Kenyon

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2020/2021

DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

KENYON COLLEGE
Gambier, OH
(“the Policyholder”)

Policy Number: WI2021OHSL04
Group Number: ST1854SH
Effective: 8/15/2020 – 8/14/2021

PLAN SPONSOR:
Kenyon College

CLAIMS ADMINISTRATOR:
Wellfleet Group, LLC

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Welcome Students…

We are pleased to provide you with this summary of the 2020 – 2021 Kenyon College Student Health Benefits Plan ("Plan"). "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 Document and other materials at **www.wellfleetstudent.com**. For questions about medical benefits or claims, please call Wellfleet Student at (877) 657-5030, TTY 711.

Where to Find Help

For Questions About:	Please Contact:
Enrollment **Insurance Benefits** **Claims Processing** **ID Cards**	**Wellfleet Group, LLC** **PO Box 15369** **Springfield, Massachusetts 01115-5369** **(877) 657-5030, TTY 711** **www.wellfleetstudent.com**
Prescription Drug Provider	**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.**

Am I Eligible?

All full time students enrolled are eligible for coverage as determined by the Policyholder unless coverage is waived.

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
Annual	8/15/2020	8/14/2021
Spring	1/15/2021	8/14/2021

Plan Costs for all Full Time Students

	Annual	Spring
Student*	$2,800	$1,650
Spouse*	$3,300	$1,950
Each Child*	$2,500	$1,480

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

Kenyon College Schedule of Benefits

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

SCHEDULE OF BENEFITS

Preventive Services:
The Deductible and Coinsurance are not applicable to Preventive Services. Benefits are paid at 100% of the Actual Charge.

Medical Deductible Individual: $250

Out-of-Pocket Maximum: Individual: $6,825

The Out of Pocket Maximum will never exceed the amount shown above for an Covered Person. Benefits will be paid at 100% after the Out of Pocket Maximum has been satisfied.

Coinsurance Amounts: 80% of Covered Medical Expenses

THE COVERED MEDICAL EXPENSE WILL BE:
1. **THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
3. **UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE WILL ALWAYS APPLY.**

BENEFITS FOR COVERED INJURY/SICKNESS	PLAN COST SHARE AND LIMITATIONS PLAN WILL PAY
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.	80% of the Actual Charge after Deductible for Covered Medical Expenses
Preadmission Testing	80% of the Actual Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined: Limited to 1 visit per day of Confinement per provider	80% of the Actual Charge after Deductible for Covered Medical Expenses
Inpatient Surgery:	
Surgeon Services	80% of the Actual Charge after Deductible for Covered Medical Expenses
Anesthetist	80% of the Actual Charge after Deductible for Covered Medical Expenses
Assistant Surgeon	80% of the Actual Charge after Deductible for Covered Medical Expenses

Physical Therapy while Confined (inpatient)	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Physical Therapy while Confined (inpatient) Maximum Visits per Plan Year	60	60
Skilled Nursing Facility Benefit	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Skilled Nursing Facility Benefit Maximum days per Plan Year	90	90
Inpatient Rehabilitation Facility Expense Benefit including Physical Medicine and Day Rehabilitation Therapy services	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Inpatient Rehabilitation Facility Expense Benefit Maximum days per Plan Year	60	60
INPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
Mental Health Disorder and Substance Use Disorder Benefit Including residential treatment facilities In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Outpatient Benefits		
Outpatient Surgery: Surgeon Services Anesthetist Assistant Surgeon	 80% of the Actual Charge after Deductible for Covered Medical Expenses 80% of the Actual Charge after Deductible for Covered Medical Expenses 80% of the Actual Charge after Deductible for Covered Medical Expenses	
Outpatient Surgery Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	80% of the Actual Charge after Deductible for Covered Medical Expenses	

