



# BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2020/2021

DESIGNED EXCLUSIVELY FOR THE  
INTERNATIONAL STUDENTS OF:

**COLLEGE OF SOUTHERN NEVADA**  
(including Truckee Meadows Community College  
and Western Nevada College)  
Las Vegas, NV  
("the Policyholder")

Policy Number: WI2021NVSHIP67  
Group Number: ST1264SH  
Effective: 8/15/2020 - 8/14/2021

**UNDERWRITTEN BY:**

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

**ADMINISTERED BY:**

Wellfleet Group, LLC.



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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 [csn.myahpcare.com](http://csn.myahpcare.com) for other materials and Enrollment details. For questions about medical benefits or claims, please call Wellfleet Student at (877) 657-5030, TTY 711.

## Where to Find Help

For Questions About:	Please Contact:
Servicing Agent Enrollment Waivers	<b>Academic HealthPlans</b> <b>College of Southern Nevada AHP Website:</b> <a href="http://csn.myahpcare.com">csn.myahpcare.com</a> <b>Truckee Meadows Community College AHP Website:</b> <a href="http://tmcc.myahpcare.com">tmcc.myahpcare.com</a>
Insurance Benefits Claims Processing ID Cards Preferred Provider Listings	<b>Wellfleet Group, LLC.</b> PO Box 15369 Springfield, Massachusetts 01115-5369 (877) 657-5030, TTY 711 <a href="http://www.wellfleetstudent.com">www.wellfleetstudent.com</a>
Preferred PPO Provider Listings  Cigna claims 	<a href="http://csn.myahpcare.com">csn.myahpcare.com</a> or <a href="http://www.cigna.com">www.cigna.com</a>  <b>Send Cigna claims to:</b> CIGNA PO Box 188061 Chattanooga, TN 37422 – 8061 Electronic Payor ID: 62308
Prescription Drug Provider	<b>For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit <a href="http://www.wellfleetstudent.com">www.wellfleetstudent.com</a></b>  <b>Your plan includes Wellfleet Rx – offering over 40 generics at a \$0 copay. Please ask your health care provider to review our <a href="#">formulary</a> to see if these medications are right for you. Click here <a href="http://wellfleetrx.com/students/formularies/">http://wellfleetrx.com/students/formularies/</a> for more information.</b>

## Am I Eligible?

All registered International students, Visiting Faculty, Scholars maintaining a current passport and valid F-1 and M-1 Visa status and engaged in educational activities at the College of Southern Nevada (including Truckee Meadows Community College and Western Nevada College) who are temporarily located outside their home country and have not been granted permanent residency status, are required to purchase this plan, unless proof of comparable coverage can be furnished.

Optional Practical Training Program are eligible to enroll in this Student Health Insurance Plan on a voluntary basis. Please visit [www.wellfleetstudent.com](http://www.wellfleetstudent.com) for enrollment information.

An eligible student must attend classes at the Policyholder’s school for the first 45 days of the period for which he or she is enrolled.

Except in the case of withdrawal from school due to Sickness or Injury, any student who withdraws from the Policyholder’s school during the first 45 days of the period for which he or she is enrolled shall not be covered under the insurance plan. A full refund of Premium will be made, minus the cost of any claim benefits paid by the Certificate. A student who graduates or withdraws after such 45 days of the period for which he or she is enrolled will remain covered under the Certificate for the term purchased and no refund will be allowed.

A student withdrawing due to a medical withdrawal due to a Sickness or Injury, must submit documentation or certification of the medical withdrawal to Us at least 30 days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable, or 30 days after the date of the medical leave from school. The student withdrawing due to a medical withdrawal due to a Sickness or Injury will remain covered under the Certificate for the term purchased and no refund will be allowed.

All International Students are required to have an F-1 or M-1 Visa and their eligible Dependents (who are not U.S. citizens) are required to have an F-2 or M-2 Visa to be eligible for this insurance plan.

We maintain the right to investigate eligibility status and attendance records to verify that the Certificate eligibility requirements have been and continue to be met.

If We discover that the Certificate eligibility requirements have not been met, Our only obligation is refund of premium less any claims paid.

Eligibility requirements must be met each time Premium is paid to renew Coverage.

If you no longer meet the eligibility requirements contact Academic HealthPlans at (855) 825-3985 prior to your termination date.

## Coverage for Dependents

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's lawful Spouse or lawful domestic partner and dependent children under 26 years of age. Dependent eligibility expires concurrently with that of the Named Insured.

