METROPOLITAN
Community College

# BENEFITS AT A GLANCE

**STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2020/2021**

**DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:**

## METROPOLITAN COMMUNITY COLLEGE

**Omaha, NE**

**("the Policyholder")**

**Policy Number: WI2021NESHIP21**
**Group Number: ST1537SH**
**Effective: 8/16/2020 – 8/16/2021**

**UNDERWRITTEN BY:**

Wellfleet Insurance Company | Fort Wayne, IN

("the Company")

**ADMINISTERED BY:**

Wellfleet Group, LLC

WELLFLEET STUDENT

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## Welcome Students…

We are pleased to provide you with this summary of the 2020 – 2021 Student Health Insurance Plan ("Plan"), which is fully compliant with the Affordable Care Act. "Benefits at a Glance" includes effective dates and costs of coverage, as well as other helpful information. For additional details about the Plan, please consult the Plan Certificate and other materials at **mccneb.myahpcare.com**. For questions about medical benefits or claims, please call Wellfleet Student at (877) 657-5030, TTY 711.

## Where to Find Help

| For Questions About: | Please Contact: |
|---|---|
| **Servicing Agent**<br>**Enrollment**<br>**Waivers** | **Academic HealthPlans**<br>mccneb.myahpcare.com<br>(855) 850-4296 |
| **Insurance Benefits**<br>**Claims Processing**<br>**ID Cards**<br>**Preferred Provider Listings** | **Wellfleet Group, LLC**<br>**PO Box 15369**<br>**Springfield, Massachusetts 01115-5369**<br>**(877) 657-5030, TTY 711**<br>**www.wellfleetstudent.com** |
| **Preferred PPO Provider Listings**<br><br>**Cigna Claims** | **mccneb.myahpcare.com**<br>or<br>**www.cigna.com**<br><br>**Send Cigna claims to:**<br>**CIGNA**<br>**PO Box 188061**<br>**Chattanooga, TN 37422 – 8061**<br>**Electronic Payor ID: 62308** |
| **Prescription Drug Provider** | **For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit www.wellfleetstudent.com** |

## Am I Eligible?

Metropolitan Community College requires that all F-1 international students obtain and maintain health insurance coverage while enrolled at the college. To assure compliance, all F-1 International students will be automatically enrolled in and charged the insurance premium for the Metropolitan Community College Student Health Insurance Plan.

## How Do I Enroll Dependents?

**To Purchase coverage for and Enroll dependents:**

- Go to mccneb.myahpcare.com.
- Click the "Enrollment" tab and proceed as directed to enroll and purchase coverage for dependents.

**The deadline to enroll dependents is 9/14/2020.**

## Effective Dates & Costs

**All time periods begin at 12:00 A.M. local time and end at 11:59 P.M. local time at the Policyholder's address.**

| Coverage Period | Coverage Start Date | Coverage End Date | Enrollment Deadline |
|---|---|---|---|
| **Fall** | 8/16/2020 | 11/23/2020 | 9/14/2020 |
| **Winter** | 11/24/2020 | 2/28/2021 | 12/21/2020 |
| **Spring (New Students Only)** | 3/1/2021 | 5/26/2021 | 3/29/2021 |
| **Summer** | 5/27/2021 | 8/16/2021 | 6/25/2021 |

**Plan Costs for International Students and their Dependents**

| | Fall | Winter | Spring | Summer |
|---|---|---|---|---|
| **Student** | $737.50 | $737.50 | $737.50 | $737.50 |
| **Spouse** | $737.50 | $737.50 | $737.50 | $737.50 |
| **Each Child** | $737.50 | $737.50 | $737.50 | $737.50 |
| **2 or more Children** | $1,475.00 | $1,475.00 | $1,475.00 | $1,475.00 |

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

## Preferred Provider Organization (PPO) Network

### …providing access to quality health care at discounted costs!

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

## Metropolitan Community College Schedule of Benefits

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

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

**SCHEDULE OF BENEFITS**

**Preventive Services:**

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

Out-of-Network Provider: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 60% of the Usual and Customary Charge.

**Medical Deductible:**

| | |
|---|---|
| In-Network Provider | Individual: $250 |
| Out-of-Network Provider | Individual: $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**:

| | |
|---|---|
| In-Network Provider | Individual $6,600<br>Family $13,200 |
| Out-of-Network Provider | Individual $ 25,000<br>Family $75,000 |

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

**Coinsurance Amounts:**

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

**Medical Benefit Payments for In-Network Providers and Out-of-Network Providers**
The Certificate provides benefits based on the type of health care provider You and Your Covered Dependent selects. The Certificate provides access to both In-Network Providers and Out-of-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by In-Network Providers versus Out-of-Network Providers, as shown in the Schedule of Benefits.

