible for Covered Medical Expenses	
Adult Vision Care (age 19 and older) Routine Eye Examination 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	95% of Usual and Customary Charge after Deductible for Covered Medical Expenses	
MISCELLANEOUS DENTAL SERVICES		
Accidental Injury Dental Treatment	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Sickness Dental Expense Benefit	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dental Anesthesia for Children and Developmentally Disabled Insured Persons	95% of the Negotiated Charge after Deductible for Covered Medical Expenses	85% of Usual and Customary Charge after Deductible for Covered Medical Expenses
PRESCRIPTION DRUGS		
Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy. Your benefit is limited to a 30 day supply. Coverage for more than a 30 day supply only applies if the smallest package size exceeds a 30 day supply. See “Retail Pharmacy Supply Limits” section for more information.		
TIER 1 (Including Enteral Formulas - Deductible does not apply to Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$10 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 60 day supply filled at a Retail pharmacy	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
TIER 2 (Including Enteral Formulas – Deductible does not apply to Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy	80% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered

See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.		
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	80% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 60 day supply filled at a Retail pharmacy	80% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
TIER 3 (Including Enteral Formulas - Deductible does not apply to 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.	80% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	80% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 60 day supply filled at a Retail pharmacy	80% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
Specialty Prescription Drugs		
For each fill up to a 30-day supply.	80% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 30 day supply but less than a 61 day supply	80% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 60 day supply	80% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered

Specialty Prescription Drugs with Copayment Assistance Program Copayment Assistance Program - Prior Authorization May Be Required: Amounts You pay out-of-pocket for covered Specialty Prescription Drugs will not exceed the applicable Tier's cost share per 30 day supply and will be applied towards the Deductible (if applicable) and Out-of-Pocket Maximum. Copayment Assistance may be available to You for certain Specialty Prescription Drugs when Your prescription is filled at a participating network pharmacy. Visit www.wellfleetstudent.com for the applicable Specialty Prescription Drugs. Copayment Assistance dollars paid by the drug manufacturer for covered Specialty Prescription Drugs will not be applied towards the Deductible (if applicable) or Out-of-Pocket Maximum. Any amounts paid by You for a covered Specialty Prescription Drug after Copayment Assistance will be applied to the deductible (if applicable) and Out-of-Pocket Maximum. For details, contact the Copayment Assistance Program at 636-271-5280.		
For each fill up to a 30 day supply.	75% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
Zero Cost Drugs		
	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
Orally administered anti-cancer Prescription Drugs (including Specialty Drugs)		
Benefit	If the cost share for the Prescription Drug's Tier is greater than the Chemotherapy Benefit or Infusion Therapy Benefit, the cost share will be calculated as follows: Greater of: • 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	
MANDATED BENEFITS		
Mammography Examination	Same as any other Covered Sickness, unless considered a Preventive Service	
Accidental Death and Dismemberment		
Principal Sum	$10,000	
Loss must occur within 365 days of the date of a covered Accident. This does not apply to loss of life. Only one benefit will be payable under this provision, that providing the largest benefit, when more than one (1) Loss occurs as the result of any one (1) Accident. This benefit is payable in addition to any other benefits payable under this Certificate.		

Exclusions and Limitations

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

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

General Exclusions

- **International Students Only -** Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible.
- Treatment, service or supply which is not Medically Necessary for the diagnosis, care or Treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended or approved by the Student Health Center, or by Your attending Physician or dentist.
- Medical services rendered by a provider employed for or contracted with the Policyholder, including team Physicians or trainers, except as specifically provided in the Schedule of Benefits or as part of the Student Health Center benefits provided by this plan.
- Professional services rendered by an Immediate Family Member or anyone who lives with You.
- Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services covered by Student Health Fees.
- Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
- Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which You are required to pay.
- Services that are duplicated when provided by both a certified Nurse midwife and a Physician.
- Expenses payable under any prior policy which was in force for the person making the claim.
- Loss resulting from war or any act of war, whether declared or not, or Loss sustained while in the armed forces of any country or international authority.
- Injury sustained as the result of Your operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle Accident takes place.
- Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
- Expenses incurred after:
    - The date insurance terminates as to an Insured Person, except as specified in the extension of benefits provision; and
    - The end of the Policy Year specified in the Policy.
- Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
- You are:
    - committing or attempting to commit a felony,
    - engaged in an illegal occupation, or
    - participating in a riot.
- Custodial Care service and supplies.
- Charges for hot or cold packs for personal use.
- Services of private duty Nurse except as provided in the Certificate.
- Expenses that are not recommended and approved by a Physician.
- Experimental or Investigative drugs, devices, Treatments or procedures unless otherwise covered under Covered Clinical Trials. See the Other Benefits section for more information.
- Routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal or artificial organs or tissues.
- Loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
- Non-chemical addictions.
- Outpatient non-physical, occupational, speech therapies (art, dance, etc.).
- Modifications made to dwellings.
- General fitness, exercise programs.
- Hypnosis.
- Rolfing.

