Benefits at a Glance

Student Health Insurance Plan (2026/2027)

Designed exclusively for the students of:

PROVIDENCE COLLEGE

Providence, RI
("the policyholder")
Policy Number: WI2627RISHIP105
Group Number: ST0893SH
Effective: 09/01/2026 - 08/31/2027

Underwritten by: Wellfleet Insurance Company
Fort Wayne, IN
("the Company")
Administered by: Wellfleet Group, LLC

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Welcome Students…

We are pleased to provide you with this summary of the 2026 – 2027 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 RI SHIP Cert (2026). 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 & Waivers

Risk Strategies Education, University Health Plans
PO Box 818078
Cleveland, OH 44181
www.universityhealthplans.com
(833) 251-1150

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

PPO Network

Cigna

Cigna
www.mycigna.com

Pharmacy Benefits Manager

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

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

Lower Davis Hall
Phone: 401.865.2422
Fax: 401.865.2809
By appointment only during the academic year:
Monday - Friday: 8:30 a.m. to 4:30 p.m.

Telehealth Service

Your plan includes access to virtual healthcare advice by phone, video, or app.

- Scheduled mental health services – 7 days a week Register at https://www.teladoc.com/wellfleetstudent/
- In addition, your plan includes virtual physical therapy and other musculoskeletal services from Hinge Health
- Register at https://hinge.health/wellfleet

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

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General Information

Am I Eligible?

Domestic Students

All registered Full-time Domestic undergraduate students taking 9 credits or more (3 courses) 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 at registration and the premium is added to the student's tuition fees unless proof of comparable coverage is provided by completing the waiver.

International Students

All registered Full-time International students taking 9 credits or more (3 courses) are required to have health insurance coverage. Students are automatically enrolled in the Student Health Insurance Plan at registration and the premium is added to the student's tuition fees and do not have the option to waive coverage.

Dependents

Dependents are not eligible.

How Do I Waive?

To Waive:

- Go to: www.universityhealthplans.com/providence.
- Search **Providence College**.
- Follow the directions for Waiver and proceed as directed. You must fill in all of the required information on the waiver form. If any information is missing, your waiver will not be accepted.
- Click submit and review the information being provided is accurate.
- When your online waiver form is successfully submitted you will receive a confirmation e-mail.
- **Please Note:** Waivers are required to be completed for each plan year.

The deadline to waive Annual coverage is 08/01/2026.

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	Domestic Students Waiver Deadline
Annual	09/01/2026	08/31/2027	08/01/2026
Fall	09/01/2026	12/31/2026	08/01/2026
Spring/Summer	01/01/2027	08/31/2027	01/26/2027

Plan Costs for Domestic Undergraduate and International Students

	Annual	Fall	Spring/Summer
Student*	$2,066	$690	$1,376

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

Plan Benefits

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

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.

Pre-Certification Requirement:
What types of Inpatient and Outpatient services or supplies require Pre-Certification?
Pre-Certification is required for the following:

1. All Inpatient admissions, including length of stay, to a Hospital, Skilled Nursing Facility, a facility established primarily for the Treatment of a Substance Use Disorder, or a residential Treatment facility, surgical procedures;
2. All Inpatient maternity care after the initial 48/96 hours;
3. Home Health Care;
4. Durable Medical Equipment over $500 per item;
5. Outpatient Surgical Procedures;
6. Transplant Services;
7. Diagnostic Testing and Radiology services listed at www.wellfleetstudent.com/providers/. See Prior Authorization Requirements section;
8. Complex Imaging;
9. Chemotherapy/Radiation;
10. Infusion Therapy;
11. Botox Injections;
12. Genetic Testing, except for BRCA;
13. Orthotics/Prosthetics;

14. Non-emergency air Ambulance (fixed wing);
15. Outpatient Private Duty Nursing;
16. Physical Therapy (Outpatient) Pre-Certification required after the 24th visit;
17. Occupational Therapy (Outpatient) Pre-Certification required after the 24th visit;
18. Speech Therapy (Outpatient) Pre-Certification required after the 24th visit.

