WELLFLEET STUDENT

Stanford University

# Benefits at a Glance

Student Health Insurance Plan (2026/2027)



**Designed exclusively for the students of:**

**STANFORD UNIVERSITY**
**CARDINAL CARE**
**Stanford, CA**
("the policyholder")
**Policy Number:** WI2627CASHIP245
**Group Number:** ST2369SH
**Effective:** 09/01/2026 – 08/31/2027

**Underwritten by:** Wellfleet Insurance Company

Fort Wayne, IN
("the Company")
**Administered by:** Wellfleet Group, LLC dba Wellfleet Administrators, LLC

WELLFLEET STUDENT

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# Welcome Students…

We are pleased to provide you with this summary of the 2026 – 2027 Cardinal Care Plan , sponsored by Stanford University, which is fully compliant with the Affordable Care Act. This is only a brief description of the coverage(s) available under Certificate form CA SHIP Cert (2026). The Certificate will contain reductions, limitations, exclusions, and termination provisions. Full details of coverage are contained in the Certificate. If there are any conflicts between this document and the Certificate, the Certificate shall govern in all cases.

"Benefits at a Glance" includes effective dates and costs of coverage, as well as other helpful information. For additional details about the Plan, please consult the Plan Certificate and other materials at **www.wellfleetstudent.com**.

This is not an insurance Policy and your receipt of this document does not constitute the insurance or delivery of a policy of insurance. Any provisions of the Policy, as described in this Summary, that may be in conflict with the laws of the state where the school is located will be administered to conform with the requirements of that state's laws, including those relating to mandated benefits.

The information contained in this Summary is accurate at the time of publication, but may change in accordance with state and federal insurance regulations during the course of the Policy year. The most current version of this document will be posted online. In the case of a discrepancy between two versions of the Summary, the most recent will apply.

# Important Contact Information & Resources

## Contact Us

Wellfleet Group, LLC
dba Wellfleet Administrators, LLC
PO Box 15369
Springfield, Massachusetts 01115-5369
(833) 343-8387, TTY 711

## Plan Administration

### Dependent Enrollment & Cardinal Care Waiver Requests

**Academic Health Plans**
https://stanford.myahpcare.com/cardinalcare
**1-855-343-8387**

### Benefits, Claim Status, & ID Cards

Wellfleet Group, LLC
dba Wellfleet Administrators, LLC
PO Box 15369
Springfield, Massachusetts 01115-5369
**(833) 343-5338, TTY 711**
www.wellfleetstudent.com
Monday–Friday, 8:00 a.m. to 5:00 p.m.
Pacific Standard Time
WCS@wellfleetinsurance.com

**Ameritas Dental Group**
800-487-5553
Monday - Thursday 7 a.m. - Midnight
Friday 7 a.m. - 6:30 p.m.
ameritas.com

### Claims

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

## PPO Network

### In the State of California:

**Blue Shield of CA**

Health insurance plans | Blue Shield of California

### Outside of the State of California:

Cigna

**www.mycigna.com**

### Pharmacy Benefits Manager

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

Your plan includes Wellfleet Rx – offering over 40 generics at a $0 copay. Please ask your health care provider to review our formulary to see if these medications are right for you. Click here http://wellfleetrx.com/students/formularies/ for more information.

### Member Pharmacy Help

**(877) 640-7940**

## Telehealth Service

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

- Scheduled mental health services – 7 days a week

Register at
https://www.teladoc.com/wellfleetstudent/

- In addition, your plan includes virtual physical therapy and other musculoskeletal services from Hinge Health
- Register at https://hinge.health/wellfleet

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

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# General Information

## Am I Eligible?

Students, while attending Stanford University, must be covered by health insurance that meets specific parameters. Cardinal Care, the student health insurance plan, is one such option. Students are automatically enrolled in the Cardinal Care Plan at the start of their entry quarter each year and have until the waiver deadline of their entry quarter to choose to remain enrolled or waive. Students entering Stanford for the first time who need coverage for dependents can enroll them only during a defined period

### Dependents

Students enrolled in Cardinal Care can enroll their spouse, registered domestic partner, and dependent children up to the age of 26. Students can enroll a dependent in Dependent Care only during a defined period of open enrollment that coincides with their first 30 days of matriculation unless a qualifying life event occurs at a later date. A qualifying life event will open a 60-day enrollment period. Only students who are enrolled in Cardinal Care may enroll dependents in Dependent Care. Open enrollment takes place in the month of September, or in the first month of the student's entry quarter each plan year.