Individuals who enroll their dependents must enroll them within 31 days of the Insured Student's enrollment in the plan with the exception of adopted children or newborn children (see the Certificate provision entitled **Dependent Child Coverage**). They will be enrolled for the same term of coverage for which the Insured Student enrolls. Dependents of an **Eligible International Student** must possess a valid passport and a proper Visa (either an F-2 or M-2 visa).

## How Do I Waive/Enroll?

You must enroll in the International student health insurance plan offered through College of Southern Nevada unless you are a dependent on an insurance plan of a spouse or parent or sponsor and are enrolled in a health insurance plan that's comparable to the offered plan. In order to waive out of the student health insurance plan coverage, you will need to submit a waiver. Please contact the international student's office for more information.

## Refund of Premium

Premiums received by Us are fully earned upon receipt. Refund of premium will be considered only:

1. If a student ceases to be eligible for the insurance and coverage is terminated prior to the next premium due date, a pro rata refund of Premium (less any claims paid) will be made for such person. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.
2. For any student who withdraws from school during the first 45 days of the period for which he or she is enrolled for a reason other than withdrawal due to Sickness or Injury. Such a student will not be covered under the Certificate and a full refund of the Premium will be made (less any claims paid) when written request is made within 90 days of withdrawal from school. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.
3. For an Insured Student entering the Armed Forces of any country. Such a student will not be covered under the Certificate as of the date of his/her entry into the service. A pro rata refund of Premium (less any claims paid) will be made upon written request received by Us within 90 days of withdrawal from school. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.
4. For an Insured International Student, Scholar, Visiting Faculty member departing school to return to his or her Home Country on a permanent basis. We will refund a pro rata refund of Premium (less any claims paid) when written request and proof from the Policyholder that the student is no longer an eligible person is received by Us within 60 days of such departure. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.

## Effective Dates & Costs

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

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Fall	8/15/2020	1/14/2021	9/7/2020
Spring/Summer (New Students Only)	1/15/2021	8/14/2021	1/31/2021
Summer	5/15/2021	8/14/2021	6/7/2021

### Plan Costs for International Students and their Dependents

	Fall	Spring/Summer (New Students Only)	Summer
Student*	\$564.44	\$781.11	\$338.89
Spouse*	\$564.44	\$781.11	\$338.89
Each Child*	\$564.44	\$781.11	\$338.89
2 or more Children*	\$1,128.88	\$1,562.22	\$677.78

\*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 Plan, you have the Cigna PPO Choice Fund Network of participating Providers. To find a complete listing of the Network's participating Providers, go to [www.cigna.com](http://www.cigna.com), or contact Wellfleet Student toll-free at (877) 657-5030, TTY, or [www.wellfleetstudent.com](http://www.wellfleetstudent.com) for assistance.

## College of Southern Nevada Schedule of Benefits

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

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

### SCHEDULE OF BENEFITS

#### Preventive Services:

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

Out-of-Network Provider: Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through an Out-of-Network Provider. Benefits are paid at 50% of the Usual and Customary Charge.

<b>Medical Deductible</b>	In-Network Provider	Individual:	\$50
	Out-of-Network Provider	Individual:	\$300

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.

<b>Out-of-Pocket Maximum:</b>	In-Network Provider	Individual: \$5,000
		Family: \$10,000
	Out-of-Network Provider	Individual: \$7,000
		Family: \$14,000

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

**Medical Benefit Payments for In-Network Providers and Out-of-Network Providers**

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

**Dental and Vision Benefit Payments**

For dental and vision benefits, You may choose any dental or vision provider.

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

**Preferred Provider Organization:**

To locate an In-Network Provider in Your area, consult Your Provider Directory or call toll free 877-657-5030, TTY 711 or visit Our website at [www.cigna.com](http://www.cigna.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
<b>Inpatient Benefits</b>		
<p>Hospital Care Includes hospital room &amp; board expenses and miscellaneous services and supplies. Subject to Semi-Private room rate unless intensive care unit is required.</p> <p>Room and Board includes intensive care.</p> <p>Pre-Certification Required</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Preadmission Testing</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Physician's Visits while Confined: Limited to 1 visit per day of Confinement per provider</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Inpatient Surgery: Pre-Certification Required</p> <p style="padding-left: 40px;">Surgeon Services</p> <p style="padding-left: 40px;">Anesthetist</p> <p style="padding-left: 40px;">Assistant Surgeon</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Registered Nurse Services for private duty nursing while Confined</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Physical Therapy while Confined (inpatient)</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Skilled Nursing Facility Benefit Pre-Certification Required</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>