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

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

**Preferred Provider Organization:**
To locate an In-Network Provider in Your area, consult Your Provider Directory or call toll free 1-877-657-5030 or visit Our website at www.wellfleetstudent.com .

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

1. **THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
3. **DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY AN IN-NETWORK OR OUT-OF-NETWORK PROVIDER.**

**4. UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE WILL ALWAYS APPLY.**

| BENEFITS FOR COVERED INJURY/SICKNESS | IN-NETWORK PROVIDER | OUT-OF-NETWORK PROVIDER |
|---|---|---|
| **Inpatient Benefits** | | |
| Hospital Care<br>Includes hospital room & board expenses and miscellaneous services and supplies.<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 | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Preadmission Testing | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Physician's Visits while Confined:<br>Limited to 1 visit per day of Confinement per provider | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Inpatient Surgery:<br>Pre-Certification Required<br><br>Surgeon Services<br><br>Anesthetist<br><br>Assistant Surgeon | <br><br>80% of the Negotiated Charge after Deductible for Covered Medical Expenses<br><br>80% of the Negotiated Charge after Deductible for Covered Medical Expenses<br><br>80% of the Negotiated Charge after Deductible for Covered Medical Expenses | <br><br>60% of Usual and Customary Charge after Deductible for Covered Medical Expenses<br><br>60% of Usual and Customary Charge after Deductible for Covered Medical Expenses<br><br>60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Registered Nurse Services for private duty nursing while Confined | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Physical Therapy while Confined (inpatient) | $20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | $40 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |

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|---|---|---|
| Skilled Nursing Facility Benefit<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Inpatient Rehabilitation Facility Expense Benefit<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **INPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER** | | |
| Mental Health Disorder and Substance Use Disorder Benefit<br><br>Pre-Certification Required<br><br>In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-certification requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness. | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **Outpatient Benefits** | | |
| Outpatient Surgery:<br>Pre-Certification Required | | |
| Surgeon Services | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Anesthetist | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Assistant Surgeon | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Outpatient Surgery Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |

| | | |
|---|---|---|
| Physician's Office Visits | $20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | $40 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Specialist/Consultant Physician Services | $20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | $40 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Telemedicine or Telehealth Services | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Cardiac Rehabilitation | $20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | $40 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Cardiac Rehabilitation Maximum Visits per Policy Year | 20 | 20 |
| Pulmonary Rehabilitation | $20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | $40 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Pulmonary Rehabilitation Maximum Visits per Policy Year | 20 | 20 |
| Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy<br><br>Pre-Certification Required | $20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | $40 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Maximum Visits per Policy Year for Physical Therapy, Occupational Therapy, and Chiropractic Physiotherapy, and Speech Therapy Combined | 80 | 80 |
| Habilitative Services including, Physical Therapy, and Occupational Therapy and Speech Therapy<br><br>Pre-Certification Required | $20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | $40 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Habilitative Services Maximum Visits per Policy Year for Physical Therapy, Occupational Therapy, Chiropractic Physiotherapy and Speech Therapy<br><br>Combined with Rehabilitation Therapy | 80 | 80 |

| | | |
|---|---|---|
| Emergency Services | $200 Copayment per visit then the plan pays 80% 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 | $20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | $40 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Diagnostic Imaging Services<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| CT Scan, MRI and/or PET Scans<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Laboratory Procedures (Outpatient) | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Chemotherapy and Radiation Therapy<br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Infusion Therapy<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Home Health Care Expenses<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Home Health Care Expenses<br>Maximum visits per Policy Year | 60 | 60 |
| Hospice Care Coverage | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Maximum Bereavement visits per lifetime | 2 visits | 2 visits |
| Outpatient Private Duty Nursing<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |

| OUTPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER | | |
|---|---|---|
| Mental Health Disorder and Substance Use Disorder Benefit Pre-Certification Required except for office visits<br><br>In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-Certification requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness. | $20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | $40 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **Prescription Drugs Retail Pharmacy**<br>No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy . | | |
| TIER 1<br>For each fill up to a 30 day supply filled at a Retail pharmacy | $15 Copayment then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | Not Covered |
| More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy | $30 Copayment then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | Not Covered |
| More than a 60 day supply filled at a Retail pharmacy | $45 Copayment then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | Not Covered |
| TIER 2<br>For each fill up to a 30 day supply filled at a Retail pharmacy | $45 Copayment then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | Not Covered |
| More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy | $90 Copayment then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | Not Covered |
| More than a 60 day supply filled at a Retail pharmacy | $135 Copayment then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | Not Covered |
| TIER 3<br>For each fill up to a 30 day supply filled at a Retail Pharmacy | $75 Copayment then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | Not Covered |