### NOTICE

**California requires residents and their dependents to obtain, and maintain, health coverage or pay a penalty, unless they qualify for an exemption. Enrolling in student health insurance offered by the college or university You are attending is one way to meet this requirement.**

**You may be eligible to get free or low-cost health coverage through Medi-Cal regardless of immigration status. In addition, You may be eligible for free or low-cost health coverage through Covered California. Visit Covered California at www.coveredca.com to learn about health coverage options that are available for You and Your dependents, and how You might qualify to get financial assistance with the cost of coverage.**

**If You are under 26 years of age, You may be eligible for coverage as a dependent in a group health plan of Your parent's employer or under Your parents' individual market coverage. In addition, You may be eligible to buy individual health insurance directly from a health insurer or health plan, regardless of immigration status.**

**Please examine Your options carefully to see if other options are more affordable and whether You are currently eligible to enroll in these other forms of coverage pursuant to an open or special enrollment period.**

## How to remain enrolled or request a waiver?

All students of Stanford taking 1 or more credit hours are automatically enrolled in Cardinal Care health insurance coverage.

All students must take action to acknowledge their understanding of the Cardinal Care Enrollment Policy in Axess, at which time the student can opt to remain enrolled in the Cardinal Care insurance cover OR can choose to submit a request to waive out of coverage. Students must submit their choice by the applicable deadline.

All students of Stanford University taking 1 or more credit hours are automatically enrolled in Cardinal Care Health Insurance Coverage. All students must take action to either acknowledge the enrollment policy in the Cardinal Care Plan or to waive the coverage. Student must submit their choice by the applicable deadline.

Regardless of your decision, as part of this process, ALL students are required to acknowledge their understanding of the Cardinal Care Enrollment Policy.

### Cardinal Care Enrollment Policy: Next Steps/ACTION REQUIRED

### Reminder

**All Students are automatically enrolled in Cardinal Care health insurance coverage.** By the applicable deadline, students must take action to acknowledge the Cardinal Care Enrollment Policy. Students who wish to waive Cardinal Care coverage must submit their request to waive by the waiver deadline of their entry quarter each year.

## Acknowledge Cardinal Care Enrollment Policy

Once you have decided whether to remain enrolled in the Cardinal Care coverage or to request a waiver, the next step is to take action in Axess. Regardless of your decision, as part of this process, ALL students are required to acknowledge their understanding of the Cardinal Care Enrollment Policy:

- **Log into Axess** (axess.stanford.edu)
- Review your to do list on your Axess Home Page
- Select the 'Mandatory Insurance Decision'
- Read the Cardinal Care Enrollment Policy and click 'Accept" to indicate you have done so
- Click 'Submit' to clear your To Do item

All students who are enrolled in the Cardinal Care Plan will automatically be enrolled in the Group Dental Plan with Ameritas. Students will also have the opportunity to purchase a separate individual voluntary vision plan with Ameritas. See https://myplan.ameritas.com/id/8f45aa2.

## Don't Miss the Deadline!

If you fail to take action by the deadline that is applicable to you (see table below), unexpected consequences and charges may apply.

| Quarter of Entry | Deadline to: 1) Acknowledge Cardinal Care Enrollment Policy in Axess*(for All students), and 2) Submit a Request to Waive Cardinal Care Coverage (for students who wish to waive) | Population of Students |
|---|---|---|
| **Autumn Quarter** | September 15 | This deadline is only applicable to students entering Stanford in the Autumn Quarter |
| **Winter Quarter** | December 15 | This deadline is only applicable to students entering Stanford in the Winter Quarter |
| **Spring Quarter** | March 15 | This deadline is only applicable to students entering Stanford in the Spring Quarter |
| **Summer Quarter** | June 15 | This deadline is only applicable to students entering Stanford in the Summer Quarter |

***Axess typically opens a few weeks prior to the date class enrollment begins.**

## 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.**

### Entering Students

| Coverage Period | Coverage Start Date | Coverage End Date | Dependent Enrollment Deadine/ Student Waiver Deadline Date |
|---|---|---|---|
| **Annual** | 09/01/2026 | 08/31/2027 | 09/15/2026 |
| **Winter** | 01/01/2027 | 08/31/2027 | 12/15/2026 |
| **Spring** | 04/01/2027 | 08/31/2027 | 03/15/2026 |
| **Summer** | 06/01/2027 | 08/31/2027 | 06/15/2026 |

**Total Plan Costs (Premiums + Fees) for Students and their Dependents***

| Entering Students | Annual | Winter | Spring | Summer |
|---|---|---|---|---|
| **Student** | $8,808 | $5,872 | $3,670 | $2,202 |

| Dependents of Entering Students | Annual | Winter | Spring | Summer | Monthly |
|---|---|---|---|---|---|
| **Spouse** | $8,808 | $5,872 | $3,670 | $2,202 | $734 |
| **Each Child** | $4,680 | $3,120 | $1,950 | $1,170 | $390 |

***Rates shown reflect the premium costs of the Cardinal Care Plan underwritten by Wellfleet Insurance Company and premium payable to Ameritas Insurance Company for the Group Dental Plan with Ameritas.***

# Plan Benefits

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

When You receive Emergency Services, or Out-of-Network air Ambulance Services, or certain non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center without Your consent, You are protected from Surprise Billing. Refer to the Preferred Provider Organization provision in the How The Plan Works And Description Of Benefits section for additional information.

