ST JOHN'S College

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2020/2021

DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

ST. JOHN'S COLLEGE - ANNAPOLIS

Annapolis, MD
("the Policyholder")

Policy Number: WI2021MDSHIP84
Group Number: ST1735SH
Effective: 8/1/2020 – 7/31/2021

UNDERWRITTEN BY:

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

ADMINISTERED BY:

Wellfleet Group, LLC

WELLFLEET STUDENT

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Welcome Students…

We are pleased to provide you with this summary of the 2020 – 2021 Student Health Insurance Plan ("Plan"), which is fully compliant with the Affordable Care Act. "Benefits at a Glance" includes effective dates and costs of coverage, as well as other helpful information. For additional details about the Plan, please consult the Plan Certificate and other materials at **www.wellfleetstudent.com**. If you have questions about Enrollment into the Plan, please call University Health Plans at (800) 437-6448 or at www.universityhealthplans.com. 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:
Insurance Benefits **Enrollment** **Waiver**	**University Health Plans, a Division of Risk Strategies** **15 Pacella Park Drive, Suite 130** **Randolph, MA 02368** **www.universityhealthplans.com** **Phone: 1 (800) 437-6448**
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 **www.cigna.com** **Send Cigna claims to:** **CIGNA** **PO Box 188061** **Chattanooga, TN 37422 – 8061** **Electronic Payor ID: 62308**
Prescription Drug Provider	**For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit www.wellfleetstudent.com** **Your plan includes Wellfleet Rx – offering over 40 generics at a $0 copay. Please ask your health care provider to review our formulary to see if these medications are right for you. Click here http://wellfleetrx.com/students/formularies/ for more information.**

Am I Eligible?

All Domestic Graduate, Undergraduate and Part-time Students taking 3 or more credit hours, are required to purchase this insurance plan unless proof of comparable coverage is furnished. All International Students are eligible for coverage on a mandatory basis.

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

How Do I Waive/Enroll?

To Waive or Enroll:

- Go to **www.universityhealthplans.com**
- Search **St. John's College**.
- Follow directions on how to waive/enroll

The deadline to waive coverage for Annual coverage is 8/10/2020

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
Annual	8/1/2020	7/31/2021	8/10/2020
Fall	8/1/2020	12/31/2020	8/10/2020
Spring/Summer (New Students Only)	1/1/2021	7/31/2021	TBD

Plan Costs for Domestic and International Undergraduate Students and their Dependents

	Annual	Fall	Spring (New Students Only)
Student	$2,570	$1,077	$1,493
Spouse	$2,570	$1,077	$1,493
One Child	$2,570	$1,077	$1,493
Two or more Children	$5,140	$2,154	$2,986
Spouse + Two or more Children	$7,710	$3,231	$4,479

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

Plan Costs for Domestic and International Graduate Students and their Dependents

	Annual	Fall	Spring (New Students Only)
Student	$3,498	$1,466	$2,032
Spouse	$3,498	$1,466	$2,032
One Child	$3,498	$1,466	$2,032
Two or more Children	$6,996	$2,932	$4,064
Spouse + Two or more Children	$10,494	$4,398	$6,096

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

Preferred Provider Organization (PPO) Network

…providing access to quality health care at discounted costs!

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

St. John's College Schedule of Benefits

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

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 . No cost sharing shall apply to services provided by an Out-of-Network Provider for male sterilization.

Medical Deductible*

In-Network Provider	Individual:	$250
Out-of-Network Provider	Individual:	$600

*Medical Deductibles apply towards the Out-of-Pocket Maximum.

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	$6,850*
		Family	$13,700*
	Out-of-Network Provider	Individual	$15,000**
		Family	No Maximum

*This is the most You will incur during a Policy Year. After You incur this amount on Deductibles, Copayments, and Coinsurance, We will begin to pay 100% of the Negotiated Charge for Covered Medical Expenses incurred for Treatment provided by an In-Network Provider. This maximum will never include Premium, balance-billed charges or health care the Certificate does not cover

**This is the most You will incur during a Policy Year. After You incur this amount on Deductibles, Copayments, and Coinsurance, We will begin to pay 100% of the Usual and Customary Charge for Covered Medical Expenses incurred for Treatment provided by an Out-of-Network Provider. This maximum will never include Premium, balance-billed charges or health care the Certificate does not cover.

Cost sharing You incur for Covered Medical Expenses that is applied to the Out-of-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the In-Network Provider Out-of-Pocket Maximum and cost sharing You incur for Covered Medical expenses that is applied to the In-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the Out-of-Network Provider Out-of-Pocket Maximum.

