AUSTIN COLLEGE

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2023/2024

DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

AUSTIN COLLEGE

Sherman, TX

("the Policyholder")

Policy Number: WI2324TXSHIP49

Group Number: ST1488SH

Effective: 08/01/2023 – 07/31/2024

UNDERWRITTEN BY:

Wellfleet Insurance Company | Fort Wayne, IN

("the Company")

ADMINISTERED BY:

Wellfleet Group, LLC

WELLFLEET STUDENT

Welcome Students…

We are pleased to provide you with this summary of the 2023 – 2024 Student Health Insurance Plan ("Plan"), which is fully compliant with the Affordable Care Act. This is only a brief description of the coverage(s) available under Certificate form TX SHIP Cert (2023). 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 at the website listed on the cover. 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
PO Box 15369
Springfield, Massachusetts 01115-5369
(877) 657-5030, TTY 711

Plan Administration

Servicing Agent (Enrollment, Waivers)

Academic HealthPlans
PO Box 1605
Colleyville, TX 76034
austincollege.myahpcare.com

Benefits, Claim Status, & ID Cards

Wellfleet Group, LLC
PO Box 15369
Springfield, Massachusetts 01115-5369
(877) 657-5030, TTY 711
www.wellfleetstudent.com
Monday–Thursday, 8:30 a.m. to 7:00 p.m.
Eastern Time
Friday, 9:00 a.m. to 5:00 p.m.
Eastern Time

Claims

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

PPO Network

Cigna Open Access Plus (OAP)
www.mycigna.com

Pharmacy Benefits Manager

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

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

Member Pharmacy Help

(877) 640-7940

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

What's Inside (Click on section title below to go to section in "Benefits at a Glance.")

General Information

Am I Eligible

All registered full-time students (including International Teaching Assistants taking 1 or more credit hours) are required to have health insurance coverage and will be automatically enrolled in the Student Health Insurance Plan at registration and the premium will be added to the student's tuition fees unless proof of comparable coverage is provided by completing the waiver prior to the deadline of 06/17/2023 for the fall and 02/6/2024 for the spring.

Dependents

Dependents are not eligible.

How Do I Waive?

To Waive:

- Go to austincollege.myahpcare.com.
- Click the Opt-Out/Waive tab and proceed as directed. You must fill in all of the required information on the waiver form. If any information is missing, your waiver will not be accepted.
- Click submit and review the information being provided is accurate.
- When your online waiver form is successfully submitted you will receive a confirmation e-mail.

- **The deadline to waive coverage for Annual coverage is 06/17/2023.**

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	Waiver Deadline Date
Annual	08/01/2023	07/31/2024	06/17/2023
Spring (January Start)	01/01/2024	07/31/2024	02/06/2024
Spring (February Start)	02/01/2024	07/31/2024	02/06/2024

Plan Costs for all Full-time Students and International Teaching Assistants

	Annual	Spring (January Start)	Spring (February Start)
Student*	$2,549	$1,484	$1,268

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

Plan Benefits

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

Pre-Authorization is required for Inpatient Services Care, selected Outpatient Services, and Outpatient Surgery. For a complete list of these services, see the Plan Certificate.

When You receive Emergency Services, or certain non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, 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.

Key Plan Benefits

BENEFIT	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Policy Year Deductible Combined In-network and Out-of-Network Individual (Waived at the Student Health Center)	$500	
Cost sharing You incur for Covered Medical Expenses that is applied to the Out-of-Network Deductible will 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 be applied to satisfy the Out-of-Network Provider Deductible.		
Out-of-Pocket Maximum Individual Combined In-network and Out-of-Network	$8,150	