Physician's Office Visits	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Specialist/Consultant Physician Services	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Telemedicine or Telehealth Services	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Cardiac Rehabilitation	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Cardiac Rehabilitation Maximum Visits per Plan Year	36	36
Pulmonary Rehabilitation	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Pulmonary Rehabilitation Maximum Visits per Plan Year	20	20
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy and Inhalation Therapy	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Maximum Visits for each therapy per Plan Year for Physical Therapy, Occupational Therapy and Speech Therapy	20	20
Habilitative Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Habilitative Services are covered to the extent that they are Medically Necessary – including services for children (up to age 21) with a medical diagnosis of Autism Spectrum Disorder. Clinical Therapeutic intervention, including but not limited to Applied Behavior Analysis, These are separate limits and are not combined with therapy limits for other conditions.	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Habilitative Services Maximum Visits for each therapy per Plan Year for Physical Therapy, Occupational Therapy and Speech Therapy These limits do not apply to the above limits for the condition of Autism.	20	20
Emergency Services (includes Ambulance and Urgent Care for Emergency Medical Conditions).	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Urgent Care Centers for non-life-threatening	80% of the Actual Charge after Deductible for Covered Medical Expenses	

<table>
<tr><td>Diagnostic Imaging Services</td><td colspan="2">80% of the Actual Charge after Deductible for Covered Medical Expenses</td></tr>
<tr><td>CT Scan, MRI and/or PET Scans</td><td colspan="2">80% of the Actual Charge after Deductible for Covered Medical Expenses</td></tr>
<tr><td>Laboratory Procedures (Outpatient)</td><td colspan="2">80% of the Actual Charge after Deductible for Covered Medical Expenses</td></tr>
<tr><td>Chemotherapy and Radiation Therapy Including orally administered cancer drugs</td><td colspan="2">80% of the Actual Charge after Deductible for Covered Medical Expenses</td></tr>
<tr><td>Home Infusion Therapy</td><td colspan="2">80% of the Actual Charge after Deductible for Covered Medical Expenses</td></tr>
<tr><td>Home Health Care Expenses</td><td colspan="2">80% of the Actual Charge after Deductible for Covered Medical Expenses</td></tr>
<tr><td>Home Health Care Expenses
Maximum visits per Plan Year</td><td>100</td><td>100</td></tr>
<tr><td>Hospice Care Coverage</td><td colspan="2">80% of the Actual Charge after Deductible for Covered Medical Expenses</td></tr>
<tr><td>Outpatient Private Duty Nursing</td><td colspan="2">80% of the Actual Charge after Deductible for Covered Medical Expenses</td></tr>
<tr><td>Outpatient Private Duty Nursing
Maximum visit per Plan Year</td><td>90</td><td>90</td></tr>
<tr><td colspan="3">OUTPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER</td></tr>
<tr><td>Mental Health Disorder and Substance Use Disorder Benefit
except for office visits

In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits 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.</td><td colspan="2">80% of the Actual Charge after Deductible for Covered Medical Expenses</td></tr>
<tr><td colspan="3">Prescription Drugs Retail Pharmacy
No cost sharing applies to ACA Preventive Care medications filled at a participating pharmacy</td></tr>
<tr><td>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.</td><td colspan="2">$10 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses</td></tr>
<tr><td>More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy</td><td colspan="2">$20 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses</td></tr>
<tr><td>More than a 60 day supply filled at a Retail pharmacy</td><td colspan="2">$30 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses</td></tr>
</table>

TIER 2 (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 Actual Charge after Deductible for Covered Medical Expenses
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 Actual Charge after Deductible for Covered Medical Expenses
More than a 60 day supply filled at a Retail pharmacy	$90 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses
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.	$50 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$100 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses
More than a 60 day supply filled at a Retail pharmacy	$150 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses
Zero Cost Generics	
In addition to ACA Preventive Care medications, certain Generic Drugs are covered at no cost to you. These zero cost generics can be identified in the Formulary posted on Our website www.wellfleetstudent.com	100% of Actual Charge for Covered Medical Expenses Deductible waived
Specialty Prescription Drugs	
Specialty Prescription Drugs For each fill up to a 30day supply	$100 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses
More than a 30 day supply but less than a 61 day supply	$200 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses
More than a 60 day supply	$300 Copayment then the plan pays 100% of Actual Charge after Deductible for Covered Medical Expenses

