Kenyon

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2022/2023

DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

KENYON COLLEGE

Gambier, OH
("the Policyholder")

Policy Number: WI2223OHSHIP205

Group Number: ST1854SH

Effective: 8/15/2022 – 8/14/2023

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 2022 – 2023 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 OH SHIP Cert (2022). 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

Enrollment, Eligibility, & Waivers
Benefits, Claim Status, & ID Cards

Wellfleet Group, LLCPO
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

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

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.

Table of Contents

General Information

Am I Eligible

All full time students enrolled are eligible for coverage as determined by the Policyholder unless coverage is waived. Students will need to opt-in or waive the coverage.

Dependents

Dependents are not eligible.

How Do I Waive/Enroll?

Eligible Students will need to opt-in or waive the coverage following the instructions below.

To Waive:

- Go to www.wellfleetstudent.com.
- Search **Kenyon College**
- Click the waiver 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.
- Returning students should "Log in" to their existing account with Wellfleet.
- New students will have to "Create a New Account."
- 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 8/15/2022.

To Purchase coverage and Enroll yourself:

- Go to www.wellfleetstudent.com.
- Select **Kenyon College**
- Click the "Enroll" tab and proceed as directed to enroll in and purchase the student health insurance plan.
- Once enrolled, you will have the ability to print or email your online ID Card under "Student Options."

The deadline to enroll and purchase coverage for Annual coverage is 8/15/2022.

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	8/15/2022	8/14/2023	8/15/2022
Spring/Summer	1/16/2023	8/14/2023	1/16/2023

Insurance Premiums

	Annual	Spring
Student*	$2,100	$1,214

Broker Administration Fees

	Annual	Spring
Student*	$93	$54

Total Plan Costs (Premiums + Fees) for Students

	Annual	Spring
Student*	$2,193	$1,268

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

Plan Benefits

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

Pre-Certification 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 **Individual** **Combined In-network and Out-of-Network**	$250	
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**	$6,825	
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 Negotiated Charge (NC)	70% of Usual & Customary (U&C)
Preventive Services	100% of NC Deductible Waived	70% of U&C Deductible, Coinsurance, and any Copayment are applicable
Physician Office Visits including specialist and consultant visits ***Check below for additional copayments if applicable**	80% of the NC after Deductible for Covered Medical Expenses	70% of U&C Charge after Deductible for Covered Medical Expenses
Emergency Services	80% of Negotiated Charge (NC) after Deductible for Covered Medical Expenses	The cost-share is the same as In-network Provider however, the benefit will be based on the Recognized Amount.
Urgent Care	80% of Negotiated Charge (NC) after Deductible for Covered Medical Expenses	70% of U&C 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 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 & 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	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary 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 Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Maximum days per Policy Year	90	90
Inpatient Rehabilitation Facility Expense Benefit including Physical Medicine and Day Rehabilitation Therapy services Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient) Maximum Visits per Policy Year	60	60
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-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. You can obtain information on opioid over-use, prevention programs, and case management tools available for high risk individuals by calling the toll free customer service number 877-657-5030 listed on the back of Your ID card.		

Inpatient Mental Health Disorder and Substance Use Disorder Benefit, including Behavioral Health Services Including residential treatment facilities Pre-Certification Required In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-certification requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Mental Health Disorder and Substance Use Disorder Benefit, including Behavioral Health Services Pre-Certification Required except for office visits		
Physician's Office Visits including, but not limited to, Physician visits; individual and group therapy; medication management	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
All Other Outpatient Services including, but not limited to, Intensive Outpatient Programs (IOP); partial hospitalization; Electronic Convulsive Therapy (ECT); Repetitive Transcranial Magnetic Stimulation (rTMS); Psychiatric and Neuro Psychiatric testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
PROFESSIONAL AND OUTPATIENT SERVICES		
Surgical Expenses		
Inpatient and Outpatient Surgery includes: Pre-Certification Required Surgeon Services Anesthetist Assistant Surgeon	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge 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	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

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 Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Reconstructive Surgery Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Other Professional Services		
Home Health Care Expenses Pre-Certification required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Maximum visits per Policy Year	100	100
Hospice Care Coverage	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Office Visits		
Physician's Office Visits including Specialists/Consultants	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telehealth Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Allergy Testing and Treatment including injections	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Maximum visits per Policy Year	12	12
Emergency Services, Ambulance And Non-Emergency Services		
Emergency Services in an emergency department for Emergency Medical Conditions.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	The cost-share is the same as In-network Provider however, the benefit will be based on the Recognized Amount.