Cost sharing You incur for Covered Medical Expenses that is applied to the Out-of-Network Provider Out-of-Pocket Maximum will 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 be applied to satisfy the Out-of-Network Provider Out-of-Pocket Maximum.		
Coinsurance	80% of the Negotiated Charge (NC)	50% of Usual & Customary (U&C) Rate
Preventive Services	100% of the (NC) Deductible Waived	50% of (U&C) Rate The Deductible and any Copayment are not applicable. Immunizations required under Federal and State Law are paid at no charge to the Insured Person.
Physician Office Visits including Specialist and Consultants *Check below for additional copayments	$25 Copayment per visit then the plan pays 100% of the (NC) for Covered Medical Expenses Deductible Waived	50% of (U&C) Rate after Deductible for Covered Medical Expenses
Emergency Services in an Emergency department for Emergency Medical Conditions.	$150 Copayment per visit after Deductible then the plan pays 80% of the (NC) for Covered Medical Expenses	Paid the same as In-Network Provider subject to (U&C) Rate.
Urgent Care Centers for non-life-threatening conditions	$25 Copayment per visit then the plan pays 100% of the (NC) for Covered Medical Expenses Deductible Waived	50% of (U&C) Rate after Deductible for Covered Medical Expenses

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 Includes Hospital Room and Board Expenses and Hospital Miscellaneous Expenses. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses

Preadmission Testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Physician's Visits while Confined	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate 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	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER BENEFITS 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-Authorization 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.		
Inpatient Mental Health Disorder and Substance Use Disorder Benefit Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Outpatient Mental Health Disorder and Substance Use Disorder Benefit Physician's Office Visits	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
All Other Outpatient Services except Emergency Services and Prescription Drugs	80% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
PROFESSIONAL AND OUTPATIENT SERVICES		
Surgical Expenses		
Inpatient and Outpatient Surgery includes: Pre-Authorization Required Surgeon Services Anesthetist Assistant Surgeon	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate 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	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Organ Transplant Surgery travel and lodging expenses a maximum of $2,000 per Policy Year or $250 per day, whichever is less while at the transplant facility. Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Reconstructive Surgery Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Other Professional Services		
Gender Affirming Treatment Benefit Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Home Health Care Expenses Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Home Health Care Expenses Maximum visits per Policy Year	60	60
Hospice Care Coverage	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Office Visits		
Physician's Office Visits including Specialists/Consultants	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Telemedicine, Teledentistry, and Telehealth Services	Payable the same as any other Physician or Specialist Office Visit	
Allergy Testing and Treatment including injections	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Chiropractic Care Benefit	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Maximum visits per Policy Year	35	35

Shots and Injections unless considered Preventive Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Tuberculosis screening (TB), Titers, QuantiFERON B tests including shots (other than covered under preventive services)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
EMERGENCY SERVICES, AMBULANCE AND NON-EMERGENCY SERVICES		
Emergency Services in an emergency department for Emergency Medical Conditions.	$150 Copayment per visit after Deductible then the plan pays 80% of the Negotiated Charge for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Rate.
Urgent Care Centers for non-life-threatening conditions	$25 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Rate.
Non-Emergency Ambulance Expenses ground and/or air, (fixed wing) transportation Pre-Authorization Required for non-emergency air Ambulance (fixed wing)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
DIAGNOSTIC LABORATORY, TESTING AND IMAGING SERVICES		
Diagnostic Imaging Services Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses

REHABILITATION AND HABILITATION THERAPIES		
Cardiac Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Cardiac Rehabilitation Maximum Visits per Policy Year	35	35
Pulmonary Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation Maximum Visits per Policy Year	35	35
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Rehabilitation Therapy Maximum Visits for each therapy for Physical Therapy, and Occupational Therapy and Speech Therapy Combined with Habilitation Services Therapy. The Maximum Visits do not apply to Rehabilitation Therapy for a Mental Health Disorder or Substance Use Disorder.	35	35
Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Habilitation Services Maximum Visits for each therapy for Physical Therapy, and Occupational Therapy and Speech Therapy Combined with Rehabilitation Therapy The Maximum Visits do not apply to Rehabilitation Therapy for a Mental Health Disorder or Substance Use Disorder.	35	35
OTHER SERVICES AND SUPPLIES		
Covered Clinical Trials	Same as any other Covered Sickness	
Diabetic Services and Supplies (including equipment and training) 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	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Dialysis Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses

Durable Medical Equipment Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Enteral Formulas and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Hearing Aids and Cochlear Implants Limited to 1 hearing aid per ear per 3-year period; and one cochlear implant in each ear with internal replacement as medically or audiologically necessary	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
Prosthetic and Orthotic Devices Pre-Authorization Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Student Health Center/Infirmary Expense Benefit	100% of the Usual and Customary Rate for Covered Medical Expenses Deductible Waived	
Sports Accident Expense - incurred as the result of the play or practice of Intercollegiate or club sports Up to $2,500 per Accident	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate 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 Subject to $10,000 maximum per Policy Year	
PEDIATRIC AND ADULT DENTAL AND VISION CARE		
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)	See the Dental Care Benefit Schedule of Benefits and Pediatric Dental Care Benefits description in the Certificate for further information.	
Type A :Basic Services Preventive Dental Care Limited to 1 dental exams every 6 months	100% of Usual and Customary Rate for Covered Medical Expenses	
The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care:		
Type B :Intermediate Services	50% of Usual and Customary Rate for Covered Medical Expenses	
Type C : Major Services	50% of Usual and Customary Rate for Covered Medical Expenses	

Type D: • Medically Necessary Orthodontic Services • General Services Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	50% of Usual and Customary Rate for Covered Medical Expenses	
Pediatric Vision Care Benefit (to including low vision services) (the end of the month in which the Insured Person turns age 19) 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 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 Rate for Covered Medical Expenses Deductible Waived	
Adult Vision Care (age 19 and older) Routine Eye Examination once every 12 months Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions	80% of Usual and Customary Rate after Deductible for Covered Medical Expenses	
MISCELLANEOUS DENTAL SERVICES		
Accidental Injury Dental Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Sickness Dental Expense Benefit	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Rate after Deductible for Covered Medical Expenses

PRESCRIPTION DRUGS		
Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy. or Student Health Center. When You get a Prescription from a pharmacy, the pharmacy will only require you at the time to pay the lesser of (1) the applicable Copayment; (2)the allowable claim amount for the Prescription Drug; or the amount You would pay for the Prescription Drug if You purchased the drug without using health benefits or discounts You may later have to pay additional cost sharing for these Prescription Drugs. For example, if You have not yet met your deductible, if applicable, You may owe additional cost sharing. 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.		
TIER 1 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$20 Copayment then the plan pays 50% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$40 Copayment then the plan pays 50% of Actual Charge for Covered Medical Expenses Deductible waived
More than a 60 day supply filled at a Retail pharmacy	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$60 Copayment then the plan pays 50% of Actual Charge for Covered Medical Expenses Deductible Waived
TIER 2 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	$45 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$45 Copayment then the plan pays 50% of Actual Charge for Covered Medical Expenses Deductible Waived

See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.		
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$90 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$90 Copayment then the plan pays 50% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Retail pharmacy	$135 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$135 Copayment then the plan pays 50% of Actual Charge for Covered Medical Expenses Deductible Waived
TIER 3 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail Pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$60 Copayment then the plan pays 50% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$120 Copayment then the plan pays 50% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Retail pharmacy	$180 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$180 Copayment then the plan pays 50% of Actual Charge for Covered Medical Expenses Deductible Waived
Specialty Prescription Drugs		
For each fill up to a 30 day supply	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$60 Copayment then the plan pays 50% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$120 Copayment then the plan pays 50% of Actual Charge for Covered Medical Expenses Deductible Waived