Tobacco Cessation	
Tobacco cessation prescription and over-the-counter drugs will be covered for two 90-day treatment regimens only. Any additional prescription drug treatment regimens will be subject to the cost sharing below. For details on the current list of tobacco cessation prescription drugs and OTC drugs covered with no cost sharing during the two 90-day treatment regimens allowed, visit www.wellfleetstudent.com or call 877-657-5030	100%
Tobacco cessation prescription drugs beyond the coverage above. Additional regiments of over-the-counter drugs are excluded.	80% of Actual Charge after Deductible for Covered Medical Expenses Deductible Waived
Orally administered anti-cancer prescription drugs (including specialty drugs)	
Benefit	Greater of: • Chemotherapy Benefit; or • Home Infusion Therapy Benefit
Diabetic Supplies (for Prescription supplies purchased at a pharmacy)	80% of Actual Charge after Deductible for Covered Medical Expenses Deductible Waived
Other Benefits	
Allergy Testing	80% of the Actual Charge after Deductible for Covered Medical Expenses
Allergy Injections/Treatment	80% of the Actual Charge after Deductible for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	80% of the Actual Charge after Deductible for Covered Medical Expenses
Non-Emergency Ambulance Service ground and/or air, water transportation	80% of the Actual Charge after Deductible for Covered Medical Expenses
Covered Cancer Clinical Trials	80% of the Actual Charge after Deductible for Covered Medical Expenses
Durable Medical Equipment	80% of the Actual Charge after Deductible 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.	80% of the Actual Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	80% of the Actual Charge after Deductible for Covered Medical Expenses
Maternity Benefit	80% of the Actual Charge 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 Actual Charge after Deductible for Covered Medical Expenses

Prosthetic and Orthotic Devices	80% of the Actual Charge after Deductible for Covered Medical Expenses
Reconstructive Surgery	80% of the Actual Charge after Deductible for Covered Medical Expenses
Pediatric Dental Care Benefit (to the end of the month in which the Covered turns age 19)	
Type A services: Diagnostic and Preventive care	100% of Actual Charge
Type B services: Basic Restorative Care	50% of Actual Charge
Type C services: Major Restorative care	50% of Actual Charge
Orthodontic services	50% of Actual Charge
Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	

PREVENTIVE AND DIAGNOSTIC SERVICES (TYPE A)
Diagnostic and Treatment Services:
Periodic oral evaluation- Limited to 1 every 6 months
Limited oral evaluation- problem focused- Limited to 1 every 6 months
Comprehensive oral evaluation- Limited to 1 every 6 months
Comprehensive periodontal evaluation- Limited to 1 every 6 months
Intraoral-complete series (including bitewings) 1 every 60 (sixty) months film
Intraoral- periapical first
Intraoral- periapical - each additional film
Intraoral- occlusal film
Bitewing- single film 1 set every 6 months
Bitewings -two films 1 set every 6 months
Bitewings - four films 1 set every 6 months
Vertical bitewings-7 to 8 films 1 set every 6 months
Panoramic film-1 film every 60 (sixty) months
Cephalometric x-ray
Oral/ Facial Photographic Images
Diagnostic Models
Preventative Services:
Prophylaxis-Child- Limited to 1 every 6 months
Topical application of fluoride (excluding prophylaxis)--Limited to 2 every 12 months
Topical application of fluoride (excluding prophylaxis)- 2 every 12 months
Topical fluoride varnish- 2 in 12 months
Sealant- per tooth- unrestored permanent molars - 1 sealant per tooth every 36 months
Preventative resin restorations in a moderate to high caries risk patient- permanent tooth- 1 sealant per tooth every 36 months
Space maintainer-fixed -unilateral
Space maintainer-fixed- bilateral
Space maintainer-removable-unilateral
Space maintainer-removable-bilateral
Re-cementation of space maintainer
Additional Procedures covered as Preventive and Diagnostic:
Palliative treatment of dental pain- minor procedure
BASIC RESTORATIVE SERVICES (TYPE B)
Minor Restorative Services:
Amalgam- one surface, primary or permanent
Amalgam- two surfaces, primary or permanent
Amalgam- three surfaces, primary or permanent

