BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2021/2022

DESIGNED EXCLUSIVELY FOR THE STUDENTS

UIC GLOBAL
Chicago, IL
("the Policyholder")

Fall Policy Number: WI2122ILSHIP177-00
Fall Annual Effective: 8/1/2021 – 7/31/2022
Spring Policy Number: WI2122ILSHIP177-01
Spring Annual Effective: 1/1/2022 – 12/31/2022
Summer Policy Number: WI2122ILSHIP177-02
Summer Annual Effective: 5/10/2022 – 5/9/2023
Group Number: ST0932SH

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

ADMINISTERED BY:
Wellfleet Group, LLC

WELLFLEET STUDENT

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Welcome Students…

We are pleased to provide you with this summary of the 2021 – 2022 Student Health Insurance Plan ("Plan"), which is fully compliant with the Affordable Care Act. "Benefits at a Glance" includes effective dates and costs of coverage, as well as other helpful information. For additional details about the Plan, please consult the Plan Certificate and other materials at **www.wellfleetstudent.com**. If you have questions about Enrollment into the Plan, please call University Health Plans at (800) 437-6448 **www.universityhealthplans.com/uic**. For questions about medical benefits or claims, please call Wellfleet Student at (877) 657-5030, TTY 711.

Where to Find Help

For Questions About:	Please Contact:
Servicing Agent **Enrollment**	**University Health Plans** **15 Pacella Park Drive, Suite 130** **Randolph, MA 02368** **www.universityhealthplans.com/uic** (800) 437-6448
Insurance Benefits **Claims Processing** **ID Cards** **Preferred Provider Listings**	**Wellfleet Group, LLC** **PO Box 15369** **Springfield, Massachusetts 01115-5369** **(877) 657-5030, TTY 711** **www.wellfleetstudent.com**
Preferred PPO Provider Listings **Cigna Claims**	**Wellfleet Student** **www.wellfleetstudent.com** or **www.cigna.com** **Send Cigna claims to:** **CIGNA** **PO Box 188061** **Chattanooga, TN 37422 – 8061** **Electronic Payor ID: 62308**
Prescription Drug Provider	**For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit www.wellfleetstudent.com** **Your plan includes Wellfleet Rx – offering over 40 generics at a $0 copay. Please ask your health care provider to review our formulary to see if these medications are right for you. Click here http://wellfleetrx.com/students/formularies/ for more information.**

Am I Eligible?

All eligible International students are required to have health insurance coverage and will be automatically enrolled in this health insurance plan and billed the plan costs for the health insurance plan. Eligible students do not have the option to waive coverage.

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

How Do I Enroll My Dependents?

To Enroll your eligible dependents:

- Go to **www.universityhealthplans.com/uic**.
- Click the "Enroll" tab and proceed as directed to enroll in and purchase the student health insurance plan.

Refer to the dates below for the deadline to purchase dependent coverage.

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	Dependent Enrollment Deadline
Fall Annual	8/1/2021	7/31/2022	9/30/2021
Spring Annual	1/1/2022	12/31/2022	2/2/2022
Summer Annual	5/10/2022	5/9/2023	6/30/2022

Plan Costs for International Students and their Dependents

	Fall Annual	Spring Annual	Summer Annual
Student	$2,000	$2,000	$2,000
Spouse	$2,000	$2,000	$2,000
Each Child	$2,000	$2,000	$2,000
3 or more Children	$6,000	$2,000	$6,000

***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.

UIC Global Schedule of Benefits

This is only a brief description of coverage available under Certificate form IL SHIP CERT (2019). The Certificate will contain full details of coverage, coinsurance, limitations, exclusions, and termination provisions. If there are any conflicts between this document and the Certificate, the Certificate governs in all cases.

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

SCHEDULE OF BENEFITS

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

Out-of-Network Provider: Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through an Out-of-Network Provider. Benefits are paid at 80% of the Usual and Customary Charge

Medical Deductible *	In-Network Provider	Individual:	$100
	Out-of-Network Provider	Individual:	$200

***Deductible** is waived if Covered Medical Expenses are incurred at the Student Health Center

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

Out-of-Pocket Maximum:	In-Network Provider	Individual	$2,500
		Family	$5,000
	Out-of-Network Provider	Individual	$5,000
		Family	$10,000

The Out-of-Pocket Maximum is the amount of Covered Medical Expenses You have to incur before Covered Medical Expense will be paid at 100% for the reminder of the Policy Year. Any applicable Coinsurance amounts, Deductibles and Copayments paid by You, or paid on Your behalf by another person, will apply toward the Out-of-Pocket Maximum. Cost-sharing does not include balance billing amounts for Out-of-Network Providers.

