MGH INSTITUTE OF HEALTH PROFESSIONS

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2021/2022

DESIGNED EXCLUSIVELY FOR THE STUDENTS

MGH INSTITUTE OF HEALTH PROFESSIONS
Boston, MA
("the Policyholder")

Policy Number: WI2122MASHIP27
Group Number: ST0874SH
Effective: 5/1/2021 - 4/30/2022

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

ADMINISTERED BY:
Wellfleet Group, LLC

WELLFLEET STUDENT

Table of Contents (Click on section title below to go to section in "Benefits at a Glance.")

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) 251-1706. 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 **Insurance Benefits** **Enrollment** **Waiver**	**University Health Plans, a Risk Strategies Company** 15 Pacella Park Drive Randolph, MA 02368 Phone: (833) 251-1706 Fax: (617) 472-6419 www.universityhealthplans.com or email us at info@univhealthplans.com University Health Plans, Inc. A RISK STRATEGIES COMPANY
Claims Processing **ID Cards** **Preferred Provider Listings** **ID card Requests**	**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 **Cigna** 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?

An eligible student must carry at least ¾ of the full-time course load and actively attend classes at the Policyholder's school for the first 31 days of class in the period for which he or she is enrolled.
To ensure compliance with Massachusetts law, **all MGHIHP students, including those who take all courses online, are initially billed for the Student Health Insurance Plan (SHIP). All registered students must submit the online Waiver or Enrollment Form prior to the posted deadline each academic year. Failure to do so will result in your record being placed on hold.** Students with records on hold are not allowed to register for subsequent semesters, grades and transcripts are held, and only limited access to your student record on will be allowed.

How Do I Waive/Enroll?

If You do not want to be enrolled in the Plan, You must submit an online Waiver Form documenting proof of comparable coverage under another health insurance plan prior to the applicable Waiver Deadline Date shown below. To document proof of comparable coverage, You must go to **www.universityhealthplans.com** and select MGH Institute of Health Professions. The Waiver Form can be accessed by clicking the "Waiver Form" link on the left of the page and following the instructions. Immediately upon submitting the online Waiver Form, You will receive a confirmation number as verification that the form has been submitted.

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	Enrollment/Waiver Deadline
Semester 1	5/1/2021	8/31/2021	5/31/2021
Semester 2	9/1/2021	12/31/2021	9/30/2021
Semester 3	1/1/2022	4/30/2022	1/30/2022

Plan Costs for all Full-time Students

	Semester 1	Semester 2	Semester 3
Student*	$2,740	$2,740	$2,740

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

Preferred Provider Organization (PPO) Network

…providing access to quality health care at discounted costs!

By enrolling in this 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.

MGH Institute Schedule of Benefits

This is only a brief description of coverage available under Certificate form MA 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 80% of the Usual and Customary Charge.

Medical Deductible

In-Network Provider	Individual: $100
Out-of-Network Provider	Individual: $200

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: $2,000
	Out-of-Network Provider	Individual: $4,000

Coinsurance Amounts:

In-Network Provider:	100% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below.
Out-of-Network Provider:	80% of the Usual and Customary Charge (U&C) for Covered Medical Expenses unless otherwise stated below.

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.

Medical Benefit Payments for In-Network Providers and Out-of-Network Providers
The Certificate provides benefits based on the type of health care provider You select. 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.

How You Can Request an Estimate for Proposed Covered Services
You may request an estimate of the costs you will have to pay when your health care provider proposes an inpatient admission, procedure, or other covered service. You can request this cost estimate by logging on to the wellfleetstudent.com website. Just follow the steps to request a cost estimate for health care services you are planning to receive. To request an estimate by phone, call the tollfree phone number shown on your ID card.

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 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	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% 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	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Surgery: Pre-Certification Required		
Surgeon Services	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Anesthetist	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Assistant Surgeon	70% 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)	$30 Copayment 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
Physical Therapy while Confined (inpatient) Maximum Visits per Policy Year	60	60

Skilled Nursing Facility Benefit Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Maximum days per Policy Year	Unlimited	Unlimited
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit Maximum days per Policy Year	Unlimited	Unlimited
INPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE ABUSE DISORDER		
Mental Health Disorder and Substance Abuse Disorder Benefit 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 Abuse Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Benefits		
Outpatient Surgery: Surgeon Services	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Anesthetist	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Assistant Surgeon	70% 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	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's and Other Practitioner Office Visits	$30 Copayment 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
Specialist/Consultant Physician Services	$30 Copayment 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
Telemedicine or Telehealth Services	Paid on the same basis as in-network physician office visit cost share.	
Cardiac Rehabilitation	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Short-Term Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy This benefit limit does not apply for: speech therapy; and when any of these covered services are furnished to treat Autism Spectrum Disorders or as part of covered Home Health Care Pre-Certification Required	$30 Copayment 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
Maximum Visits per Policy Year for Physical Therapy, and Occupational Therapy	60	60
Maximum Visits per Policy Year for Speech Therapy	Unlimited	Unlimited
Habilitative Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	$30 Copayment 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
Habilitative Services Maximum Visits per Policy Year for Physical Therapy, and Occupational Therapy and Combined	60	60

Maximum Visits per Policy Year for Speech Therapy	Unlimited	Unlimited
Emergency Services in an emergency department (includes Urgent Care for Emergency Medical Conditions).	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Copayment waived if admitted	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Urgent Care Centers for non-life-threatening conditions	$30 Copayment 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	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Certification Required	$50 Copayment then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	$50 Copayment then the plan pays 80% 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	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hospice Care Coverage	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses

OUTPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE ABUSE DISORDER		
Mental Health Disorder and Substance Abuse Disorder Benefit Pre-Certification Required except for office visits.		
Physician's Office Visits including, but not limited to, physician visits; individual and group therapy; medication management	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
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 neuropsych testing 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 Abuse Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	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		
TIER 1 (Including Enteral Formulas)	$20 Copayment then the plan pays 100% of the Negotiated Charge Deductible Waived	Not Covered
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	Not Covered
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	Not Covered

TIER 2 (Including Enteral Formulas)	$30 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	$60 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	$90 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
TIER 3 For each fill up to a 30 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
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	Not Covered
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	Not Covered
Specialty Prescription Drugs		
Specialty Prescription Drugs For each fill up to a 30 day supply	$30 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	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 60 day supply	$90 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
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	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Allergy Injections/Treatment	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	100% 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	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Bariatric Surgery & Morbid Obesity Benefit Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Covered Clinical Trials Benefit for Cancer or other Life-Threatening Disease	Same as any other Covered Sickness	
Durable Medical Equipment Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% 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.	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hearing Aids Limited to 1 hearing aid per ear up to a maximum of $2,000 for each hearing aid per 36 month period	100% of the Negotiated Charge Deductible Waived	100% of Usual and Customary Charge Deductible Waived
Maternity Benefit	Same as any other Covered Sickness	
Non-Prescription Enteral Formulas and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Prosthetic and Orthotic Devices Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Reconstructive Surgery Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% 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) Preventive Dental Care Limited to 2 dental exams every 12 months 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.	See the Pediatric Dental Care Benefit description in the Certificate for further information. 100% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge	
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 24 months 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	
Abortion Expense	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Acupuncture Services Expense Benefit (Medically Necessary Treatment) for Pain Management (in lieu of opioids)	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Acupuncture Services Expense Benefit Maximum visits per Policy Year.	unlimited	unlimited
Sickness Dental Expense	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Pre-Certification Required	$30 Copayment 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
Chiropractic Care Benefit Maximum visits per Policy Year	Unlimited	Unlimited
Infertility Treatment Pre-Certification Required	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 travel and lodging expenses a maximum of $2,000 per Policy Year or $250 per day, whichever is less Pre-Certification Required	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Shots and Injections unless considered Preventive Services	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Podiatry Benefit	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% 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)	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Non-emergency Care While Traveling Outside of the United States	80% 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	

Mandated Benefits	
Autism Spectrum Disorder Benefit	Same as any other Covered Sickness
Cancer Treatment Benefit	Same as any other Covered Sickness, unless considered a Preventive Service
Cleft Palate and Cleft Lip Benefit	Same as any other Covered Sickness
Cytologic Screening (pap smear) and Mammographic Examination	Same as any other Covered Sickness, unless considered a Preventive Service. Subject to the limitations described in the Benefit.
Early Intervention Services	Benefits are payable at 100%
Fitness Benefit	Up to 2 months of a membership to a Fitness Facility, subject to a maximum of $150 per Policy Year.
Hormone Replacement Therapy Services; Outpatient Contraceptive Services Same as other prescription drugs or devices	Same as any other Covered Sickness, unless considered a Preventive Service. Subject to the limitations described in the Benefit.
Human Leukocyte Testing	Same as any other Covered Sickness
Mastectomy Surgery and Rehabilitation Benefit	Same as any other Covered Sickness
Oxygen and Respiratory Therapy Benefit (for home use)	Same as any other Covered Sickness
Pediatric Specialty Care	Same as any other Covered Sickness
Treatment of Speech, Hearing and Language Disorders Benefit	Same as any other Covered Sickness
Weight Loss Program Benefit	Up to 2 months of a membership to a Fitness Facility, subject to a maximum of $150 per Policy Year.
HIV Associated Lipodystrophy Treatment	Same as any other Covered Sickness
Early Refill of Prescription Eye Drops	Same as any other Prescription drug
Pain Management Alternatives to Opiate Products	Same as any other Covered Sickness

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 Urgent Care or Hospital Confinement for the initial 48/96 hours of maternity care.

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. 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 Your attending Physician or dentist.
2. 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.
3. Professional services rendered by an Immediate Family Member or anyone who lives with You.
4. 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.
5. 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;
   - Sperm storage costs;
   - 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 Members acting as surrogate mothers);
   - Cloning; or
   - Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.
6. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
7. 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.
8. Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
9. 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.
10. 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.
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. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
13. 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.
14. Services that are duplicated when provided by both a certified Nurse-midwife and a Physician.

15. Expenses payable under any prior policy which was in force for the person making the claim.
16. 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.
17. 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.
18. Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
19. 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.
20. Treatment for obesity except surgery for morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat.
21. Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
22. Expenses for radial keratotomy.
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, hearing screening, or replacement of hearing aids or cochlear implants except as specifically provided in the Certificate.
26. 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.
27. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma.
28. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
29. Dental treatment to repair teeth due to a Covered accidental Injury.
30. You are:
    - committing or attempting to commit a felony,
    - engaged in an illegal occupation, or
    - participating in a riot.
31. Custodial Care service and supplies.
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. Treatment of Acne unless Medically Necessary.
37. Experimental or Investigational 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.
38. 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, 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 the 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;
- 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;
- immunology products.

39. Non-chemical addictions.
40. Non-physical, occupational, speech therapies (art, dance, etc.).
41. Modifications made to dwellings.
42. General fitness, exercise programs except has provided elsewhere in the Certificate.
43. Hypnosis.
44. Rolfing.
45. Biofeedback.
46. Vocational recreation: art, dance, poetry, music, or other similar-type therapies.
47. Pregnancy that results under a surrogate parenting agreement.
48. Wigs, or scalp hair prosthesis when hair loss is because of male pattern baldness, female pattern baldness or natural or premature aging.
49. personal convenience items such as telephone consultations (audio only), missed appointments, completion of claim forms.

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, 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.