Coinsurance Amounts:

In-Network Provider:	80% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below.
Out-of-Network Provider:	60% of the Usual and Customary Charge (U&C) for Covered Medical Expenses unless otherwise stated below.

The Usual and Customary Covered Medical Expense amount paid to an Out-of-Network Provider will not be less than the Negotiated Charge paid to a similarly licensed In-Network Provider for the same health care service in the same geographic region.

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 and Your Covered Dependent selects. The Certificate provides access to both In-Network Providers and Out-of-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by In-Network Providers versus Out-of-Network Providers, as shown in the Schedule of Benefits. The Usual and Customary Covered Medical Expense amount paid to an Out-of-Network Provider will not be less than the Negotiated Charge paid to a similarly licensed In-Network Provider for the same health care service in the same geographic region. No payment will be made under the Certificate for any Covered Medical Expenses incurred for services rendered by an Out-of-Network Provider which are in excess of the Usual and Customary Charge.

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.**
5. **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 PROVIDER	OUT-OF-NETWORK PROVIDER
Inpatient Benefits		
Hospital Care Includes hospital room & board expenses and miscellaneous services and supplies. **For Hospitals regulated by the Maryland Health Services Cost Review Commission (HSCRC)**, reimbursement for covered Hospital services is limited to the rate set by the HSCRC. **For all other Hospitals**, reimbursement for covered Hospital services will be limited to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Certification Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined:	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Surgery: Pre-Certification Recommended Surgeon Services Anesthetist Assistant Surgeon	 80% of the Negotiated Charge after Deductible for Covered Medical Expenses 80% of the Negotiated Charge after Deductible for Covered Medical Expenses 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Skilled Nursing Facility Benefit Pre-Certification Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
INPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE MISUSE DISORDER		
Mental Health Disorder and Substance Misuse Disorder Benefit Pre-Certification Recommended 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 Misuse Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Benefits		
Outpatient Surgery: Pre-Certification Recommended		
Surgeon Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Anesthetist	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Assistant Surgeon	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Surgery Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Office Visits	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Specialist/Consultant Physician Services	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telehealth Services	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Cardiac Rehabilitation Increased outpatient rehabilitation services (physical therapy, speech therapy and occupational therapy) for cardiac rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation limited to 1 program per Insured Person's lifetime	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy including, Physical Therapy, and occupational therapy and speech therapy Pre-Certification Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitative Services for Insured Persons age 19 and over including, Physical Therapy, and occupational therapy and speech therapy Pre-Certification Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitative Services for Insured Persons under age 19 including, Physical Therapy, and occupational therapy and speech therapy Pre-Certification Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Services	$150 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses Copayment waived if admitted	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Urgent Care Centers	$50 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	$50 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diagnostic Imaging/Testing Services Pre-Certification Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

CT Scan, MRI and/or PET Scans Pre-Certification Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Laboratory Procedures/Tests (Outpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Pre-Certification Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hospice Care Coverage	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
OUTPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE MISUSE DISORDER		
Mental Health Disorder and Substance Misuse Disorder Benefit Pre-Certification Recommended except for office visits		
Physician's Office Visits	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
All Other Outpatient Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
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 Misuse Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.		

Prescription Drugs Retail Pharmacy We will not impose a Copayment or Coinsurance requirement for a covered Prescription Drug or device that exceeds the retail price of the Prescription Drug or device. No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy.		
TIER 1 (Including Elemental 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 Medical Food Benefit section of this Schedule for supplements not purchased at a pharmacy.	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$20 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$40 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Retail pharmacy	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$60 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
TIER 2 (Including Elemental 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 Medical Foods Benefit section of this Schedule for supplements not purchased at a pharmacy.	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$40 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$80 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$80 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived

More than a 60 day supply filled at a Retail pharmacy	$120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$120 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
TIER 3 (Including Elemental 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 Medical Foods Benefit section of this Schedule for supplements not purchased at a pharmacy.	$65 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$65 Copayment then the plan pays 100% 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	$130 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$130 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Retail pharmacy	$195 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$195 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
Zero Cost Generics		
Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	100% of Actual charge for Covered Medical Expenses Deductible Waived
Specialty Prescription Drugs		
Specialty Prescription 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.	$65 Copayment per 30-day supply for Covered Medical Expenses Deductible Waived	$65 Copayment per 30-day supply for Covered Medical Expenses Deductible Waived