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:	90% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below.
Out-of-Network Provider:	70% of the Usual and Customary Charge (U&C) for Covered Medical Expenses unless otherwise stated below.
Student Health Center	100% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below.

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

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

Dental and Vision Benefit Payments
For dental and vision benefits, You may choose any dental or vision provider.

For dental, different benefits may be payable based on the type of service, as shown in the Schedule of Benefits.

Preferred Provider Organization:
To locate an In-Network Provider in Your area, consult Your Provider Directory or call toll free 877-657-5030 or visit Our website at www.wellfleetstudent.com

THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:

1. **THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
3. **DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY AN IN-NETWORK OR OUT-OF-NETWORK PROVIDER.**
4. **UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE WILL ALWAYS APPLY.**

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Inpatient Benefits		
Hospital Care Includes hospital room & board expenses and miscellaneous services and supplies. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined: Limited to 1 visit per day of Confinement per provider	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Surgery: Pre-Certification Required Surgeon Services	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Anesthetist	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Assistant Surgeon	90% of the Negotiated Charge after Deductible 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 after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Physical Therapy while Confined (inpatient)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Certification required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Maximum days per Policy Year	120	120
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
INPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
Mental Health Disorder and Substance Use Disorder Benefit Pre-Certification Required In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-certification requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Benefits		
Outpatient Surgery: Pre-Certification required Surgeon Services	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Anesthetist	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Assistant Surgeon	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Surgery Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Physician's Office Visits	$10 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Specialist/Consultant Physician Services	$10 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telemedicine or Telehealth Services	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Cardiac Rehabilitation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maximum Visits for each therapy per Policy Year for Physical Therapy, and Occupational Therapy	30	30
Maximum Visits per Policy Year for Speech Therapy	Unlimited	Unlimited
Habilitative Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitative Services Maximum Visits for each therapy per Policy Year for Physical Therapy, and Occupational Therapy	30	30
Emergency Services in an emergency department (includes Urgent Care for Emergency Medical Conditions)	$50 Copayment per visit then the plan pays 90% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary charge.
Urgent Care Centers for non-life-threatening conditions	$10 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

Diagnostic Imaging Services Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Pre-Certification required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hospice Care Coverage	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Private Duty Nursing Pre-Certification required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
OUTPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
Mental Health Disorder and Substance Use Disorder Benefit Pre-Certification Required except for office visits		
Physician's Office Visits including, but not limited to, physician visits; individual and group therapy; medication management	$10 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
All Other Outpatient Services including, but not limited to, Intensive Outpatient Programs (IOP); partial hospitalization; Electronic Convulsive Therapy (ECT); Repetitive Transcranial Magnetic Stimulation (rTMS); psychiatric and neuropsych testing	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% 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 Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.		
Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy or Student Health Center.		
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.	$10 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$10 Copayment then the plan pays 100% of Actual charge after Deductible for Covered Medical Expenses
More than a 30- day supply but less than a 61 day supply filled at a Retail pharmacy	$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 after Deductible for Covered Medical Expenses
More than a 60 day supply filled at a Retail pharmacy	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$30 Copayment then the plan pays 100% of Actual charge after Deductible for Covered Medical Expenses
TIER 2 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	$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 after Deductible for Covered Medical Expenses