Amalgam- four or more surfaces, primary or permanent
Resin-based composite - one surface, anterior
Resin-based composite -two surfaces, anterior
Resin-based composite -three surfaces, anterior
Resin-based composite- four or more surfaces or involving incisal angle (anterior)
Re-cement inlay
Re-cement crown
Prefabricated stainless-steel crown· primary tooth - Limited to I per tooth in 60 months
Prefabricated stainless-steel crown - permanent tooth - Limited to I per tooth in 60 months
Protective Restoration
Pin retention per tooth, in addition to restoration
Endodontic Services:
Therapeutic pulpotomy (excluding final restoration)- *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.*
Partial pulpotomy for apexogenesis- permanent tooth with incomplete root development *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a pan of the root canal procedure and benefits are not payable separately.*
Pulpal therapy (resorbable filling)- anterior, primary tooth (excluding final restoration)
Pulpal therapy (resorbable filling)- posterior, primary tooth (excluding final restoration). Incomplete endodontic treatment when treatment is discontinued.
Periodontal Services:
Periodontal scaling and root planing-four or more teeth per quadrant- Limited to 1 every 24 months
Periodontal scaling and root planing-one to three teeth, per quadrant- Limited to 1 every 24 months
Periodontal maintenance- 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy.
Prosthodontic Services:
Adjust complete denture-maxillary
Adjust complete denture-mandibular
Adjust partial denture-maxillary
Adjust partial denture-mandibular
Repair broken complete denture base
Replace missing or broken teeth complete denture (each tooth)
Repair resin denture base
Repair cast framework
Repair or replace broken clasp
Replace broken teeth- per tooth
Add tooth to existing partial denture
Add clasp to existing partial denture
Rebase complete maxillary denture- Limited to 1 in a 36-month period 6 months after the initial installation
Rebase maxillary partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
Rebase mandibular partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
Reline complete maxillary denture -Limited to 1 in a 36-month Period 6 months after the initial installation
Reline complete mandibular denture -Limited to l in a 36-month period 6 months after the initial installation
Reline maxillary partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
Reline mandibular partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
Reline complete maxillary denture (laboratory) -Limited to 1 in a 36-month period 6 months after the initial
Reline complete mandibular denture (laboratory)- Limited to 1 in a 36-month period 6 months after the initial
Reline maxillary partial denture (laboratory)·Limited to 1 in a 36-month period 6 months after the initial installation
Reline mandibular partial denture (laboratory) Rebase/Reline- Limited to 1 in a 36-month period 6 months after the initial installation
Tissue conditioning (maxillary)
Tissue conditioning (mandibular)
Re-cement fixed partial denture
Fixed partial denture repair, by report