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.

Pre-Certification is not a guarantee that benefits will be paid.

Key Plan Benefits

BENEFIT	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Policy Year Deductible Individual (will not exceed the Out-of-Pocket Maximum)* *(Medical Deductible is waived if Covered Medical Expenses are incurred at the Student Health Center)	$0	$100
Out-of-Pocket Maximum Individual (Including Deductible)	$9,100	$9,100
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	90% of the Negotiated Charge (NC)	70% of Usual & Customary (U&C) Charge
Preventive Services	100% of the (NC) Deductible Waived	70% of (U&C) Charge after Deductible for Covered Medical Expenses Deductible, Coinsurance, and any Copayment are applicable
Physician's Office Visits/House Calls including Specialists/Consultants visits *Check below for additional copayments if applicable	$20 Copayment per visit then the plan pays 100% of the (NC) for Covered Medical Expenses	70% of (U&C) Charge after Deductible for Covered Medical Expenses
Emergency Services in an emergency department for Emergency Medical Conditions	$150 Copayment per visit then the plan pays 90% of the (NC) for Covered Medical Expenses Copayment waived if admitted	Paid the same as In-Network Provider; however, the benefit will be based on the Recognized Amount
Urgent Care Centers for non-life-threatening conditions	90% of the (NC) for Covered Medical Expenses	90% 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	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Registered Nurse Services for private duty nursing while Confined	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physical Therapy, Speech Therapy, and Occupational Therapy while Confined (inpatient)	90% of the Negotiated Charge for Covered Medical Expenses	70% 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, 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. Day or visit limits do not apply to Mental Health Disorder and Substance Use Disorder Benefits.		
Inpatient Mental Health Disorder and Substance Use Disorder Benefits Pre-Certification Required for all inpatient admissions, including length of stay, to a Hospital, Skilled Nursing Facility, a facility established primarily for the Treatment of a Substance Use Disorder, or a residential Treatment facility.	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Mental Health Disorder and Substance Use Disorder Benefits		
Physician's Office Visits including, but not limited to, Physician visits; individual and group therapy; medication management. (For Treatment rendered at the Student Health Center/Infirmary, refer to the Student Health Center/Infirmary Expense Benefit section of this Schedule of Benefits for benefit information.)	$20 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
All Other Outpatient Services (All Other Outpatient Services does not include Emergency Services in an emergency department, Urgent Care Centers, and Emergency Ambulance Service and Prescription Drugs. Refer to the Emergency Services, Ambulance and Non-Emergency Services, and Prescription Drugs sections of this Schedule of Benefits for benefit information.) Pre-Certification may be required for certain All Other Outpatient Services. To see if Pre-Certification is required, refer to the Pre-Certification Requirement listing and specific benefit listed in this Schedule of Benefits	90% of the Negotiated Charge for Covered Medical Expenses	70% 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 for Surgery only Surgeon Services Anesthetist Assistant Surgeon	90% of the Negotiated Charge for Covered Medical Expenses	70% 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	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Bariatric Surgery Pre-Certification Required	90% of the Negotiated Charge 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 $2,000 per Policy Year or $250 per day, whichever is less while at the transplant facility. Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Reconstructive Surgery Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Other Professional Services		
Home Health Care Expenses Pre-Certification required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hospice Care Coverage	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Office Visits		
Physician's Office Visits/House Calls including Specialists/Consultants	$20 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telemedicine or Telehealth Services Benefit	$20 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Telemedicine or Telehealth Services Program Behavioral Health Musculoskeletal	$0 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived $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	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit	$20 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	$20 Copayment per visit after Deductible then the plan pays 70% of Usual and Customary Charge for Covered Medical Expenses