- Biofeedback.
- Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
- Sleep Disorders, except for a sleep study performed in the Insured Person's home, the diagnosis, and Treatment of obstructive sleep apnea.
- Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary because of Injury, infection or disease.

Activities Related

- Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate sports for which benefits are paid under another Sports Accident policy issued to the Policyholder; or for which coverage is provided by the National Collegiate Athletic Association (NCAA), National Association of Intercollegiate Athletic (NAIA) or any other sports association in excess of $2,000.00 per Intercollegiate sports Accident.
- Racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles).

Weight Management/Reduction

- Weight management. Weight reduction. Nutrition programs. This does not apply to nutritional counseling or any screening or assessment specifically provided under the Preventive Services benefit, or otherwise specifically covered under the Certificate.
- Treatment for obesity. Surgery for removal of excess skin or fat.

Family Planning

- Infertility Treatment (male or female)-this includes but is not limited to:
  - Procreative counseling;
  - Premarital examinations;
  - Genetic counseling and genetic testing;
  - Impotence, organic or otherwise;
  - Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
  - In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
  - Costs for an ovum donor or donor sperm;
  - Sperm storage costs;
  - Cryopreservation and storage of embryos;
  - Ovulation induction and monitoring;
  - 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 Insured Persons acting as surrogate mothers);
  - Cloning; or
  - Medical and surgical procedures that are Experimental or Investigative, unless Our denial is overturned by an External Appeal Agent.

Vision

- Expenses for radial keratotomy.
- Adult Vision unless specifically provided in the Certificate.
- Charges for office visit exam for the fitting of prescription contact lenses, duplicate spare eyeglasses, lenses or frames, non-prescription lenses or contact lenses that are for cosmetic purposes.

Dental

- Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.

Hearing

- Charges for hearing exams, hearing screening, hearing aids and the fitting or repair or replacement of hearing aids or cochlear implants except as specifically provided in the Certificate.

Cosmetic

- Treatment of Acne unless Medically Necessary.
- Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
- Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma.

Prescription Drugs

- Any drug or medicine which does not, by federal or state law, require a prescription order, i.e. over-the-counter drugs, even if a prescription is written, except as specifically provided under Preventive Services or in the Prescription Drug Benefit section of this Certificate. Insulin and OTC preventive medications required under ACA are exempt from this exclusion;
- Drugs with over-the-counter equivalents except as specifically provided under Preventive Services;
- Allergy sera and extracts administered via injection;
- Vitamins, and minerals, except as specifically provided under Preventive Services;
- Food supplements, dietary supplements; except as specifically provided in the Certificate;
- Cosmetic drugs or medicines including, but not limited to, products that improve the appearance of wrinkles or other skin blemishes;
- Refills in excess of the number specified or dispensed after 1 year of date of the prescription;
- Drugs labeled, “Caution – limited by federal law to Investigational use” or Experimental Drugs;
- Any drug or medicine purchased after coverage under the Certificate terminates;
- Any drug or medicine consumed or administered at the place where it is dispensed;
- If the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
- Prescription digital therapeutics;
- Bulk chemicals;
- Non-insulin syringes, surgical supplies, Durable Medical Equipment/medical devices, except as specifically provided in the Prescription Drug Benefit section of the Certificate;
- Repackaged products;
- Blood components except factors;
- Any drug or medicine for the purpose of weight control;
- Sexual enhancements drugs;
- Vision correction products.

VALUE ADDED SERVICES

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

VISION DISCOUNT PROGRAM

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

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

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

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

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

How to Access Services

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

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

Please provide the following information when you call:

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

24 Hour Nurseline

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

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

Appropriate care may include:

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

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

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

Teladoc

By phone or internet, **Teladoc** gives you 24/7 access to board-certified physicians for Behavioral Health services. Whether you are at school, home or traveling, Teladoc can diagnose and treat most minor medical conditions wherever and whenever you need treatment.

Register your account today and request a visit at https://www.teladoc.com/wellfleetstudent or call (800)-Teladoc (835-2362).

CareConnect
Integrated Behavioral Health from Wellfleet Student

24/7 Behavioral Telehealth and Nurseline Access

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

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