



BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2020/2021

DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

BATES COLLEGE

Lewiston, ME
("the Policyholder")

Policy Number: W12021MESHIP19

Group Number: ST0800SH

Effective: 8/15/2020 – 8/14/2021

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 www.wellfleetstudent.com. If you have questions about enrollment into the Plan, please call Cross Benefit Solutions at (800) 537-6444. 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:
Domestic Student - Waiver Process	Bates College Garnet Gateway
Insurance Questions Servicing Agent 	Agent: Cross Benefit Solutions 150 Mill Street, Suite 4 Lewiston, ME 04240 1-800-537-6444 www.crossagency.com/Bates
Insurance Benefits In-Network Providers Inpatient Admission Pre-Certification Claims Processing ID Card Requests Dependent Enrollment	Wellfleet Group, LLC. PO Box 15369 Springfield, Massachusetts 01115-5369 (877) 657-5030, TTY 711 www.wellfleetstudent.com
Preferred PPO Provider Listings Cigna claim	Wellfleet Student www.wellfleetstudent.com or Cigna www.cigna.com Send Cigna claim to: CIGNA PO Box 188061 Chattanooga, TN 37422 – 8061 Electronic Payor ID: 62308
Prescription Drug Provider	For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit www.wellfleetstudent.com

Am I Eligible?

Bates College requires all full-time students to have health insurance.

Domestic students enrolled in 3 or more classes are asked annually to elect coverage through the Bates College Student Health Insurance Plan or to decline coverage if they are covered through another comparable insurance policy. This selection is made through the Garnet Gateway. The 20/21 enrollment period ends on August 14, 2020. Domestic students who have not made a selection by that date will be automatically enrolled in the Bates College Student Health Insurance Plan.

All International students & Scholars will automatically be enrolled in and billed for the Bates College Student Health Insurance Plan. The premium for the Bates College Student Health Insurance Plan will be added to the students accounts in September.

Insured students who are enrolled in the Student Health Insurance Plan may also enroll their eligible dependents on a voluntary basis. Eligible students who choose to enroll their dependent(s) must be enrolled under the plan first.

How Do I Waive/Enroll?

Domestic students must either decline or enroll in the Bates College Student Health Plan through their Garnet Gateway account. The waive/enrollment period ends on August 14, 2020. Domestic Students who do not make a selection by August 14, 2021, will automatically be enrolled in the Bates College Student Health Insurance Plan.

Eligible students who choose to add their dependent(s) on a voluntary basis can enroll their dependent(s) by going to: <https://www.studentinsurance.com/Client/800>. Under the enroll section click on the enroll dependent button and proceed as directed. The deadline to enroll a dependent is August 31, 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/Waiver Deadline
Annual	8/15/2020	8/14/2021	8/14/2020
			Enrollment Deadline for Dependents 8/31/2020
Spring/Summer (New Students Only)	1/1/2021	8/14/2021	1/31/2021

Plan Costs for Domestic and International Students and their Dependents

	Annual	Spring/Summer (New Students Only)
Student*	\$2,153	\$1,333
Spouse*	\$2,153	\$1,333
Each Child*	\$2,153	\$1,333
3 or more Children*	\$6,459	\$3,999

*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 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.

Bates College Schedule of Benefits

This is only a brief description of coverage available under Certificate form ME 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 80% of the Usual and Customary Charge.

Medical Deductible:	In-Network Provider	Individual:	\$0
		Family:	\$0
	Out-of-Network Provider	Individual:	\$0
		Family:	\$0
Out-of-Pocket Maximum:	In-Network Provider	Individual	\$6,350
		Family	\$12,700
	Out-of-Network Provider	Individual	No maximum
		Family	No maximum

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

Coinsurance 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.

How You Can Request an Estimate for Proposed Covered Services

You may request an estimate of the costs you will have to pay when your health care provider proposes an inpatient admission, procedure, or other covered service. You can request this cost estimate by logging on to the Wellfleet student website. Just follow the steps to request a cost estimate for health care services you are planning to receive. To request an estimate by phone, call the toll-free phone number shown on your ID card.

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 or visit Our website at www.wellfleetstudent.com.

THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:

- 1. THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;**
- 2. ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
- 3. DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY AN IN-NETWORK OR OUT-OF-NETWORK PROVIDER.**
- 4. UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE WILL ALWAYS APPLY.**

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Inpatient Benefits		
Hospital Care Includes hospital room & board expenses and miscellaneous services and supplies. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Preadmission Testing	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Physician's Visits while Confined Limited to 1 visit per day of Confinement per provider	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Inpatient Surgery: Pre-Certification Required Surgeon Services Anesthetist Assistant Surgeon	90% of the Negotiated Charge for Covered Medical Expenses 90% of the Negotiated Charge for Covered Medical Expenses 90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses 70% of Usual and Customary Charge for Covered Medical Expenses 70% of Usual and Customary Charge for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Certification required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses

INPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
<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 for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge for Covered Medical Expenses</p>
Outpatient Benefits		
<p>Outpatient Surgery:</p> <p>Pre-Certification required</p> <p>Surgeon Services</p> <p>Anesthetist</p> <p>Assistant Surgeon</p>	<p>90% of the Negotiated Charge for Covered Medical Expenses</p> <p>90% of the Negotiated Charge for Covered Medical Expenses</p> <p>90% of the Negotiated Charge for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge for Covered Medical Expenses</p> <p>70% of Usual and Customary Charge for Covered Medical Expenses</p> <p>70% of Usual and Customary Charge for Covered Medical Expenses</p>
<p>Outpatient Surgery Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma</p>	<p>90% of the Negotiated Charge for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge 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 for Covered Medical Expenses</p>	<p>\$20 Copayment per visit then the plan pays 70% of Usual and Customary Charge 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 for Covered Medical Expenses</p>	<p>\$20 Copayment per visit then the plan pays 70% of Usual and Customary Charge for Covered Medical Expenses</p>
<p>Telemedicine or Telehealth Services</p>	<p>\$20 Copayment per visit then the plan pays 90% of the Negotiated Charge for Covered Medical Expenses</p>	<p>\$20 Copayment per visit then the plan pays 70% of Usual and Customary Charge for Covered Medical Expenses</p>
<p>Cardiac Rehabilitation</p>	<p>90% of the Negotiated Charge for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge for Covered Medical Expenses</p>
<p>Cardiac Rehabilitation Maximum Visits per Policy Year</p>	<p>60</p>	<p>60</p>

Pulmonary Rehabilitation	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Pulmonary Rehabilitation Maximum Visits per Policy Year	60	60
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Maximum Visits per Policy Year for Physical Therapy and Occupational Therapy Combined	60	60
Maximum Visits per Policy Year for Speech Therapy	60	60
Habilitative Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Habilitative Services Maximum Visits per Policy Year for Physical Therapy and Occupational Therapy Combined	60	60
Emergency Services	\$75 Copayment then the plan pays 90% of the Negotiated Charge 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 then the plan pays 90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Diagnostic Imaging Services Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Laboratory Procedures (Outpatient)	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Home Health Care Expenses Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Hospice Care Coverage	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses

OUTPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
<p>Mental Health Disorder and Substance Use Disorder Benefit</p> <p>Pre-Certification Required except for office visits</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 for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge for Covered Medical Expenses</p>
<p>Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy.</p>		
<p>TIER 1 (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>\$10 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</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>\$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p>	<p>Not Covered</p>
<p>More than a 60 day supply filled at a Retail pharmacy</p>	<p>\$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p>	<p>Not Covered</p>
<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>\$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</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>\$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p>	<p>Not Covered</p>

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	Not Covered
TIER 3 (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.	\$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	\$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 60-day supply filled at a Retail pharmacy	\$90 Copayment then the plan pays 100% of the Negotiated Charge 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 Deductible Waived	Not Covered
Specialty Prescription Drugs		
Specialty Prescription Drugs For each fill up to a 30-day supply.	\$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 30-day supply but less than a 61-day supply	\$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 60-day supply	\$90 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
Orally administered anti-cancer prescription drugs (including specialty drugs)		
Benefit	Greater of: <ul style="list-style-type: none"> • 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	

Other Benefits		
Allergy Testing	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Allergy Injections/Treatment	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Ambulance Service ground and/or air, water transportation	80% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Bariatric Surgery Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Covered Clinical Trials	Covered the same as any other Sickness	Covered the same as any other Sickness
Durable Medical Equipment Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Diabetic services and supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Dialysis Treatment	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Hearing Aids One hearing aid per affected ear every 36 months for an Insured age 18 years or under.	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
Enteral Formulas and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Prosthetic and Orthotic Devices Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Prosthetic Devices (Arm and Leg) Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Reconstructive Surgery Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses

Pediatric Dental and Vision Services Refer to the Pediatric Vision Services and Pediatric Dental Services	
<p>Pediatric Dental – preventive & diagnostic services, for Insured Persons (to the end of the month in which they turn age 19);</p> <p>limited to 1 exam / prophylaxis every 6 month</p> <p>Includes:</p> <ul style="list-style-type: none"> • Topical fluoride treatment – 2 per 12 months • x-rays – bitewing – 1 set per 6 months • x-rays - full-mouth and panoramic – 1 per 60 months • sealants (as needed for permanent 1st and 2nd molars only, 1 per tooth every 36 months) • space maintainers • emergency palliative treatment of pain <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 style="text-align: center;">100% of Usual and Customary Charge</p>
<p>Pediatric Dental – basic restorative services, for Insured Persons (to the end of the month in which they turn age 19)</p> <p>Includes:</p> <ul style="list-style-type: none"> • fillings (amalgam, resin-based composite) • prefabricated stainless-steel crown – 1 per tooth per 60 months • endodontics - therapeutic pulpotomy • periodontics - scaling and root planning, limited to 1 every 24 months • prosthodontics – denture repair, denture rebase/reline (1 per 36 months; 6 months after initial installation) • oral surgery 	<p style="text-align: center;">50% of Usual and Customary Charge</p>