Oral Surgery:
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
Removal of impacted tooth - soft tissue
Removal of impacted tooth- partially bony
Removal of impacted tooth - completely bony
Removal of impacted tooth - completely bony with unusual surgical complications
Surgical removal of residual tooth roots (cutting procedure)
Coronectomy- intentional partial tooth removal
Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
Surgical access of an unerupted tooth
Alveoloplasty in conjunction with extractions - per quadrant
Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
Alveoloplasty not in conjunction with extractions- per quadrant
Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
Removal of exostosis
Incision and drainage of abscess intraoral soft tissue
Suture of recent small wounds up to 5 cm
Excision of pericoronal gingiva
MAJOR SERVICES (TYPE C)
Major Restorative Services:
Detailed and extensive oral evaluation- problem focused, by report
Inlay- metallic- one surface- An alternate benefit will be provided
Inlay- metallic- two surfaces -An alternate benefit will be provided
Inlay- metallic-three surfaces -An alternate benefit will be provided
On lay- metallic- two surfaces- Limited to 1 per tooth every 60 months
On lay - metallic- three surfaces- Limited to 1 per tooth every 60 months
On lay - metallic- four or more surfaces- Limited to 1 per tooth every 60 months
Crown- porcelain/ceramic substrate- Limited to 1 per tooth every 60 months
Crown- porcelain fused to high noble metal- Limited to 1 per tooth every 60 months
Crown- porcelain fused to predominately base metal-Limited to 1 per tooth every 60 months
Crown- porcelain fused to noble metal-Limited to 1 per tooth every 60 months
Crown - 3/4 cast high noble metal- Limited to 1 per tooth every 60 months
Crown - 3/4 cast predominately base metal- Limited to 1 per tooth every 60 months
Crown - 3/4 porcelain/ceramic- Limited to 1 per tooth every 60 months
Crown - full cast high noble metal- Limited to 1 per tooth every 60 months
Crown- full cast predominately base metal-Limited to 1 per tooth every 60 months
Crown - full cast noble metal- Limited to I per tooth every 60 months
Crown-titanium- Limited to 1 per tooth every 60 months
Core buildup, including any pins- Limited to 1 per tooth every 60 months
Prefabricated post and core, in addition to crown- Limited to 1 per tooth every 60 months
Crown repair, by report
Endodontic Services:
Anterior root canal (excluding final restoration)
Bicuspid root canal (excluding final restoration)
Molar root canal (excluding final restoration)
Retreatment of previous root canal therapy-anterior
Retreatment of previous root canal therapy-bicuspid
Retreatment of previous root canal therapy-molar
Apexification/recalcification- initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
Apexification/recalcification- interim medication replacement (apical closure/calcific repair of perforations, root
Apexification/recalcification- final visit (includes completed root canal therapy, apical closure/calcific repair of perforations. root
Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp)
Apicoectomy/periradicular surgery- anterior
Apicoectomy/periradicular surgery- bicuspid (first root)

Apicoectomy/periradicular surgery -molar (first root)
Apicoectomy/periradicular surgery (each additional root)
Root amputation- per root
Hemisection (including any root removal)- not including root canal therapy
Periodontal Services:
Gingivectomy or gingivoplasty- four or more teeth-Limited to 1 every 36 months
Gingivectomy or gingivoplasty-one to three teeth
Gingival flap procedure, four or more teeth-Limited to 1 every 36 months
Clinical crown lengthening-hard tissue
Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant- Limited
Pedicle soft tissue graft procedure
Free soft tissue graft procedure (including donor site surgery)
Subepithelial connective tissue graft procedures (including donor site surgery)
Full mouth debridement to enable comprehensive evaluation and diagnosis
Prosthodontic Services:
Complete denture - maxillary-Limited to 1 every 60 months
Complete denture- mandibular-Limited to 1 every 60 months
Immediate denture- maxillary-Limited to 1 every 60 months
Immediate denture- mandibular-Limited to 1 every 60 months
Maxillary partial denture- resin base (including any conventional clasps, rests and teeth)- Limited to 1 every 60
Mandibular partial denture- resin base (including any conventional clasps, rests and teeth)-Limited to 1 every 60
Maxillary partial denture- cast metal framework with resin denture base (including any conventional clasps, rests
Mandibular partial denture- cast metal framework with resin denture base (including any conventional clasps, rests
Removable unilateral partial denture-one-piece cast metal (including clasps and teeth)-Limited to 1 every 60 months
Endosteal Implant- 1 every 60 months
Surgical Placement of Interim Implant Body- 1 every 60 months
Eposteal Implant- 1 every 60 months
Transosteal Implant. Including Hardware- 1 every 60 months
Implant supported complete denture
Implant supported partial denture
Connecting Bar-implant or abutment supported- 1 every 60 months
Prefabricated Abutment- 1 every 60 months
Abutment supported porcelain ceramic crown - 1 every 60 months
Abutment supported porcelain fused to high noble metal- 1 every 60 months
Abutment supported porcelain fused to predominately base metal crown- 1 every 60 months
Abutment supported porcelain fused to noble metal crown 1 every 60 months
Abutment supported cast high noble metal crown - 1 every 60 months
Abutment supported cast predominately base metal crown – 1 every 60 months
Abutment supported Cast noble metal crown 1 every 60 months
Implant supported porcelain/ceramic crown- 1 every 60 months
Implant supported porcelain fused to high metal crown - 1 every 60 months
Implant supported metal crown- 1 every 60 months
Abutment supported retainer for porcelain/ceramic fixed partial denture- 1 every 60 months
Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months
Abutment supported retainer for porcelain fused to noble metal fixed partial denture- 1 every 60 months
Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months
Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months
Abutment supported retainer for cast noble metal fixed partial denture- 1 every 60 months
Implant supported retainer for ceramic fixed Partial denture- 1 every 60 months
Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
Implant supported retainer for cast metal fixed partial denture - 1 every 60 months
Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months
Implant/abutment supported fixed partial denture for partially edentulous arch- 1 every 60 months
Implant Maintenance Procedures -1 every 60 months
Repair Implant Prosthesis -1 every 60 months
Replacement of Semi-Precision or Precision Attachment- 1 every 60 months