<b>INPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER</b>		
<p>Mental Health Disorder and Substance Use Disorder Benefit</p> <p>Pre-Certification Required</p> <p>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.</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<b>Outpatient Benefits</b>		
<p>Outpatient Surgery: Pre-Certification required</p> <p>Surgeon Services</p> <p>Anesthetist</p> <p>Assistant Surgeon</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p> <p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p> <p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Outpatient Surgery Facility and Miscellaneous expenses for services &amp; supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood &amp; plasma</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Physician's Office Visits</p>	<p>\$20 Copayment per visit then the plan pays 90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Specialist/Consultant Physician Services</p>	<p>\$20 Copayment per visit then the plan pays 90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Telemedicine or Telehealth Services</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>



Cardiac Rehabilitation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitative Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Services	\$150 Copayment per visit then the plan pays 90% of the Negotiated Charge after Deductible for Covered Medical Expenses  Copayment waived if admitted	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Urgent Care Centers	\$50 Copayment per visit then the plan pays 90% of the Negotiated Charge after Deductible for Covered Medical Expenses	\$50 Copayment per visit then the plan pays 70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diagnostic Imaging Services Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scan Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Home Health Care Expenses Maximum visits per Policy Year	30	30
Hospice Care Coverage	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maximum Group Therapy Bereavement visits	5 visits	5 visits
<b>OUTPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER</b>		
Mental Health Disorder and Substance Use Disorder Benefit  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 90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
<b>Prescription Drugs Retail Pharmacy</b> No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy		
TIER 1 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy  See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	\$15 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses  Deductible Waived	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 for Covered Medical Expenses  Deductible Waived	Not Covered
More than a 60 day supply filled at a Retail pharmacy	\$45 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses  Deductible Waived	Not Covered

<p>TIER 2 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy</p> <p>See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.</p>	<p>\$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>Not Covered</p>
<p>More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy</p>	<p>\$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>Not Covered</p>
<p>More than a 60 day supply filled at a Retail pharmacy</p>	<p>\$90 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>Not Covered</p>
<p>TIER 3 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail Pharmacy</p> <p>See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.</p>	<p>\$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>Not Covered</p>
<p>More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy</p>	<p>\$100 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>Not Covered</p>
<p>More than a 60 day supply filled at a Retail pharmacy</p>	<p>\$150 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>Not Covered</p>
<p><b>Zero Cost Generics</b></p>		
<p>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.</p>	<p>100% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>100% of Actual charge for Covered Medical Expenses</p> <p>Deductible Waived</p>

<b>Specialty Prescription Drugs</b>		
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  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  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  Deductible Waived	Not Covered
<b>Orally administered anti-cancer prescription drugs (including specialty drugs)</b>		
Benefit	Greater of: <ul style="list-style-type: none"> <li>• Chemotherapy Benefit; or</li> <li>• Infusion Therapy Benefit</li> </ul>	
<b>Diabetic Supplies (for Prescription supplies purchased at a pharmacy)</b>		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill	
<b>Other Benefits</b>		
Allergy Testing	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Allergy Injections/Treatment	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Ambulance Service ground and/or air, water transportation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	90% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Bariatric Surgery  Pre-Certification Required	Covered the same as any other Surgery	Covered the same as any other Surgery
Clinical Trials or Chronic Fatigue Syndrome	Same as any other Covered Sickness	
Durable Medical Equipment Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

<p>Diabetic services and supplies (including equipment and training)</p> <p>Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Dialysis Treatment</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Hearing Aids Limited to 1 pair of hearing aids per 36 month period</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Maternity Benefit</p>	<p>Same as any other Covered Sickness</p>	
<p>Enteral Formulas and Nutritional Supplements</p> <p>See the Prescription Drug section of this Schedule when purchased at a pharmacy.</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Prosthetic Devices Pre-Certification Required</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Reconstructive Surgery Pre-Certification Required</p>	<p>Covered the same as any other Surgery</p>	<p>Covered the same as any other Surgery</p>
<p>Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)</p> <p>Preventive Dental Care Limited to 2 dental exams every 12 months</p> <p>The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care:</p> <p>Emergency Dental Routine Dental Care Endodontic Services Prosthodontic Services Periodontics Services Medically Necessary Orthodontic Care</p> <p>Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.</p>	<p>See the Pediatric Dental Care Benefit description in the Certificate for further information.</p> <p>100% of Usual and Customary Charge</p> <p>50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge</p>	<p>See the Pediatric Dental Care Benefit description in the Certificate for further information.</p> <p>100% of Usual and Customary Charge</p> <p>50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge</p>