Chiropractic Care Benefit Maximum visits per Policy Year	30	30
Tuberculosis screening (TB), Titers, QuantiFERON B tests including shots (other than covered under Preventive Services)	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
EMERGENCY SERVICES, AMBULANCE AND NON-EMERGENCY SERVICES		
Emergency Services in an emergency department for Emergency Medical Conditions.	$150 Copayment per visit then the plan pays 90% of the Negotiated Charge for Covered Medical Expenses Copayment waived if admitted	Paid the same as In-Network Provider; however, the benefit will be based on the Recognized Amount
Urgent Care Centers for non-life-threatening conditions	90% of the Negotiated Charge for Covered Medical Expenses	90% 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 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)	100% of the Negotiated Charge for Covered Medical Expenses	Ground Ambulance transportation: 70% 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, RADIOLOGY, TESTING AND IMAGING SERVICES		
Diagnostic Complex Imaging Services Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diagnostic Laboratory, Radiological Services and Testing (Outpatient) Pre-Certification may be required. See Prior Authorization Requirements section listed at www.wellfleetstudent.com/providers.	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
REHABILITATION AND HABILITATION THERAPIES		
Cardiac Rehabilitation	$20 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	$20 Copayment per visit after Deductible then the plan pays 70% of Usual and Customary Charge for Covered Medical Expenses
Pulmonary Rehabilitation	$20 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	$20 Copayment per visit after Deductible then the plan pays 70% of Usual and Customary Charge for Covered Medical Expenses
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
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.	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Dialysis Treatment	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Durable Medical Equipment Pre-Certification Required	100% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Enteral Formulas and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hearing Aids	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infertility Treatment Benefit Pre-Certification Required		
• For Diagnosis, Treatment of Infertility when a Medically Necessary medical Treatment may directly or indirectly cause iatrogenic infertility to an Insured Person	Same as any other Covered Sickness	Same as any other Covered Sickness
• For Tests/Procedures attendant to the diagnosis and Treatment of infertility when the sole purpose is the Treatment of Infertility. Note, the Insured Person's cost share will not exceed 20% for Covered Medical Expenses.	90% of the Negotiated Charge for Covered Medical Expenses	80% 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	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Private Duty Nursing Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hemophilia Services Outpatient/In a Physician's Office	Same as any other Covered Sickness	
Asthma Education	Same as any other Covered Sickness	
Student Health Center/Infirmary Expense Benefit	100% of the Negotiated 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 $5,000 per Accident Pre-Certification not Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary 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	
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	
DENTAL BENEFITS		
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)	See the Pediatric Dental Care Benefit provision in the Certificate for further information.	
Preventive Dental Care Limited to 2 dental exams every 12 months (twice per Policy Year)	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	50% of Usual and Customary Charge for Covered Medical Expenses	
Routine Dental Care	50% of Usual and Customary Charge for Covered Medical Expenses	
Endodontic Services	50% of Usual and Customary Charge for Covered Medical Expenses	
Prosthodontic Services	50% of Usual and Customary Charge for Covered Medical Expenses	
Periodontic Services	50% of Usual and Customary Charge for Covered Medical Expenses	
Medically Necessary Orthodontic Care	50% of Usual and Customary Charge for Covered Medical Expenses	
Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	Deductible Waived	