Repair Implant Abutment -1 every 60 months
Implant Removal-1 every 60 months
Implant Index -1 every 60 months
Pontic-cast high noble metal- Limited to 1 every 60 months
Pontic-cast predominately base metal -Limited to 1 every 60 months
Pontic-cast noble metal- Limited to 1 every 60 months
Pontic-titanium-Limited to 1 every 60 months
Pontic -porcelain fused to high noble metal-Limited to 1 every 60 months
Pontic-porcelain fused to predominately base metal-Limited to 1 every 60 months
Pontic-porcelain fused to noble metal Limited to 1 every 60 months
Pontic-porcelain/ceramic-Limited to 1 every 60 months
Inlay/on lay- porcelain/ceramic-Limited to 1 every 60 months
Inlay-metallic-two surfaces-Limited to 1 every 60 months
Inlay- metallic-three or more surfaces- Limited to 1 every 60 months
On lay- metallic- three surfaces- 1 every 60 months
On lay- metallic- four or more surfaces -1 every 60 months
Retainer -cast metal for resin bonded fixed prosthesis -1 every 60 months
Retainer- porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months
Crown- porcelain/ceramic- 1 every 60 months
Crown -porcelain fused to high noble metal - 1 every 60 months
Crown- porcelain fused to predominately base metal- 1 every 60 months
Crown- porcelain fused to noble metal - 1 every 60 months
Crown -3/4 cast high noble metal - 1 every 60 months
Crown- 314 cast predominately base metal • 1 every 60 months
Crown 3/4 cast noble metal 1 every 60 months
Crown - 3/4 porcelain/ceramic- 1 every 60 months
Crown • full cast high noble metal- 1 every 60 months
Crown -full cast predominately base metal- 1 every 60 months
Crown full cast noble metal 1 every 60 months
Core build up for retainer including any pins 1 every 60 months
Occlusal guard, by report- 1 in 12 months
GENERAL SERVICES (TYPE C)
Anesthesia Services:
Deep sedation/general anesthesia- first 30 minutes
Deep sedation/general anesthesia- each additional 15 minutes
Intravenous Sedation:
Intravenous conscious sedation/analgesia- first 30 minutes
Intravenous conscious sedation/analgesia each additional 15 minutes
Consultations:
Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)
Medications:
Therapeutic drug injection, by report
Post-Surgical Services:
Treatment of complications (post-surgical) unusual circumstances, by report
MEDICALLY NECESSARY ORTHODONTIA SERVICES (TYPE D)
Orthodontic Services -covered for persons with severe and handicapping malocclusion
Limited orthodontic treatment of the primary dentition
Limited orthodontic treatment of the transitional dentition
Limited orthodontic treatment of the adolescent dentition
Interceptive orthodontic treatment of the primary dentition
Interceptive orthodontic treatment of the transitional dentition
Comprehensive orthodontic treatment of the transitional dentition
Comprehensive orthodontic treatment of the adolescent dentition
Removable appliance therapy
Periodic orthodontic treatment visits (as part of contract)
Orthodontic retention (removal of appliances, construction and placement of retainer(s)