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

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

Pre-Certification is not required for an Emergency Medical Condition, or Urgent Care, or Hospital Confinement for the initial 48 hours following a normal vaginal delivery or 96 hours following a cesarean section of maternity care.

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

## Student Health Center ("Vaden") Referral Parameters

When available, the Insured Student must first use the resources of the Student Health Center ("Vaden") where Treatment may be administered, or a referral is issued indicating the services were not available at Vaden. The Insured Student is then free to seek services outside Vaden. Covered Medical Expenses incurred for medical Treatment rendered outside of Vaden for which no prior approval or referral is obtained will be subject to the Referral Penalty shown below. A referral issued by Vaden must be made available to Us so that the claim can be processed accurately.

A Vaden referral for outside care is **un**necessary for the following conditions:

1. For an Emergency Medical Condition;
2. For medical care provided at Stanford Health Care's Express Care Clinic or Walk in Clinic;
3. For medical care received when the student is more than 25 miles from campus;
4. For maternity care;*
5. When service is rendered at another facility during breaks, holidays, or periods when Vaden is closed;
6. For medical care obtained by a student who is not eligible to use Vaden;
7. For mental health care, including Psychiatry;
8. For the routine annual eye exam;

*Additionally, no authorization or referral requirement will apply to obstetrical or gynecological care provided by In-Network Providers (including IUD services, colposcopy, and pregnancy termination).

The applicable Deductible(s); Coinsurance and Copayment(s) shall apply to all of the exceptions to the referral requirement shown above.

Dependents are not eligible to use Vaden and therefore are exempt from the above limitations and referral requirements**.**

**Referral Penalty:**
Unless an exception to the Student Health Center Referral applies, if an Insured Student does not obtain a Referral from the Student Health Center then, We will not pay for Covered Medical Expenses under this Certificate. The additional percentage or dollar amount which the Insured Student may pay as a penalty for failure to obtain a Referral is not a Covered Medical Expense and will not be applied towards the Deductible amount, if applicable or the Out-Of-Pocket Maximum.

## Key Plan Benefits

**Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.**

| BENEFIT | IN-NETWORK PROVIDER | OUT-OF-NETWORK PROVIDER |
|---|---|---|
| **Policy Year Deductible**<br>**Individual**<br>**Family** | <br>$150<br>$300 | <br>$1,500<br>$4,500 |
| 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**<br>**Individual**<br>**Family** | <br>$3,000<br>$6,000 | <br>No Maximum |
| 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** | 100% of the Negotiated Charge (NC) | 50% of Usual & Customary (U&C) Charge |
| **Preventive Services** | 100% of the (NC) for Covered Medical Expenses<br>Deductible Waived | 50% of (U&C) Charge for Covered Medical Expenses<br>Deductible, Coinsurance, and any Copayments are applicable |

| | | |
|---|---|---|
| **Physician's Office Visits**<br><br>**For Mental Health and Substance Use Disorder see the Mental Health and Substance Use Disorder Benefits section** | $35 Copayment per visit then the plan pays 100% of the (NC) for Covered Medical Expenses<br>Deductible Waived | 50% of (U&C) Charge after Deductible for Covered Medical Expenses |
| **Specialists Visits**<br><br>**For Mental Health and Substance Use Disorder see the Mental Health and Substance Use Disorder Benefits section** | $50 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **Emergency Services in an emergency department for Emergency Medical Conditions.** | $300 Copayment per visit then the plan pays 100% of the (NC) for Covered Medical Expenses<br>Deductible Waived<br>Copayment waived if admitted | Paid the same as In-Network Provider subject to (U&C) Charge. |
| **Urgent Care Centers for non-life-threatening conditions** | $100 Copayment per visit then the plan pays 100% of the (NC) for Covered Medical Expenses<br>Deductible Waived | $100 Copayment per visit then the plan pays 100% of (U&C) Charge for Covered Medical Expenses<br>Deductible Waived |