<p>Pediatric Dental – major and general services, for Covered Persons (to the end of the month in which the Insured Person turns age 19); Includes:</p> <ul style="list-style-type: none"> • prosthodontics - crowns, bridges, and dentures - 1 per tooth/arch every 60 months • endodontics (root canals on permanent teeth limited to one per tooth per lifetime) • periodontics – gingivectomy or gingivoplasty, limited to 1 every 36 months for 4 or more teeth • occlusal guard – 1 in 12 months for ages 13 and older • general anesthesia and IV sedation* – in conjunction with complex oral surgery • consultations, therapeutic drug injection, and treatment of post-surgical complications, except as Covered elsewhere in the Policy 	<p>50% of Usual and Customary Charge</p>	
<p>Pediatric Dental – Medically Necessary orthodontia services*, for Covered Persons up to age nineteen (19) with severe and handicapping malocclusion</p> <p>*Requires pre-authorization</p>	<p>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 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>100% of Usual and Customary Charge for Covered Medical Expenses</p>	
<p>Abortion Expense</p>	<p>90% of the Negotiated Charge for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge for Covered Medical Expenses</p>
<p>Acupuncture Expense Benefit</p>	<p>90% of the Negotiated Charge for Covered Medical Expenses</p>	<p>70% of Usual and Customary Charge for Covered Medical Expenses</p>

Accidental Injury Dental Treatment for Insured Person's over age 18	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Sickness Dental Expense for Insured Person's over age 18	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Chiropractic Care Benefit Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Chiropractic Care Benefit Maximum visits per Policy Year	40	40
Organ Transplant Surgery travel and lodging expenses a maximum of \$2,000 per Policy Year \$250 per day, whichever is less while at the transplant facility. Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Tuberculosis screening, Titers, Quantiferon B tests including shots (other than covered under preventive services)	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Bedside Visits (International Students and their Dependents)	100% of Usual and Customary Charge for Covered Medical Expenses Subject to \$5,000 maximum per Policy Year	
Non-emergency Care While Traveling Outside of the United States	70% of Usual and Customary Charge for Covered Medical Expenses Subject to \$10,000 maximum per Policy Year	
Medical Evacuation Expense	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived	
Repatriation Expense	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived	
Mandated Benefits		
Anesthesia and Facility Charges for Dental Procedures	90% of the Negotiated Charge for Covered Medical Expenses	70% of Usual and Customary Charge for Covered Medical Expenses
Autism Spectrum Disorders	Same as any other Covered Sickness	
Breast Cancer Treatment	Same as any other Covered Sickness	
Breast Reduction/Varicose Vein Surgery	Same as any other Covered Sickness	
Children's Early Intervention	Same as any other Covered Sickness, subject to the following limitations. The coverage is limited to \$3,200 worth of visits per Policy Year for each child, not to exceed \$9,600 worth of visits by the child's 3 rd birthday.	
Colorectal Cancer Screening	Same as any other Preventive Service	
Gynecological and Obstetrical Services	Same as any other Preventive Service	
Leukocyte Antigen Testing	Same as any other Preventive Service, subject to a maximum of \$150 per lifetime lab fee and may not be applied to any deductible.	
Pap Tests	Same as any other Preventive Service	
Prostate Cancer Screening	Same as any other Preventive Service	
Screening Mammogram	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;
 - 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. 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.
21. Treatment for obesity except surgery for morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat.
22. Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
23. Expenses for radial keratotomy.
24. Adult Vision unless specifically provided in the Certificate.
25. 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.
26. Charges for hearing exams, hearing screening, or cochlear implants except as specifically provided in the Certificate.
27. 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.
28. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma.
29. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
30. Treatment of Temporomandibular Joint Dysfunction (TMJ) other than a surgical procedure for those covered conditions affecting the upper or lower jawbone or associated bone joints. Such a procedure must be considered Medically Necessary based on the Certificate definition of same.
31. You are:
 - committing or attempting to commit a felony,
 - engaged in an illegal occupation, or
 - participating in a riot.
32. Custodial Care service and supplies.
33. Charges for hot or cold packs for personal use.
34. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.

35. Services of private duty Nurse except as provided in the Certificate.
36. Expenses that are not recommended and approved by a Physician.
37. 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.
38. 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.
39. Treatment of Acne unless Medically Necessary.
40. 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.
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;
 - 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.
42. Non-chemical addictions.
43. Non-physical, occupational, speech therapies (such as art, dance, drama, horticulture, music, writing, 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

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

Wellfleet Student provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Wellfleet Student at (877) 657-5030, TTY 711. **If you are traveling and need assistance in North America, call the Assistance Center toll-free at: (877) 305-1966 or if you are in a foreign country, call collect at: (715) 295-9311.** When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

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



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.