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	$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 after Deductible for Covered Medical Expenses
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 after Deductible for Covered Medical Expenses
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.	$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 after Deductible for Covered Medical Expenses
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 after Deductible for Covered Medical Expenses
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 after Deductible for Covered Medical Expenses
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 the Actual Charge for Covered Medical Expenses Deductible Waived
Specialty Prescription Drugs		
Specialty Prescription Drugs For each fill up to a 30- day supply Out-of-Network Provider benefits are provided on a reimbursement basis.	$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 after Deductible 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.		
More than a 30- day supply but less than a 61- day supply	$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 after Deductible for Covered Medical Expenses
More than a 60- day supply	$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 after Deductible for Covered Medical Expenses
Orally administered anti-cancer prescription drugs (including specialty drugs)		
Benefit	Greater of: • Chemotherapy Benefit; or • Infusion Therapy Benefit	
Diabetic Supplies (for Prescription supplies purchased at a pharmacy)		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill, except that the Copayment for prescription insulin drugs will not exceed $100 for a 30-day supply.	
Other Benefits		
Allergy Testing	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Allergy Injections/Treatment	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Non-Emergency Ambulance Service ground and/or air, water transportation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Bariatric Surgery Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Clinical Cancer Trial Benefit	Same as any other Covered Sickness	
Durable Medical Equipment Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diabetic services and supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Dialysis Treatment	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hearing Aids Limited to 2 pair of hearing aids per 36 month period	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
Enteral Formulas and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Prosthetic and Customized Orthotic Devices Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Reconstructive Surgery Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19) Preventive Dental Care Limited to 2 dental exams every 12 months The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care: Emergency Dental Routine Dental Care Endodontic Services Prosthodontic Services Periodontic Services Medically Necessary Orthodontic Care Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	See the Pediatric Dental Care Benefit description in the Certificate for further information. 100% of Usual and Customary Charge 80% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge	

Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19) Limited to 1 visit(s) per Policy Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of Usual and Customary Charge after Deductible for Covered Medical Expenses per Policy Year	
Abortion Expense	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Accidental Injury Dental Treatment	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Sickness Dental Expense	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Pre-Certification Required	$10 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
Infertility Treatment Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Organ Transplant Surgery travel and lodging expenses a maximum of $10,000 per Policy Year or $250 per day, whichever is less while at the transplant facility Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Shots and Injections unless considered Preventive Services	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Opioid Use Disorder Benefits	Same as any other Covered Sickness	
Tuberculosis screening, Titers, Quantiferon B tests including shots (other than covered under preventive services)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Naprapathic Service	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Student Health Center/Infirmary Expense	100% Negotiated Charge for Covered Medical Expenses Deductible Waived	
Sports Accident Expense - incurred as the result of the play or practice of club sports	Same as any other Covered Injury	Same as any other Covered Injury
Non-emergency Care While Traveling Outside of the United States	70% of Actual Charge after Deductible for Covered Medical Expenses Subject to $10,000 maximum per Policy Year	
Medical Evacuation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $50,000 maximum per Policy Year	
Repatriation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $25,000 maximum per Policy Year	

Mandated Benefits		
Alcohol or Narcotics Injury-Related Services Benefit	Same as any other Covered Sickness	
Autism Spectrum Disorders Benefit for Insured Persons under 21 years of age.	Same as any other Covered Sickness	
Breast Cancer Pain Medication and Therapy Benefit	Same as any other Covered Sickness	
Dental Anesthesia Care Benefit	Same as any other Covered Sickness	
Emergency Medical Care due to Criminal Sexual Assault	Benefits will be paid at 100% of Actual Charge for Covered Medical Expenses, no Deductible or Copayment will apply.	
Habilitative Services for Children Benefit	Same as any other Covered Sickness subject to the limits described in the Benefit	
Human Papillomavirus Vaccine Benefit	Same as any other Covered Sickness, unless considered a Preventive Service	
Mammography and Clinical Breast Examination	**In-Network Provider** Covered in full	**Out-of-Network Provider** 80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Mental Health Services for Children and Young Adults	Same as any other Mental Health Disorder	
Multiple Sclerosis Preventive Physical Therapy Benefit	Same as any other Covered Sickness	
Post-Mastectomy Benefit	Same as any other Covered Sickness subject to the limits described in the Benefit	

Pediatric Autoimmune Neuropsychiatric Disorders Benefit	Same as any other Covered Sickness
Shingles Vaccine Benefit for Insured Persons 60 years of age or older.	Same as any other Covered Sickness
Long-term Antibiotic Therapy for Tick-borne Diseases Benefit	Same as any other Covered Sickness
Skin Cancer Screening Benefit	Same as any other Covered Sickness, unless considered a Preventive Service

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Principal Sum $10,000

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

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

Pre-Certification

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

Exclusions and Limitations

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

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

1. **International Students Only -** Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible.
2. 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 Your attending Physician or dentist.
3. Medical services rendered by a provider employed for or contracted with the Policyholder, including team physicians or trainers, except as specifically provided in the Schedule of Benefits or as part of the Student Health Center benefits provided by this plan.
4. Professional services rendered by an Immediate Family Member or anyone who lives with You.
5. Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary because of Injury, infection or disease.
6. Infertility treatment (male or female)-this includes but is not limited to:
   - Procreative counseling;
   - Premarital examinations;
   - Genetic counseling and genetic testing;
   - Impotence, organic or otherwise;

- Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
- Costs for an ovum donor or donor sperm;
- Sperm storage costs;
- Cryopreservation and storage of embryos;
- Ovulation induction and monitoring;
- Hysteroscopy;
- Laparoscopy;
- Laparotomy;
- Ovulation predictor kits;
- Reversal of tubal ligations;
- Reversal of vasectomies;
- Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
- Cloning; or
- Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.

7. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
8. Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services covered by Student Health Fees.
9. Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
10. 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.
11. 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.
12. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate sports for which benefits are paid under another Sports Accident policy issued to the Policyholder; or for which coverage is provided by the National Collegiate Athletic Association (NCAA), National Association of Intercollegiate Athletic (NAIA) or any other sports association per Accident.
13. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
14. 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.
15. Services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
16. Expenses payable under any prior policy which was in force for the person making the claim.
17. 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.
18. 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.
19. Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
20. Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
21. 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.
22. Treatment for obesity except surgery for morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat.
23. Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
24. Expenses for radial keratotomy.
25. Adult Vision unless specifically provided in the Certificate.
26. Charges for office visit exam for the fitting of prescription contact lenses, duplicate spare eyeglasses,

lenses or frames, non-prescription lenses or contact lenses that are for cosmetic purposes.

27. Charges for hearing exams, hearing screening, and the fitting or repair or replacement of hearing aids except as specifically provided in the Certificate.
28. Racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles) or other hazardous sport or hobby.
29. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma.
30. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
31. You are:
    - committing or attempting to commit a felony,
    - engaged in an illegal occupation, or
    - participating in a riot.
32. Custodial Care service and supplies.
33. Charges for hot or cold packs for personal use.
34. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
35. Services of private duty Nurse except as provided in the Certificate.
36. Expenses that are not recommended and approved by a Physician.
37. 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.
38. Cosmetic procedures related to Gender Reassignment including but not limited to rhinoplasty, face lift, facial bone reduction, lip enhancement or reduction, blepharoplasty, body contouring, reduction thyroid chondroplasty, hair removal, voice modification surgery, skin resurfacing, chin implants, nose implants.
39. Sleep Disorders, except for the diagnosis and treatment of obstructive sleep apnea..
40. Treatment of Acne unless Medically Necessary.
41. Experimental or Investigational drugs, devices, treatments or procedures unless otherwise covered under Covered Clinical Trials or covered under clinical trials (routine patient costs). See the Other Benefits section for more information.
42. Under the Prescription Drug Benefit shown in the Schedule of Benefits:
    - any drug or medicine which does not, by federal or state law, require a prescription order, i.e. over-the-counter drugs, even if a prescription is written, except as specifically provided under Preventive Services or in the Prescription Drug Benefit section of the Certificate. Insulin and OTC preventive medications required under ACA are exempt from this exclusion;
    - drugs with over-the-counter equivalents except as specifically provided under Preventive Services;
    - allergy sera and extracts administered via injection;
    - any drug or medicine for the purpose of weight control;
    - sexual enhancements drugs;
    - vitamins, and minerals, except as specifically provided under Preventive Services;
    - food supplements, dietary supplements; except as specifically provided in the Certificate;
    - cosmetic drugs or medicines, including but not limited to, products that improve the appearance of wrinkles or other skin blemishes;
    - refills in excess of the number specified or dispensed after 1 year of date of the prescription;
    - drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
    - any drug or medicine purchased after coverage under the Certificate terminates;
    - any drug or medicine consumed or administered at the place where it is dispensed;
    - if the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
    - bulk chemicals;
    - non-insulin syringes, surgical supplies, durable medical equipment/medical devices, except as specifically provided in the Prescription Drug Benefit section of the Certificate;
    - repackaged products;
    - blood components except factors;
    - immunology products.

43. Non-chemical addictions.
44. Non-physical, occupational, speech therapies (art, dance, etc.).
45. Modifications made to dwellings.
46. General fitness, exercise programs.
47. Hypnosis.
48. Rolfing.
49. Biofeedback.

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

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.