## Schedule of Benefits

**THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:**

1. **THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
3. **DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY AN IN-NETWORK OR OUT-OF-NETWORK PROVIDER.**
4. **UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE WILL ALWAYS APPLY.**
5. **UNLESS SPECIFIED BELOW, ANY APPLICABLE COPAYMENTS ARE APPLIED AFTER DEDUCTIBLE IS MET.**
6. **UNLESS OTHERWISE SPECIFIED BELOW, ANY DAY OR VISIT LIMITS WILL BE APPLIED TO IN-NETWORK AND OUT-OF-NETWORK COMBINED**.

| BENEFITS FOR COVERED INJURY/SICKNESS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **INPATIENT SERVICES** | | |
| Hospital Care<br>Includes Hospital Room and Board Expenses and Hospital Miscellaneous Expenses.<br><br>Subject to Semi-Private room rate unless intensive care unit is required.<br><br>Room and Board includes intensive care.<br><br>Pre-Certification Required | $500 Copayment per admission after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |

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|---|---|---|
| Preadmission Testing | 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Physician's Visits while Confined | 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Skilled Nursing Facility Benefit<br><br>Pre-Certification Required | $500 Copayment per admission after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Inpatient Rehabilitation Facility Expense Benefit<br><br>Pre-Certification Required | 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Physical Therapy while Confined (inpatient) | 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS**<br>In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, and any Pre-Certification requirements that apply to a Mental Health and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness. Day or visit limits do not apply to Mental Health and Substance Use Disorder Benefits. | | |
| **Inpatient Mental Health and Substance Use Disorder Benefits**<br>Pre-Certification Required<br><br>Inpatient Treatment for Mental Health, including Gender Dysphoria and Behavioral Health Treatment for Pervasive Developmental Disorder or Autism and Substance Use Disorders.<br><br>This includes inpatient Psychiatric and Residential Treatment Centers | $250 Copayment per admission after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **Outpatient Mental Health and Substance Use Disorder Benefits**<br>For the Treatment of Mental Health, including Gender Dysphoria and Behavioral Health Treatment for Pervasive Developmental Disorder or Autism and Substance Use Disorders.<br><br>Outpatient Physician and **Specialists Office Visits (including but not limited to the following: Physician visits, individual and group therapy, hormone therapy, medication management) | $35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |

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|---|---|---|
| All Other Outpatient Services<br>(All Other Outpatient Services does not include Emergency Services in an emergency department, Urgent Care Centers, and Emergency Ambulance Service and Prescription Drugs. Refer to the Emergency Services, Ambulance and Non-Emergency Services, and Prescription Drugs sections of this Schedule of Benefits for benefit information.)<br><br>Pre-Certification may be required for certain All Other Outpatient Services. To see if Pre-Certification is required, refer to the Pre-Certification Requirement listing and specific benefit listed in this Schedule of Benefits | 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Community Based Care Program (CARE) | 100% of the Negotiated Charge<br>Deductible Waived | Paid the same as In-Network Provider subject to Usual and Customary Charge. |
| Mobile Crisis Services/988 Center | 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | Paid the same as In-Network Provider subject to Usual and Customary Charge. |
| **PROFESSIONAL AND OUTPATIENT SERVICES** | | |
| ***Surgical Expenses*** | | |
| Inpatient and Outpatient Surgery includes:<br>Pre-Certification Required for Surgery only | | |
| Surgeon Services | 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Anesthetist | 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Assistant Surgeon | 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Outpatient Surgical Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma | $250 Copayment per occurrence after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Abortion Expense | 100% of the Negotiated Charge for Covered Medical Expenses<br>Deductible Waived | 100% of Usual and Customary Charge for Covered Medical Expenses<br>Deductible Waived |

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|---|---|---|
| Bariatric Surgery<br>Pre-Certification Required | 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Organ Transplant Surgery<br><br>Travel and lodging expenses a maximum of $2,000 per Policy Year or $250 per day, whichever is less while at the transplant facility.<br><br>Pre-Certification Required | 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Reconstructive Surgery<br>Pre-Certification Required | 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| ***Other Professional Services*** | | |
| Gender Affirming Services Benefit<br>Pre-Certification Required for gender affirming surgery | Same as any other Mental Health Disorder | |
| Home Health Care Expenses<br>Pre-Certification Required | 90% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Home Health Care Expenses<br>Maximum visits per Policy Year | 100 | 100 |
| Hospice Care Coverage | 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **Office Visits** | | |
| Physician's Office Visits<br><br>For Mental Health and Substance Use Disorder see the Mental Health and Substance Use Disorder Benefits section | $35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **Specialists Visits<br><br>For Mental Health and Substance Use Disorder see the Mental Health and Substance Use Disorder Benefits section | $50 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Standard Telemedicine or Telehealth Services Benefit | $35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |

| | | |
|---|---|---|
| Third Party Telemedicine or Telehealth Services Program<br><br>Behavioral Health<br><br><br><br>Musculoskeletal | <br><br>100% of the Negotiated Charge for Covered Medical Expenses<br>Deductible Waived<br><br><br>100% of the Negotiated Charge for Covered Medical Expenses<br>Deductible Waived | |
| Acupuncture Services (Medically Necessary Treatment only) | $35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br>Deductible Waived | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Acupuncture Services<br>Maximum visits per Policy Year | 30 | 30 |
| Allergy Testing and Treatment, including injections | 90% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Chiropractic Care Benefit | $35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Chiropractic Care Benefit Maximum visits per Policy Year | 30 | 30 |
| Tuberculosis screening (TB), Titers, QuantiFERON B tests including shots (other than covered under Preventive Services) | 90% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **EMERGENCY SERVICES, AMBULANCE AND NON-EMERGENCY SERVICES** | | |
| Emergency Services in an emergency department for Emergency Medical Conditions. | $300 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived<br>Copayment waived if admitted | Paid the same as In-Network Provider subject to Usual and Customary Charge. |
| Urgent Care Centers for non-life-threatening conditions | $100 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | $100 Copayment per visit then the plan pays 100% of Usual and Customary Charge for Covered Medical Expenses<br><br>Deductible Waived |

| | | |
|---|---|---|
| Emergency Ambulance Service ground and/or air, water transportation | 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | Paid the same as In-Network Provider subject to Usual and Customary Charge. |
| Non-Emergency Ambulance Expenses ground and/or air (fixed wing) transportation<br><br>Pre-Certification Required for non-emergency air Ambulance (fixed wing) | 90% of the Negotiated Charge after Deductible for Covered Medical Expenses | Ground Ambulance transportation: 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses<br><br>Air Ambulance transportation: Paid the same as In-Network Provider subject to Usual and Customary Charge. |
| **DIAGNOSTIC LABORATORY, RADIOLOGY, TESTING AND IMAGING SERVICES** | | |
| Diagnostic Complex Imaging Services<br>Pre-Certification Required<br><br>When You are referred by the Student Health Center to a different medical facility for complex imaging services, benefits include reimbursement for ground travel up to $50 round trip. | $250 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Diagnostic Laboratory, Radiological Services and Testing (Outpatient)<br><br>Pre-Certification may be required. See Prior Authorization Requirements section listed at www.wellfleetstudent.com/providers/. | 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Chemotherapy and Radiation Therapy<br>Pre-Certification Required | 90% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Infusion Therapy<br>Pre-Certification Required | 90% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **REHABILITATION AND HABILITATION THERAPIES** | | |
| Cardiac Rehabilitation | $35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br>Deductible Waived | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Pulmonary Rehabilitation | $35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br>Deductible Waived | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |

| | | |
|---|---|---|
| Rehabilitation Therapy including Physical Therapy, and Occupational Therapy and Speech Therapy | $35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Rehabilitation Therapy<br>Maximum Visits for each therapy per Policy Year for Physical Therapy, Occupational Therapy and Speech Therapy<br>Combined with Habilitation Services Therapy | 30 | 30 |
| Habilitation Services including Physical Therapy, and Occupational Therapy and Speech Therapy | $35 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Habilitation Services<br>Maximum Visits for each therapy per Policy Year for Physical Therapy, Occupational Therapy and Speech Therapy<br><br>Combined with Rehabilitation Therapy | 30 | 30 |
| **OTHER SERVICES AND SUPPLIES** | | |
| Covered Clinical Trials | Same as any other Covered Sickness | |
| Diabetic Services and Supplies (including equipment and training)<br><br>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 | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Dialysis Treatment | 90% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Durable Medical Equipment<br><br>Pre-Certification Required | $25 Copayment per device after Deductible then the plan pays 90% of the Negotiated Charge for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Enteral Formulas and Nutritional Supplements<br><br>See the Prescription Drug section of this Schedule when purchased at a pharmacy. | 90% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |

| | | |
|---|---|---|
| Infertility Treatment Benefit<br>Pre-Certification Required | 90% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Fertility Preservation Benefit<br>Pre-Certification Required | Same as any other Covered Sickness | |
| Maternity Benefit | Same as any other Covered Sickness | |
| Prosthetic and Orthotic Devices<br>Pre-Certification Required | 90% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Non-emergency Care While Traveling Outside of the United States | 50% of Actual Charge after Deductible for Covered Medical Expenses<br>Subject to $10,000 maximum per Policy Year | |
| Medical Evacuation Expense | 100% of Actual Charge for Covered Medical Expenses<br>Deductible Waived<br>Subject to $50,000 maximum per Policy Year | |
| Repatriation Expense | 100% of Actual Charge for Covered Medical Expenses<br>Deductible Waived<br>Subject to $25,000 maximum per Policy Year | |
| **DENTAL BENEFITS** | | |
| Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)<br><br>Type A Services: Diagnostic and Preventive Dental Care<br><br>Preventive Dental Care Limited to 2 dental exams every 12 months<br><br>The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care:<br><br>Type B Services: Basic Restorative Care<br><br>Type C Services: Major Restorative Care<br><br>Medically Necessary Orthodontic Care<br><br>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 Dental Care Schedule of Benefits below and Pediatric Dental Care Benefit description for further information.<br><br>100% of Usual and Customary Charge for Covered Medical Expenses<br><br>80% of Usual and Customary Charge for Covered Medical Expenses<br><br>50% of Usual and Customary Charge for Covered Medical Expenses<br><br>50% of Usual and Customary Charge for Covered Medical Expenses<br><br>Deductible Waived | |

| VISION BENEFITS | | |
|---|---|---|
| Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19)<br><br>Limited to 1 vision examination per Policy Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year.<br><br>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 Vision Care Benefit description for further information.<br><br>100% of Usual and Customary Charge for Covered Medical Expenses<br>Deductible Waived | |
| Adult Vision Care<br>(age 19 and older)<br>Routine Eye Examination once every 12 months<br><br>Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions<br><br>Lenses, frames, and contact lenses (including fittings) are not covered.<br><br>No referral requirement | $25 Copayment per visit then the plan pays 100% of Usual and Customary Charge for Covered Medical Expenses<br><br>Deductible Waived | |
| **MISCELLANEOUS DENTAL SERVICES** | | |
| Accidental Injury Dental Treatment | 90% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Sickness Dental Expense Benefit | 90% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% 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 | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Surgical Services Directly Affecting the Upper or Lower Jawbone Benefit | 90% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Dental Anesthesia | 90% of the Negotiated Charge after Deductible for Covered Medical Expenses | 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses |

| PRESCRIPTION DRUGS | | |
|---|---|---|
| **Prescription Drugs Retail Pharmacy**<br>No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy.<br><br>Your benefit is limited to a 30 day supply. Coverage for more than a 30 day supply only applies if the smallest package size exceeds a 30 day supply. See "Retail Pharmacy Supply Limits" section for more information.<br><br>Maintenance Prescription Drugs are limited to a 90-day supply subject to 3 times the applicable cost share for retail drugs | | |
| TIER 1<br><br>(Including Enteral Formulas)<br>For each fill up to a 30 day supply filled at a Retail pharmacy<br><br>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<br><br>Deductible Waived | Not Covered |
| 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<br><br>Deductible Waived | Not Covered |
| 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<br><br>Deductible Waived | Not Covered |
| TIER 2<br><br>(Including Enteral Formulas)<br>For each fill up to a 30 day supply filled at a Retail pharmacy<br><br>See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy. | $35 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | Not Covered |
| More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy | $70 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | Not Covered |
| More than a 60 day supply filled at a Retail pharmacy | $105 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br>Deductible Waived | Not Covered |

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|---|---|---|
| TIER 3<br><br>(Including Enteral Formulas)<br>For each fill up to a 30 day supply filled at a Retail Pharmacy<br><br>See the Enteral Formula and Nutritional Supplements 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<br><br>Deductible Waived | Not Covered |
| 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<br><br>Deductible Waived | Not Covered |
| 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<br><br>Deductible Waived | Not Covered |
| **Specialty Prescription Drugs** | | |
| For each fill up to a 30 day supply. | $50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | Not Covered |
| More than a 30 day supply but less than a 61 day supply | $100 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | Not Covered |
| More than a 60 day supply | $150 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | Not Covered |
| **Specialty Prescription Drugs with Copayment Assistance Program**<br>Copayment Assistance Program - Prior Authorization May Be Required: Amounts You pay out-of-pocket for covered Specialty Prescription Drugs will not exceed the applicable Tier's cost share per 30 day supply and will be applied towards the Deductible (if applicable) and Out-of-Pocket Maximum. Copayment Assistance may be available to You for certain Specialty Prescription Drugs when Your prescription is filled at a participating network pharmacy. Visit www.wellfleetrx.com/students for the applicable Specialty Prescription Drugs. Copayment Assistance dollars paid by the drug manufacturer for covered Specialty Prescription Drugs will not be applied towards the Deductible (if applicable) or Out-of-Pocket Maximum. Any amounts paid by You for a covered Specialty Prescription Drug after Copayment Assistance will be applied to the Deductible (if applicable) and Out-of-Pocket Maximum. For details, contact the Copayment Assistance Program at 636-271-5280. | | |