More than a 60 day supply filled at a Retail pharmacy	$180 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$180 Copayment then the plan pays 50% of Actual Charge for Covered Medical Expenses Deductible Waived
Specialty Prescription Drugs with Copayment Assistance Program 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.wellfleetstudent.com 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 636-271-5528		
For each fill up to a 30 day supply.	75% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
Zero Cost Drugs		
Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	[100% of Actual Charge for Covered Medical Expenses Deductible Waived
Orally administered anti-cancer Prescription Drugs (including Specialty Drugs)		
Benefit	Greater of: • Chemotherapy Benefit; or • Infusion Therapy Benefit	
Diabetic Supplies (for prescription supplies purchased at a pharmacy)		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill. except, that the Insured Person's out-of-pocket costs for covered prescription insulin drugs will not exceed $25 per 30-day supply regardless of the amount or type of insulin that is needed to fill the Insured Person's prescription.	
MANDATED BENEFITS		
Inpatient and Outpatient Treatment of Acquired Brain Injury	Same as any other Covered Sickness	
Autism Spectrum Disorder	Same as any other Mental Health Disorder	
Cervical and Ovarian Cancer Screening	Same as any other Covered Sickness, unless considered a Preventive Service	
Colorectal Cancer Screening	Same as any other Covered Sickness, unless considered a Preventive Service	
Mammography and Other Breast Imaging	Same as any other Covered Sickness, unless considered a Preventive Service	
Osteoporosis Detection and Prevention	Same as any other Covered Sickness, unless considered a Preventative Service	
Prostate Cancer Screening	Same as any other Covered Sickness, unless considered a Preventive Service	
Accidental Death and Dismemberment		
Principal Sum $10,000 Loss must occur within 365 days of the date of a covered Accident. Only one benefit will be payable under this provision, that providing the largest benefit, when more than one (1) loss occurs as the result of any one (1) Accident. This benefit is payable in addition to any other benefits payable under 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 -** 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.
- Treatment, service or supply which is not Medically Necessary for the diagnosis, care or Treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended or approved by the Student Health Center or 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 or as part of the Student Health Center benefits provided by this plan.
- Professional services rendered by an Immediate Family Member or anyone who lives with You. This exclusion does not apply to dental services.
- 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 Rates 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 certified Nurse midwife and a Physician.
- Expenses payable under any prior policy which was in force for the person making the claim.
- 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.
- 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.
- Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
- 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 Investigative drugs, devices, Treatments or procedures unless otherwise covered under Covered Clinical Trials or covered under clinical trials. See the Other Benefits section for more information.
- 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.
- 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.
- Non-chemical addictions.
- Non-physical, occupational, speech therapies (art, dance, etc.).
- Modifications made to dwellings.
- General fitness, exercise programs.
- Hypnosis.
- Rolfing.
- Biofeedback.
- Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
- Sleep Disorders, except for a sleep study performed in the Insured Person's home the diagnosis and Treatment of obstructive sleep apnea.
- 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.

Activities Related:
- Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
- 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 in excess of $2,500.00 per Intercollegiate or club sports Accident.
- 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).

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. Surgery for removal of excess skin or fat.

Family Planning:
- 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 Insured Persons acting as surrogate mothers);
  - Cloning; or
  - Medical and surgical procedures that are Experimental or Investigative, unless Our denial is overturned by an External Appeal Agent.
- Elective abortions.

Vision
- Expenses for radial keratotomy.
- Adult Vision unless specifically provided in the Certificate.
- Charges for duplicate spare eyeglasses, lenses or frames, 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 exams, hearing screening, and the fitting or repair or replacement of hearing aids 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.

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;
- 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;
- Any drug or medicine for the purpose of weight control;
- Fertility drugs;
- Sexual enhancements drugs;
- Vision correction products.

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

24/7 Behavioral Telehealth and Nurseline Access

CareConnect is an integrated behavioral health program offering students easy access to licensed behavioral health clinicians 24/7/365 via telephone (888) 857-5462.

Connect to a registered nurse within seconds, helping students manage their health on their terms through easy access.