VISION BENEFITS	
Pediatric Vision Care Examination Benefit (to the end of the month in which the Insured Person turns age 19) Limited to 1 vision examination per Policy Year A second vision care exam will be covered (if prescription changes) for Insured Persons that have the following conditions: Diabetes, Hypertension, Kidney Disease, Dementia, Pregnancy, HNCRT (head and neck cancer patients with radiation therapy). Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived
Pediatric Vision Care Hardware Benefit (to the end of the month in which the Insured Person turns age 19) Limited to 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year A second set of frames with lenses will be covered (if prescription changes) for Insured Persons that have the following conditions: Diabetes, Hypertension, Kidney Disease, Dementia, Pregnancy, HNCRT (head and neck cancer patients with radiation therapy). Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived
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	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived

MISCELLANEOUS DENTAL SERVICES		
Accidental Injury Dental Treatment	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Sickness Dental Expense Benefit	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	90% of the Negotiated Charge for Covered Medical Expenses	70% 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) 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	70% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	70% of Actual Charge for Covered Medical Expenses Deductible Waived
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	70% of Actual Charge for Covered Medical Expenses Deductible Waived
TIER 2 (Including Enteral Formulas) 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	70% of Actual Charge for Covered Medical Expenses Deductible Waived

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.		
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	70% of Actual Charge for Covered Medical Expenses Deductible Waived
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	70% of Actual Charge for Covered Medical Expenses Deductible Waived
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.	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	70% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	70% of Actual Charge for Covered Medical Expenses Deductible Waived
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	70% of Actual Charge for Covered Medical Expenses Deductible Waived

Specialty Prescription Drugs		
For each fill up to a 30 day supply. 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.	50% of the Negotiated Charge up to a maximum of $150 for each fill for Covered Medical Expenses	70% of Actual Charge up to a maximum of $150 for each fill for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply	50% of the Negotiated Charge up to a maximum of $300 for each fill for Covered Medical Expenses	70% of Actual Charge up to a maximum of $300 for each fill for Covered Medical Expenses Deductible Waived
More than a 60 day supply	50% of the Negotiated Charge up to a maximum of $450 for each fill for Covered Medical Expenses	70% of Actual Charge up to a maximum of $450 for each fill for Covered Medical Expenses Deductible Waived
Specialty Prescription Drugs with Copayment Assistance Program Copayment Assistance Program - Prior Authorization May Be Required: Amounts You pay out-of-pocket for covered Specialty Prescription Drugs will not exceed the applicable Tier's cost share per 30 day supply and will be applied towards the Deductible (if applicable) and Out-of-Pocket Maximum. Copayment Assistance may be available to You for certain Specialty Prescription Drugs when Your prescription is filled at a participating network pharmacy. Visit www.wellfleetrx.com/students 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		
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	100% of Actual Charge for Covered Medical Expenses Deductible Waived
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 except, that the Insured Person's out-of-pocket costs for covered prescription insulin drugs will not exceed $40 per 30-day supply regardless of the amount or type of insulin that is needed to fill the Insured Person's prescription. Coverage for prescription insulin drugs shall not be subject to the Deductible, if applicable.	
Epinephrine Auto-Injectors and Cartridges		
Limited to two (2) pack of the epinephrine auto-injectors or cartridges per Policy Year 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	100% of Actual Charge for Covered Medical Expenses Deductible Waived
MANDATED BENFITS		
Lyme Disease Treatment	Same as any other Covered Sickness	
Mammograms	Same as any other Covered Sickness, unless considered a Preventive Service	
Prostate and Colorectal Examinations	100% of Negotiated Charge for Covered Medical Expenses Deductible Waived, if applicable	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Principal Sum $10,000

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

If, as the result of a covered Accident, You sustain any of the following Losses within the time shown in the Schedule of Benefits, We will pay the benefit shown.

Loss of Life ..... The Principal Sum
Loss of hand ..... One-Half the Principal Sum
Loss of Foot ..... One-Half the Principal Sum
Loss of either one hand, one foot or sight of one eye ..... One-half the Principal Sum
Loss of more than one of the above losses due to one Accident ..... The Principal Sum

Loss of hand or foot means the complete severance through or above the wrist or ankle joint. Loss of eye means the total permanent loss of sight in the eye. The Principal Sum is the largest amount payable under this benefit for all Losses resulting from any one (1) Accident.