| | | |
|---|---|---|
| For each fill up to a 30 day supply. | 75% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | Not Covered |
| **Zero Cost Drugs** | | |
| | 100% of the Negotiated Charge for Covered Medical Expenses<br><br>Deductible Waived | Not Covered |
| **Orally administered anti-cancer Prescription Drugs (including Specialty Drugs)** | | |
| Benefit | Same as any other Prescription Drug. The total amount of Copayments and Coinsurance an Insured Person must pay will not exceed $250 for an individual prescription of up to a 30-day supply. | |
| **Diabetic Supplies (for prescription supplies purchased at a pharmacy)** | | |
| Benefit | Paid the same as any other Retail Pharmacy Prescription Drug Fill. | |
| **MANDATED BENEFITS** | | |
| AIDS Vaccine | Same as any other Preventive Service | |
| Alzheimer's Disease Coverage | Same as any other Covered Sickness | |
| Diethylstilbestrol (DES) Coverage | Same as any other Covered Sickness | |
| Osteoporosis | Same as any other Covered Sickness, unless considered a Preventive Service | |
| Special Shoe Benefit | Same as any other Covered Sickness | |
| Emergency Department Medical Care and Follow-Up Health Care Treatment Following Rape or Sexual Assault (first 9 months after the Insured Person initiates Treatment) | 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived | 100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived |
| Pediatric Autoimmune Neuropsychiatric Disorders Benefit | Same as any other Covered Sickness | |
| **Accidental Death and Dismemberment** | | |
| Principal Sum | | $10,000 |
| Only one benefit will be payable under this provision, that providing the largest benefit, when more than one (1) loss occurs as the result of any one (1) Accident. This benefit is payable in addition to any other benefits payable under this Certificate. | | |

## Exclusions and Limitations

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

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

## General Exclusions

- **International Students Only –** Covered Medical Expenses received within Your Home Country or country of origin that are covered under Your governmental or national health plan.
- Treatment, service or supply which is not Medically Necessary for the diagnosis, care or Treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended or approved by Your attending Physician or dentist.
- Medical services rendered by a provider employed for or contracted with the Policyholder, including team Physicians or trainers, except as specifically provided in the Schedule of Benefits.
- Professional services rendered by an Immediate Family Member or anyone who lives with You.
- Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services covered by Student Health Fees.
- Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
- Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which You are required to pay.
- Services that are duplicated when provided by both a licensed midwife and a Physician.
- Expenses payable under any prior policy which was in force for the person making the claim.
- Expenses paid by Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid or Medi-Cal.
- Expenses incurred after:
  - The date insurance terminates as to an Insured Person, except as specified in the extension of benefits provision; and
  - The end of the Policy Year specified in the Policy.
- Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
- You are:
  - committing or attempting to commit a felony,
  - engaged in an illegal occupation, or
  - participating in a riot.
- Custodial Care service and supplies.
- Charges for hot or cold packs for personal use.
- Services of private duty Nurse except as provided in the Certificate.
- Expenses that are not recommended and approved by a Physician.
- Experimental or Investigational drugs, devices, Treatments or procedures.
- Routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan.
- Modifications made to dwellings.
- General fitness, exercise programs.
- Hypnosis.
- Rolfing.
- Biofeedback.
- Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary because of Injury, infection or disease.
- Any routine services such as physical exams, vaccinations, or laboratory testing required for employment, school, camp, sports participation, travel, insurance enrollment, or licensing, as well as for joining a sport or recreational activity, except as specifically provided under Preventive Services, or otherwise specifically covered under the Certificate.

**Activities Related**

- Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.

**Weight Management/Reduction**

- Weight management. Weight reduction. Nutrition programs. This does not apply to nutritional counseling, or any screening or assessment specifically provided under the Preventive Services benefit, or otherwise specifically covered under the Certificate.
- Treatment for obesity except surgery for morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat.

**Family Planning**

- Infertility Treatment (male or female)-this includes but is not limited to:
  - Genetic counseling and genetic testing;
  - Impotence, organic or otherwise;
  - Costs for an ovum donor or donor sperm;
  - Sperm, Ova, Embryo, Non-medical storage costs, except as specifically provided under the Fertility Preservation Expense benefit;
  - Ovulation predictor kits;
  - Reversal of tubal ligations;
  - Reversal of vasectomies;
  - Costs for and relating to surrogate motherhood if the individual is not an Insured Person under the Certificate;
  - Cloning; or
  - Medical and surgical procedures that are Experimental or Investigational unless Our denial is overturned by an External Appeal Agent.