Prescription Mail Order Drugs We will not impose a Copayment or Coinsurance requirement for a covered Prescription Drug or device that exceeds the retail price of the Prescription Drug or device. No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy.		
TIER 1 For each fill up to a 30-36 day supply filled at a Mail Order 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.	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$20 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Mail Order pharmacy	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$40 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Mail Order pharmacy	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$60 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
TIER 2 For each fill up to a 30 day supply filled at a Mail Order 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.	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$40 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Mail Order pharmacy	$80 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$80 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Mail Order pharmacy	$120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$120 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived

TIER 3 For each fill up to a 30 day supply filled at a Mail Order 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.	$65 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$65 Copayment then the plan pays 100% 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 Mail Order pharmacy	$130 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$130 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Mail Order pharmacy	$195 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$195 Copayment then the plan pays 100% of Actual charge for Covered Medical Expenses Deductible Waived
Zero Cost Generics		
Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	100% of Actual charge for Covered Medical Expenses Deductible Waived
Orally administered anti-cancer prescription drugs (including specialty drugs)		
Benefit	Greater of: • Chemotherapy Benefit; or • Infusion Therapy Benefit	
Diabetic Supplies (for Prescription supplies purchased at a pharmacy)		
Benefit	Paid the same as any other Retail or Mail Order Pharmacy Prescription Drug Fill, except no cost share shall apply to blood glucose test strips	
Other Benefits		
Allergy Testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Allergy Injections/Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Ambulance Service ground and/or air, water transportation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Bariatric Surgery Pre-Certification Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Covered Clinical Trials	Same as any other Covered Sickness	
Durable Medical Equipment Pre-Certification Recommended	90% 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.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hearing Aids Limited to 1 hearing aid per impaired ear per 36-month period	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
Prosthetic Devices Pre-Certification Recommended	90% 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 Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pediatric Dental Care Benefit (through the end of the month in which the Insured Person turns age 19) Preventive Dental Care Limited to 3 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	See the Pediatric Dental Care Benefit description in the Certificate for further information. 100% of Usual and Customary Charge 80% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge	

Prosthodontic Services Periodontic Services Medically Necessary Orthodontic Care Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge Deductible Waived	
Pediatric Vision Care Benefit (through 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 for Covered Medical Expenses Deductible Waived	
Acupuncture Expense Benefit (Medically Necessary Treatment) only	80% of the Negotiated Charge for Covered Medical Expenses	60% of Usual and Customary Charge for Covered Medical Expenses
Accidental Injury Dental Treatment	80% 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 Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infertility Treatment Pre-Certification Recommended • Infertility Services • Standard Fertility Preservation Procedures	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% 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 Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Treatment for Temporomandibular Joint (TMJ) Disorders (age 19 and over)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Mandated Benefits		
Breast Cancer Screening	Same as any other Preventive Service, except services provided by a Non-Preferred Provider are not subject to the Deductible, if applicable.	
Case Management Approved Services	Same as any other Covered Sickness	
Family Planning	Same as any other Preventive Service, except no cost sharing shall apply to services provided by an In-Network or Out-of-Network Provider for male sterilization. For contraceptive coverage, see the benefit for Contraceptive Drugs and Devices listed under Prescription Drugs in Section V – Description of Benefits.	
General Anesthesia for Dental Care	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Lymphedema Diagnosis, Evaluation, and Treatment	Same as any other Covered Sickness	
Medical Foods Benefit	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Nutritional Counseling	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Osteoporosis Benefit	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Patient Centered Medical Home Expense Benefit Pre-Certification Recommended	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Prostate Cancer Screening	Same as any other Preventive Service	
Reconstructive Breast Surgery	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Second Opinion Benefit	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Wellness Benefit Wellness Program Exercise Facility Reimbursement	Same as any other Preventive Service Up to $200 per six (6) month period; and up to an additional $100 per six (6) month period for Covered Dependents	

Additional Benefits		
Student Health Center	$25 Copayment per visit then the plan pays 100% Usual and Customary for Covered Medical Expenses Deductible Waived	
Medical Evacuation Expense (International Students, and Domestic Students and their dependents)	100% of Covered Medical Expenses Deductible Waived Subject to $50,000 maximum per Policy Year	
Repatriation Expense (International Students, and Domestic Students and their dependents)	100% of Covered Medical Expenses Deductible Waived Subject to $25,000 maximum per Policy Year	
Non-emergency Care While Traveling Outside of the United States	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses Subject to $10,000 maximum per Policy Year	
Tuberculosis screening, Titers, Quantiferon B tests including shots (other than covered under preventive services)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Private Duty Nursing while confined	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Abortion Expense	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Principal Sum …… $10,000