<p>Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19)</p> <p>Limited to 1 visit(s) per Policy Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year</p> <p>Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.</p>	<p>\$20 Copayment per visit then the plan pays 100% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>	<p>\$20 Copayment per visit then the plan pays 100% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Abortion Expense</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Acupuncture Expense Benefit (Medically Necessary Treatment) only</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Accidental Injury Dental Treatment for Insured Person's</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Chiropractic Care Benefit Pre-Certification Required.</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Infertility Treatment Pre-Certification Required</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Organ Transplant Surgery Pre-Certification Required</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Shots and Injections unless considered Preventive Services</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Treatment for Temporomandibular Joint (TMJ) Disorders</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Tuberculosis screening, Titers, Quantiferon B tests including shots (other than covered under preventive services)</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Sports Accident Expense - incurred as the result of the play or practice of Intercollegiate or club sports</p>	<p>90% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>

Mandated Benefits	
Autism Spectrum Disorders	Same as any other Covered Sickness
Human Papillomavirus Vaccine	Same as any other Preventive Service
Prostate Cancer Screening	Same as any other Preventive Service
Cytological and Mammography Screening	Same as any other Preventive Service
Contraceptives and Hormone Replacement Therapy	Same as any other Covered Sickness, except Contraceptives and hormone replacement therapy covered under Preventive services will be subject to Preventive services cost share
Colorectal Cancer Screening	Same as any other Preventive Service

**Pre-Certification**

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

Additionally, no authorization requirement will apply to obstetrical or gynecological care provided by In-Network Providers.

**Exclusions and Limitations**

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

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

1. **International Students Only** - Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible.
2. Treatment, service or supply which is not Medically Necessary for the diagnosis, care or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended or approved by 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;
  - 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 professional sport.
  13. 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.
  14. Services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
  15. Expenses payable under any prior policy which was in force for the person making the claim.
  16. 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.
  17. 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.
  18. Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
  19. 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.
  20. Treatment for obesity except surgery for morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat.
  21. Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
  22. Expenses for radial keratotomy.
  23. Adult Vision unless specifically provided in the Certificate.
  24. 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.
  25. 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.
  26. 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.
  27. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma.
  28. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
  29. Extraction of impacted wisdom teeth or dental abscesses.
  30. You are:
    - committing or attempting to commit a felony,



- engaged in an illegal occupation, or
- participating in a riot.
- 31. Custodial Care service and supplies.
- 32. Charges for hot or cold packs for personal use.
- 33. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
- 34. Services of private duty Nurse except as provided in the Certificate.
- 35. Expenses that are not recommended and approved by a Physician.
- 36. 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.
- 37. 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.
- 38. Sleep Disorders, except for the diagnosis and treatment of obstructive sleep apnea.
- 39. Treatment of Acne unless Medically Necessary.
- 40. Experimental or Investigational drugs, devices, treatments or procedures unless otherwise covered under Clinical Trials or Chronic Fatigue Syndrome or covered under clinical trials (routine patient costs). See the Other Benefits section for more information.
- 41. Under the Prescription Drug Benefit shown in the Schedule of Benefits:
  - any drug or medicine which does not, by federal or state law, require a prescription order, i.e. over-the-counter drugs, even if a prescription is written, except as specifically provided under Preventive Services or in the Prescription Drug Benefit section of the Certificate. Insulin and OTC preventive medications required under ACA are exempt from this exclusion;
  - drugs with over-the-counter equivalents except as specifically provided under Preventive Services;
  - allergy sera and extracts administered via injection;
  - any drug or medicine for the purpose of weight control;
  - sexual enhancements drugs;
  - vitamins, and minerals, except as specifically provided under Preventive Services;
  - food supplements, dietary supplements; except as specifically provided in the Certificate;
  - cosmetic drugs or medicines, including but not limited to, products that improve the appearance of wrinkles or other skin blemishes;
  - refills in excess of the number specified or dispensed after 1 year of date of the prescription;
  - drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
  - any drug or medicine purchased after coverage under the Certificate terminates;
  - any drug or medicine consumed or administered at the place where it is dispensed;
  - if the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
  - bulk chemicals;
  - non-insulin syringes, surgical supplies, durable medical equipment/medical devices, except as specifically provided in the Prescription Drug Benefit section of the Certificate;
  - repackaged products;
  - blood components except factors;
  - immunology products.
- 42. Non-chemical addictions.
- 43. Non-physical, occupational, speech therapies (art, dance, etc.).
- 44. Modifications made to dwellings.
- 45. General fitness, exercise programs.
- 46. Hypnosis.
- 47. Rolfing.
- 48. Biofeedback.

## Value Added Services

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

### **VISION DISCOUNT PROGRAM**

For Vision Discount Benefits please go to:

[www.wellfleetstudent.com](http://www.wellfleetstudent.com)

### **24 HOUR NURSELINE (800) 634-7629**

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.



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.