Pediatric Vision Care Benefit (including low vision services) (to the end of the month in which the Covered Person turns age 19) Limited to 1 visit(s) per Plan Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Plan Year 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 Actual Charge for Covered Medical Expenses per Plan Year	
Accidental Injury Dental Treatment Limited to $3,000 per Injury	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Chiropractic Care Benefit	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Chiropractic Care Benefit Maximum visits per Plan Year	12	12
Organ Transplant Surgery Donor's search for bone marrow/stem cell transplants limited to $30,000 per Transplant Maximum benefit payable for travel and lodging expenses for any one transplant $10,000	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Treatment for Temporomandibular (TMJ) or Craniomandibular Joint (CMJ) Disorder and Craniomandibular Jaw Disorder	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Abortion Expense	80% of the Actual Charge after Deductible for Covered Medical Expenses	
Adult Vision Care for Covered Persons beyond the end of the month they turn 19 Routine Eye Exam once every 12months 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 the Actual Charge after Deductible for Covered Medical Expenses	
Medical Evacuation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $50,000 maximum per Plan Year	
Repatriation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $25,000 maximum per Plan Year	
Non-emergency Care While Traveling Outside of the United States	80% of Actual Charge after Deductible for Covered Medical Expenses for Medically Necessary treatment when You are traveling outside of the United States. Subject to $10,000 maximum per Plan Year	

Sickness Dental Expense beyond the end of the month the Covered Person turns 19.	80% of Actual Charge after Deductible for Covered Medical Expenses
Tuberculosis screening, Titers, Quantiferon B tests including shots (other than covered under preventive services)	80% of Actual Charge after Deductible for Covered Medical Expenses
Sports Accident Expense - incurred as the result of the play or practice of Intercollegiate or club sports	80% of Actual Charge after Deductible for Covered Medical Expenses

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

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 anyone (1) Accident. This benefit is payable in addition to any other benefits payable under this Plan.

Exclusions and Limitations

The following services or charges shall not be considered Covered Medical Expenses under the Plan:

1. 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 an attending Physician or dentist.
2. Medical services rendered by a provider employed for or contracted with the Plan Sponsor, including team physicians or trainers, except as specifically provided in the Schedule of Benefits.
3. Professional services rendered by an Immediate Family Member or anyone who lives with the Covered Person.
4. 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.
5. 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.

6. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
7. 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.
8. Any expenses in excess of Usual and Customary Charges except as provided in the Plan.
9. 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.
10. 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.
11. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
12. 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 the Covered Person is required to pay.
13. Services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
14. Expenses payable under any prior policy which was in force for the person making the claim.
15. Injury sustained as the result of the Covered Person's operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.
16. Expenses incurred after:
    - The date insurance terminates as to an Covered Person, except as specified in the extension of benefits provision; and
    - The end of the Plan Year
17. Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Plan.
18. Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
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 Plan.
20. Treatment for obesity and Surgery for removal of excess skin or fat.
21. Charges for hair growth or removal unless otherwise specifically covered under the Plan.
22. Expenses for radial keratotomy.
23. Adult Vision unless specifically provided in the Plan.
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 Plan.
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. The Covered Person is:
    - committing or attempting to commit a felony,
    - engaged in an illegal occupation, or
    - participating in a riot.
30. Custodial Care service and supplies.
31. Charges for hot or cold packs for personal use.
32. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
33. Services of private duty Nurse except as provided in the Plan.

34. Expenses that are not recommended and approved by a Physician.
35. 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.
36. 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.
37. Sleep Disorders, except for the diagnosis and treatment of obstructive sleep apnea..
38. Treatment of Acne unless Medically Necessary.
39. Experimental or Investigational drugs, devices, treatments or procedures unless otherwise covered under Covered Clinical Trials or covered under clinical trials (routine patient costs).
40. 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 this Plan. 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 Plan;
    - 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 Plan 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 Plan;
    - repackaged products;
    - blood components except factors;
    - immunology products.
41. Non-chemical addictions.
42. Non-physical, occupational, speech therapies (art, dance, etc.).
43. Modifications made to dwellings.
44. General fitness, exercise programs.
45. Hypnosis.
46. Rolfing.
47. Biofeedback

Value Added Services

Value Added options are provided by Wellfleet Group, LLC.

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.