**Vision**

- Expenses for radial keratotomy.
- Adult Vision unless specifically provided in the Certificate.
- Charges for office visit exam for the fitting of prescription contact lenses, duplicate spare eyeglasses, non-prescription lenses or contact lenses that are for cosmetic purposes.

**Dental**

- Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.

**Hearing**

- Charges for hearing screening, hearing aids and the fitting or repair or replacement of hearing aids or cochlear implants except as specifically provided in the Certificate.

**Cosmetic**

- Treatment of Acne unless Medically Necessary.
- Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
- Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma, or otherwise covered under the Gender Affirming Services Benefit.

**Prescription Drugs**

- Any drug or medicine which does not, by federal or state law, require a prescription order, i.e., over-the-counter drugs, even if a prescription is written, except as specifically provided under Preventive Services or in the Prescription Drug Benefit section of this Certificate. Insulin and OTC preventive medications required under ACA are exempt from this exclusion;
- Drugs with over-the-counter equivalents except as specifically provided under Preventive Services;
- Allergy sera and extracts administered via injection;
- Vitamins, and minerals, except as specifically provided under Preventive Services;
- Food supplements, dietary supplements; except as specifically provided in the Certificate;
- Cosmetic drugs or medicines including, but not limited to, products that improve the appearance of wrinkles or other skin blemishes;

- Refills in excess of the number specified or dispensed after 1 year of date of the prescription;
- Drugs labeled, “Caution – limited by federal law to Investigational use” or Experimental Drugs;
- Any drug or medicine purchased after coverage under the Certificate terminates;
- Any drug or medicine consumed or administered at the place where it is dispensed;
- If the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
- Prescription digital therapeutics;
- Medical marijuana, cannabis, or other supplies and/or services rendered at a cannabis dispensary. This does not include synthetic pharmaceutical products approved by the FDA and included on the Formulary;
- Sexual enhancements drugs;
- Vision correction products.

# CONTRACTED PROVIDERS FOR TELEMEDICINE/TELEHEALTH

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

**Teladoc** gives you access to board-certified physicians for **Mental Health (at no additional cost to you)** services. Whether you are at school, home or traveling, Teladoc can diagnose and treat most minor medical conditions wherever and whenever you need treatment.

Register your account today and request a visit at https://www.teladochealth.com/benefits/wellfleetstudent or call (800)-Teladoc (835-2362).

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

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

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

# VALUE ADDED SERVICES

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

# EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

Wellfleet Student provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Wellfleet Student at (877) 657-5030, TTY 711.

If you are traveling and need assistance in North America, call the Assistance Center toll-free at: (877) 305-1966 or if you are in a foreign country, call collect at: (715) 295-9311.

When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

### How to Access Services

If you require medical assistance or you need assistance with a non-medical situation, such as lost luggage, lost documents or other travel issues, follow these steps:

- Inside the U.S. and Canada:Dial toll-free **(877) 305-1966**
- Outside the U.S. and Canada:
  - **a)** Request an international operator.
  - **b)** Request the operator to place a collect call to the U.S. at **+1 (715) 295-9311**.

Please provide the following information when you call:

- Policy number or school name
- Nature of your call and/or emergency
- Current location
- Contact phone number and email address
- Secondary point of contact
- Date of birth

## 24/7 Nurseline

You have **free** access to the 24/7 Nurseline by calling (800) 634-7629. This program provides:

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

Appropriate care may include:

- Self-care at home
- an office or telehealth visit with a healthcare provider
- Or a visit to an urgent care center or emergency room.

Calls are answered 24/7/365 by experienced registered nurses who have been specifically trained to handle telephone health inquiries.

This program is not a substitute for doctor visits or emergency response systems. The Nurseline does not answer health plan benefit questions. Health benefit questions should be referred to the Plan Administrator.

## Contracted Providers for Telemedicine/Telehealth

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

**Teladoc** gives you access to board-certified physicians for **Mental Health (at no additional cost to you)** services. Whether you are at school, home or traveling, Teladoc can diagnose and treat most minor medical conditions wherever and whenever you need treatment.

Register your account today and request a visit at https://hinge.health/wellfleet or call (800)-Teladoc (835-2362).




Your Wellfleet Student health plan gives you access to purchase voluntary Dental and/or Vision plans through our partnership with Ameritas. For more information and to enroll, visit https://myplan.ameritas.com/id/8f45aa2
Please enter the zip code of your resident address during your college placement. Note: voluntary dental plans are not available in MA, and voluntary vision plans are not available in MD.