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

Exclusions and Limitations

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

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

General Exclusions

- **International Students Only –** Covered Medical Expenses received within Your Home Country or country of origin that are covered under Your governmental or national health plan.
- 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 Investigational drugs, devices, Treatments or procedures.
- 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.
- Sleep Disorders, except for the diagnosis and Treatment of obstructive sleep apnea including testing performed in a home or outpatient setting.
- Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
- 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.
- Any routine services such as physical exams, vaccinations, or laboratory testing required for employment, school, camp, sports participation, travel, insurance enrollment, or licensing, as well as for joining a sport or recreational activity, except as specifically provided under Preventive Services, or otherwise specifically covered under the Certificate.

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 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 in excess of $5,000.00 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 except surgery for morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat.

Family Planning

- Infertility Treatment (male or female)-this includes but is not limited to:
  - Genetic counseling and genetic testing;
  - Impotence, organic or otherwise;
  - Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
  - Assisted Reproductive Technology (ART) which includes In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
  - Costs for an ovum donor or donor sperm;
  - Ovulation induction and monitoring;
  - Reversal of tubal ligations;
  - Reversal of vasectomies;

  - Costs for and relating to surrogate motherhood if the individual is not an Insured Person under the Certificate;
  - Cloning; or
  - Medical and surgical procedures that are Experimental or Investigative unless Our denial is overturned by an External Appeal Agent.
- Birth control, including elective surgical procedures or devices.
  NOTICE: Your institution of higher education has certified that Your student health insurance coverage qualifies for an accommodation with respect to the federal requirement to cover all Food and Drug Administration-approved contraceptive services for women, as prescribed by a health care provider, without cost sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and filled at a participating pharmacy. This means that Your institution of higher education will not contract, arrange, pay, or refer for contraceptive coverage. Instead, Wellfleet Insurance Company will provide separate payments for covered contraceptive services that You use, without cost sharing and at no other cost, for so long as You are enrolled in Your student health insurance coverage. Your institution of higher education will not administer or fund these payments. If You have any questions about this notice, contact the Administrator shown on page 1.
- Elective abortions.

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, , 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, the 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;
- Medical marijuana, cannabis, or other supplies and/or services rendered at a cannabis dispensary. This does not include synthetic pharmaceutical products approved by the FDA and included on the Formulary;
- Any drug or medicine for the purpose of weight control;
- Sexual enhancements drugs;
- Vision correction products.

Contracted Providers for Telemedicine/Telehealth

The right care when you need it most
Your Wellfleet health plan gives you access to virtual healthcare by phone, video, or app.

Teladoc gives you access to board-certified physicians for **Mental Health (at no additional cost to you)** 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.teladochealth.com/benefits/wellfleetstudent or call (800)-Teladoc (835-2362).

Hinge Health gives you access to licensed physical therapists and health coaches for personalized musculoskeletal services including **virtual physical therapy** to help alleviate pain concerns.

Whether you are at school, home, or traveling, Hinge Health can assist in providing exercise therapy wherever and whenever you need treatment at **no additional cost to you**.

Register your account today and start your exercise therapy at https://hinge.health/wellfleet.

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.

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

24/7 Nurseline

You have **free** access to the 24/7 Nurseline by calling (800) 634-7629. This 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
- an office or telehealth visit with a healthcare provider
- Or a visit to an urgent care center or emergency room.

Calls are answered 24/7/365 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.

CareConnect BY WELLFLEET

24/7 Telehealth Counseling for Mental Health

CareConnect is an integrated behavioral health program offering students easy access to licensed mental health clinicians 24/7/365 via telephone (888) 857-5462 and website access to expert mental health and emotional wellbeing resources.

The CareConnect hotline is available at **no additional cost to you**, and you also have free access to courses, articles, and short videos that support mental health and wellbeing by visiting https://careconnect.mysupportportal.com/welcome.

Ameritas

Your Wellfleet Student health plan gives you access to purchase voluntary Dental and/or Vision plans through our partnership with Ameritas. For more information and to enroll, visit https://myplan.ameritas.com/id/a113314a. Please enter the zip code of your resident address during your college placement.