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

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

Pre-Certification

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

Exclusions and Limitations

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

The following are exclusions and limitations to the covered services:

1. Services that are not Medically Necessary and Elective Surgery/Treatment;
2. Services performed or prescribed under the direction of a person who is not a health care practitioner;
3. Services that are beyond the scope of practice of the health care practitioner performing the service;
4. Services to the extent they are covered by any government unit, except for veterans in Veterans' Administration or armed forces facilities for services received for which the recipient is liable;
5. Services for which an Insured Person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan;
6. The purchase, examination, or fitting of eyeglasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for use in the treatment of a disease or injury. This exclusion does not apply to the Pediatric Vision Care Benefit;
7. Personal care services and domiciliary care services;
8. Services rendered by a health care practitioner who is an Insured Person's spouse, mother, father, daughter, son, brother, or sister;
9. Experimental services;
10. Practitioner, hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error;
11. ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.
12. Services to reverse a voluntary sterilization procedure;
13. Services for sterilization or reverse sterilization for a Dependent minor, except for FDA approved sterilization procedures for women with reproductive capacity as required under the Affordable Care Act;
14. Medical or surgical Treatment or regimen for reducing or controlling weight, unless otherwise specified in the covered services;
15. Services incurred before the effective date of coverage for an Insured Person;
16. Services incurred after an Insured Person's termination of coverage, including any extension of benefits;
17. Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies;
18. Services for injuries or diseases related to an Insured Person's job to the extent the Insured Person is required to be covered by a workers' compensation law;
19. Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups;
20. Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment;
21. Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form, except as provided in the Telehealth benefit;
22. Inpatient admissions primarily for diagnostic studies;
23. The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, except as required as a covered service;
24. Except for covered ambulance services, travel, whether or not recommended by a health care practitioner, except for the cost of air transportation for the recipient and a companion (or two companions if recipient is under the age of 18) to and from the site of a covered Organ Transplant;
25. Except for Emergency Services, services received while the Insured Person is outside the United States, except as otherwise covered under the Policy;
26. Immunizations related to foreign travel;
27. Unless otherwise specified in covered services, dental work or treatment which includes Hospital or

professional care in connection with:

- The operation or Treatment for the fitting or wearing of dentures,
- Orthodontic care or malocclusion,
- Operations on or for Treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or Treatment of Injury to natural teeth due to an Accident if the Treatment is received within 6 months of the Accident; and
- Dental implants;

28. Accidents occurring while and as a result of chewing, except as provided in the Pediatric Dental Care Benefit;
29. 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;
30. Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be Medically Necessary;
31. Treatment of sexual dysfunction not related to organic disease;
32. Services that duplicate benefits provided under federal, State, or local laws, regulations, or programs;
33. Nonhuman organs and their implantation;
34. Nonreplacement fees for blood and blood products;
35. Lifestyle improvements, including nutrition counseling, or physical fitness programs, unless included as a covered service;
36. Wigs or cranial prosthesis unless included as a covered service for Insured Persons whose hair loss results from chemotherapy or radiation Treatment for cancer;
37. Weekend admission charges, except for emergencies and maternity;
38. Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements;
39. Temporomandibular joint syndrome (TMJ) Treatment and Treatment for craniomandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if Medically Necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or Injury;
40. Services for conditions that State or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution;
41. Services for, or related to, the removal of an organ from an Insured Person for purposes of transplantation into another person, unless the:
    - Transplant recipient is covered under the plan and is undergoing a covered transplant, and
    - Services are not payable by another carrier;
42. Physical examinations required for obtaining or continuing employment, insurance, or government licensing;
43. Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy;
44. Private Hospital room;
45. Payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines was provided as a result of a prohibited referral.

Value Added Services

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

VISION DISCOUNT PROGRAM

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

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

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

24 HOUR NURSELINE

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

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

Appropriate care may include self-care at home, a call to a physician, or a visit to the emergency room.
Calls are answered 24 hours a day, 365 days a year by experienced registered nurses who have been specifically trained to handle telephone health inquiries.
This program is not a substitute for doctor visits or emergency response systems. The *Nurseline* does not answer health plan benefit questions. Health benefit questions should be referred to the Plan Administrator. The *24 Hour Nurseline* toll free number will be on the ID card.

(800) 634-7629

CareConnect
Integrated Behavioral Health from Wellfleet Student

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

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