WASHINGTON COLLEGE

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2021/2022

DESIGNED EXCLUSIVELY FOR THE STUDENTS

WASHINGTON COLLEGE
Chestertown, MD
("the Policyholder")

Policy Number: WI2122MDSHIP65
Group Number: ST0973SH
Effective: 8/15/2021 - 8/14/2022

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

ADMINISTERED BY:
Wellfleet Group, LLC

WELLFLEET STUDENT

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

Welcome Students…

We are pleased to provide you with this summary of the 2021 – 2022 Student Health Insurance Plan ("Plan"), which is fully compliant with the Affordable Care Act. "Benefits at a Glance" includes effective dates and costs of coverage, as well as other helpful information. For additional details about the Plan, please consult the Plan Certificate and other materials at **www.wellfleetstudent.com**. If you have questions about enrollment into the Plan, please call University Health Plans at (833)251-1117. 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 (833) 251-1117**
Claims Processing **ID Cards** **Preferred Provider Listings** **ID card Requests**	**Wellfleet Group, LLC** **PO Box 15369** **Springfield, Massachusetts 01115-5369** **(877) 657-5030, TTY 711** **www.wellfleetstudent.com**
Preferred PPO Provider Listings **Cigna Claims**	**Wellfleet Student** **www.wellfleetstudent.com** or **Cigna Open Access Plus (OAP)** **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 registered full-time Domestic and International students taking at least 12 credits are required to have health insurance coverage, either through this Student Health Insurance Plan or through another individual or family plan. Students are automatically enrolled in the Student Health Insurance Plan at registration and the premium is added to the student's tuition fees unless proof of comparable coverage is provided by completing the waiver.

How Do I Waive/Enroll?

Eligible Students who DO NOT WANT to be enrolled in the Student Health Insurance Plan must submit an online Waiver Form documenting proof of comparable coverage in another health insurance plan prior to the posted waiver deadline date.

Recognizing that health insurance situations may change, students will be required to provide proof of comparable coverage each academic year in order to waive participation in the Student Health Insurance Plan.

To complete the Waiver process, please go to **www.univhealthplans.com**, and follow the directions.

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	8/15/2021	8/14/2022	8/1/2021
Fall	8/15/2021	1/14/2022	8/1/2021
Spring (New Students Only)	1/15/2022	8/14/2022	1/15/2022

Plan Costs for Domestic and International Students

	Annual	Fall	Spring (New Students Only)
Student*	$2,355	$988	$1,367

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

Preferred Provider Organization (PPO) Network

…providing access to quality health care at discounted costs!

By enrolling in this Plan, you have the Cigna Open Access Plus (OAP) 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.

Washington 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.

SCHEDULE OF BENEFITS

Actuarial value and metallic level: 92.35%- Platinum metallic level

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

Medical Deductible*

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

*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	$2,500*
Out-of-Network Provider	Individual	$2,500**

*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.

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.

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 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, TTY 711 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. **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	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:	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 Recommended		
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
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 Recommended	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Recommended	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 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.	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 Recommended		
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	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Specialist/Consultant Physician Services	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
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 Increased outpatient rehabilitation services (physical therapy, speech therapy and occupational therapy) for 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
Cardiac Rehabilitation Maximum Visits per therapy per Policy Year	90	90
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 Recommended	90% of the Negotiated Charge after Deductible for Covered Medical Expenses Pre-Certification Required after the 5th visit for Physical and/or Occupational Therapy.	70% 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	90% of the Negotiated Charge after Deductible for Covered Medical Expenses Pre-Certification Required after the 5th visit for Physical and/or Occupational Therapy.	70% 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	90% of the Negotiated Charge after Deductible for Covered Medical Expenses Pre-Certification Required after the 5th visit for Physical and/or Occupational Therapy.	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Services in an emergency department (includes Urgent Care for Emergency Medical Conditions).	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	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diagnostic Imaging/Testing Services Pre-Certification Recommended	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 Recommended	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/Tests (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 Recommended	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 Recommended	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 Recommended	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 MENTAL HEALTH DISORDER AND SUBSTANCE MISUSE DISORDER		
Mental Health Disorder and Substance Misuse Disorder Benefit Physician's Office Visits including, but not limited to, physician visits; individual and group therapy; medication management All Other Outpatient Services including, but not limited to, Intensive Outpatient Programs (IOP); partial hospitalization; Electronic Convulsive Therapy (ECT); Repetitive Transcranial Magnetic Stimulation (rTMS); psychiatric and neuropsych testing In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing	90% of the Negotiated Charge after Deductible for Covered Medical Expenses 90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses 70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

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 or Student Health Center.		
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.	$10 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% 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	80% 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	80% of Actual charge after Deductible for Covered Medical Expenses
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.	$25 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% of Actual charge after Deductible for Covered Medical Expenses

See the Medical Foods Benefit 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	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% of Actual charge after Deductible for Covered Medical Expenses
More than a 60 day supply filled at a Retail pharmacy	$75 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% of Actual charge after Deductible for Covered Medical Expenses
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.	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% 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	$100 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% of Actual charge after Deductible for Covered Medical Expenses
More than a 60 day supply filled at a Retail pharmacy	$150 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	80% 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 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.	$50 Copayment per 30-day supply for Covered Medical Expenses Deductible Waived	$50 Copayment per 30-day supply 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 Pharmacy Prescription Drug Fill, except no cost share shall apply to blood glucose test strips	
Prescription Drugs to treat Diabetes, HIV or AIDS		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill, except that the Insured Person's cost share shall not exceed $150 for up to a 30-day supply for prescription drugs prescribed to treat diabetes, HIV, or AIDS.	
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 Recommended	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% 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	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	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	
Prosthetic Devices Pre-Certification Recommended	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 Recommended	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 (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 Prosthodontic Services Periodontic Services Medically Necessary Orthodontic Care Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	See the Pediatric Dental Care Benefit description in the Certificate for further information. 100% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge	

Pediatric Vision Care Benefit (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 after Deductible for Covered Medical Expenses	
Acupuncture Expense Benefit (Medically Necessary Treatment) only	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
Chiropractic Care Benefit Pre-Certification Recommended	90% of the Negotiated Charge after Deductible for Covered Medical Expenses Pre-Certification Required after the 5th visit.	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infertility Treatment Pre-Certification Recommended • Infertility Services • Standard Fertility Preservation Procedures	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 $2,000 per Policy Year or $250 per day, whichever is less while at the transplant facility. Pre-Certification Recommended	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 (age 19 and over)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% 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.	
General Anesthesia for Dental Care	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% 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	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Nutritional Counseling	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Osteoporosis Benefit	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Patient Centered Medical Home Expense Benefit Pre-Certification Recommended	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Prostate Cancer Screening	Same as any other Preventive Service, except no cost sharing shall apply to services provided by an In-Network or Out-of-Network Provider.	
Reconstructive Breast Surgery	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Second Opinion Benefit	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% 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	
Pediatric Autoimmune Neuropsychiatric Disorders	Same as any other Covered Sickness	
Additional Benefits		
Medical Evacuation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to Unlimited maximum per Policy Year	
Repatriation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to Unlimited maximum per Policy Year	

Non-emergency Care While Traveling Outside of the United States	70% of Actual Charge after Deductible for Covered Medical Expenses	
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
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

Pre-Certification

Pre-certification is required for inpatient hospital, surgery and selected outpatient services. Pre-Certification is not required for an Emergency Medical Condition or Urgent Care or Hospital Confinement for the initial 48/96 hours of maternity care.

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. Private duty nursing;
46. 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

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

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.

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.