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|---|---|---|
| More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy | $150 Copayment then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | Not Covered |
| More than a 60 day supply filled at a Retail pharmacy | $225 Copayment then the plan pays 100% of the Negotiated Charge after Deductible for Covered Medical Expenses | Not Covered |
| **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<br><br>Deductible Waived | Not Covered |
| **Specialty Prescription Drugs** | | |
| Specialty Prescription Drugs<br>For each fill up to a 30 day supply<br><br>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. | $150 Copayment then the plan pays 75% of the Negotiated Charge after Deductible for Covered Medical Expenses | Not Covered |
| More than a 30 day supply but less than a 61 day supply | $300 Copayment then the plan pays 75% of the Negotiated Charge after Deductible for Covered Medical Expenses | Not Covered |
| More than a 60 day supply | $450 Copayment then the plan pays 75% of the Negotiated Charge after Deductible for Covered Medical Expenses | Not Covered |
| **Diabetic Supplies (for Prescription supplies purchased at a pharmacy)** | | |
| Benefit | Paid the same as any other Retail Pharmacy Prescription Drug Fill | |
| **Other Benefits** | | |
| Allergy Testing | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Allergy Injections/Treatment | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Ambulance Service ground and/or air, water transportation | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 80% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Covered Clinical Trials | Same as any other Covered Sickness | |

| | | |
|---|---|---|
| Durable Medical Equipment<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| 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. | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Dialysis Treatment | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Maternity Benefit | Same as any other Covered Sickness | |
| Prosthetic and Orthotic Devices<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Reconstructive Surgery<br><br>Pre-Certification Required | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)<br><br>Preventive Dental Care<br>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>Emergency Dental<br>Routine Dental Care<br>Endodontic Services<br>Prosthodontic Services<br>Periodontic Services<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 Pediatric Dental Care Benefit description in the plan documents for further information.<br><br>100% of Usual and Customary Charge<br><br>50% of Usual and Customary Charge<br>50% of Usual and Customary Charge<br>50% of Usual and Customary Charge<br>50% of Usual and Customary Charge<br>50% of Usual and Customary Charge<br>50% of Usual and Customary Charge | |

| | | |
|---|---|---|
| Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19)<br><br>Limited to 1 visit 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. | 100% of Usual and Customary Charge for Covered Medical Expenses | |
| Accidental Injury Dental Treatment | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 80% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Sickness Dental Expense for Insured Person's over age 18 | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Chiropractic Care or Osteopathic Physiotherapy Benefit<br><br>Pre-Certification Required | $20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | $40 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Organ Transplant Surgery<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 | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Treatment for Temporomandibular Joint (TMJ) Disorders | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| Non-emergency Care While Traveling Outside of the United States | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses<br><br>Subject to $10,000 maximum per Policy Year | |
| Tuberculosis screening, Titers, Quantiferon B tests including shots (other than covered under preventive services) | 80% of the Negotiated Charge after Deductible for Covered Medical Expenses | 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses |
| **Mandated Benefits** | | |
| Colorectal Cancer Screening | Same as any other Preventive Service | |
| Dental Anesthesia Benefit | Same as any other Covered Sickness | |
| Mammography Screening | Same as any other Preventive Service | |
| Screening for Hearing Loss for Newborn and Infant | Same as any other Covered Sickness unless considered a Preventive Service | |

### Preauthorization

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

## Exclusions and Limitations

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

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

1. **International Students Only -** Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible.
2. Treatment, service or supply which is not Medically Necessary for the diagnosis, care or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended by Your attending Physician or dentist.
3. Medical services rendered by a provider employed for or contracted with the Policyholder, including team physicians or trainers, except as specifically provided in the Schedule of Benefits.
4. Professional services rendered by an Immediate Family Member or anyone who lives with You.
5. Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary because of Injury, infection or disease.
6. Infertility treatment (male or female)-this includes but is not limited to:
   - Procreative counseling;
   - Premarital examinations;
   - Genetic counseling and genetic testing;
   - Impotence, organic or otherwise;
   - Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
   - In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
   - Costs for an ovum donor or donor sperm;
   - Sperm storage costs;
   - Cryopreservation and storage of embryos;
   - Ovulation induction and monitoring;
   - Artificial insemination;
   - Hysteroscopy;
   - Laparoscopy;
   - Laparotomy;
   - Ovulation predictor kits;
   - Reversal of tubal ligations;
   - Reversal of vasectomies;
   - Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
   - Cloning; or
   - Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.
7. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
8. Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services covered by Student Health Fees.
9. Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.

10. Loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
11. Loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority.
12. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate or club sports for which benefits are paid under another Sports Accident policy issued to the Policyholder; or for which coverage is provided by the National Collegiate Athletic Association (NCAA), National Association of Intercollegiate Athletic (NAIA) or any other sports association .
13. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
14. Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which You are required to pay.
15. Services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
16. Expenses payable under any prior policy which was in force for the person making the claim.
17. Injury sustained as the result of Your operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.
18. Expenses incurred after:
    - The date insurance terminates as to an Insured Person , except as specified in the extension of benefits provision; and
    - The end of the Policy Year specified in the Policy.
19. Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
20. Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
21. Weight management. Weight reduction. Nutrition programs. This does not apply to nutritional counseling or any screening or assessment specifically provided under the Preventive Services benefit, or otherwise specifically covered under the Certificate.
22. Treatment for obesity .Surgery for removal of excess skin or fat.
23. Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
24. Expenses for radial keratotomy.
25. Adult Vision unless specifically provided in the Certificate.
26. Charges for office visit exam for the fitting of prescription contact lenses, duplicate spare eyeglasses, lenses or frames, non-prescription lenses or contact lenses that are for cosmetic purposes.
27. Charges for hearing exams, hearing screening, hearing aids and the fitting or repair or replacement of hearing aids or cochlear implants except as specifically provided in the Certificate.
28. organized racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles) or other hazardous sport or hobby.
29. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma.
30. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric and Adult Dental Care Benefit.
31. You are:
    - committing or attempting to commit a felony,
    - engaged in an illegal occupation, or
    - participating in a riot.
32. Elective abortions.
33. Custodial Care service and supplies.
34. Charges for hot or cold packs for personal use.
35. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
36. Services of private duty Nurse except as provided in the Certificate.
37. Expenses that are not recommended and approved by a Physician.
38. Routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan, or services for or related

to the transplantation of animal or artificial organs or tissues.

39. Cosmetic procedures related to Gender Reassignment including but not limited to rhinoplasty, face lift, facial bone reduction, lip enhancement or reduction, blepharoplasty, breast augmentation, body contouring, reduction thyroid chondroplasty, hair removal, voice modification surgery, skin resurfacing, chin implants, nose implants.
40. Sleep Disorders, except for the diagnosis and treatment of obstructive sleep apnea.
41. Treatment of Acne unless Medically Necessary.
42. Experimental or Investigational drugs, devices, treatments or procedures unless otherwise covered under Covered Clinical Trials or covered under clinical trials (routine patient costs). See the Other Benefits section for more information.
43. Under the Prescription Drug Benefit shown in the Schedule of Benefits:
    - any drug or medicine which does not, by federal or state law, require a prescription order, i.e. over-the-counter drugs, even if a prescription is written, except as specifically provided under Preventive Services or in the Prescription Drug Benefit section of the Certificate. Insulin and OTC preventive medications required under ACA are exempt from this exclusion;
    - drugs with over-the-counter equivalents except as specifically provided under Preventive Services;
    - allergy sera and extracts administered via injection;
    - any drug or medicine for the purpose of weight control;
    - fertility drugs;
    - sexual enhancements drugs;
    - vitamins, and minerals, except as specifically provided under Preventive Services;
    - food supplements, dietary supplements; except as specifically provided in the Certificate;
    - cosmetic drugs or medicines, including but not limited to, products that improve the appearance of wrinkles or other skin blemishes;
    - refills in excess of the number specified or dispensed after 1 year of date of the prescription;
    - drugs labeled, “Caution – limited by federal law to Investigational use” or Experimental Drugs;
    - any drug or medicine purchased after coverage under the Certificate terminates;
    - any drug or medicine consumed or administered at the place where it is dispensed;
    - if the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
    - bulk chemicals;
    - non-insulin syringes, surgical supplies, durable medical equipment/medical devices, except as specifically provided in the Prescription Drug Benefit section of the Certificate;
    - repackaged products;
    - blood components except factors;
    - immunology products.
44. Non-chemical addictions.
45. Non-physical, occupational, speech therapies (art, dance, etc.).
46. Modifications made to dwellings.
47. General fitness, exercise programs.
48. Hypnosis.
49. Rolfing.
50. Biofeedback except for the Treatment of a Mental Health Disorder.

## 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**

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.