Urgent Care Centers for non-life-threatening conditions	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water, fixed wing and rotary wing air transportation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Non-Emergency Ambulance Service ground and/or air, water, fixed wing and rotary wing air transportation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diagnostic Laboratory, Testing and Imaging Services		
Diagnostic Imaging Services Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Including orally administered cancer drugs Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Infusion Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation and Habilitation Therapies		
Cardiac Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Cardiac Rehabilitation Maximum Visits per Policy Year	36	36
Pulmonary Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation Maximum Visits per Policy Year	20	20
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy and Inhalation Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Maximum Visits for each therapy per Policy Year for Physical Therapy, Occupational Therapy, Speech Therapy, and Inhalation Therapy	20	20
Habilitative Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required 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, limited to 20 hours per week These are separate limits and are not combined with therapy limits for other conditions.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitative Services Maximum Visits for each therapy per Policy Year for Physical Therapy, and Occupational Therapy, and Speech Therapy These limits do not apply to the above limits for the condition of Autism.	20	20
OTHER SERVICES AND SUPPLIES		
Covered Cancer 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	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Durable Medical Equipment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary 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 Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Maternity Benefit	Same as any other Covered Sickness	
Prosthetic and Orthotic Devices Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Private Duty Nursing Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Child Health Supervision Services, when Dependent Coverage is part of this Certificate.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pediatric Dental and Vision Care		
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19) Type A services: Diagnostic and Preventive care	See the Pediatric Dental Care Benefit description in the Certificate for further information. 100% of Usual and Customary Charge	
Type B services: Basic Restorative Care Type C services: Major Restorative care	50% of Usual and Customary Charge 50% of Usual and Customary Charge	
Medically Necessary Orthodontic Services	50% of Usual and Customary Charge	
Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.		
Pediatric Vision Care Benefit (including low vision services) (to the end of the month in which the Insured Person turns age 19) 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 Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived	
Miscellaneous Dental Services		
Accidental Injury Dental Treatment Limited to $3,000 per Injury per Policy Year	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Treatment for Temporomandibular (TMJ) or Craniomandibular Joint (CMJ) Disorder and Craniomandibular Jaw Disorders	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge 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. **Retail Pharmacy Supply Limits -** We will pay for no more than a 30-day supply of the Prescription Drug purchased at a retail pharmacy. You are responsible for one (1) Cost Sharing amount for up to a 30-day supply.		
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.	$10 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$10 Copayment then the plan pays 70% 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	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$20 Copayment then the plan pays 70% of Actual Charge after Deductible for Covered Medical Expenses
More than a 60 day supply filled at a Retail pharmacy	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$30 Copayment then the plan pays 70% of Actual Charge after Deductible for Covered Medical Expenses
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 the Negotiated Charge for Covered Medical Expenses Deductible Waived	$30 Copayment then the plan pays 70% 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 the Negotiated Charge for Covered Medical Expenses Deductible Waived	$60 Copayment then the plan pays 70% 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 the Negotiated Charge for Covered Medical Expenses Deductible Waived	$90 Copayment then the plan pays 70% 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 the Negotiated Charge for Covered Medical Expenses Deductible Waived	$50 Copayment then the plan pays 70% 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 the Negotiated Charge for Covered Medical Expenses Deductible Waived	$100 Copayment then the plan pays 70% 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 the Negotiated Charge for Covered Medical Expenses Deductible Waived	$150 Copayment then the plan pays 70% of Actual Charge after Deductible for Covered Medical Expenses
Specialty Prescription Drugs		
Specialty Prescription Drugs For each fill up to a 30- day supply	$100 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$100 Copayment then the plan pays 70% 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 the Negotiated Charge for Covered Medical Expenses Deductible Waived	$200 Copayment then the plan pays 70% of Actual Charge after Deductible for Covered Medical Expenses
More than a 60 day supply	$300 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$300 Copayment then the plan pays 70% of Actual Charge after Deductible for Covered Medical Expenses
Zero Cost Medications		
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.wellfleetsudent.com	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	100% of Actual Charge for Covered Medical Expenses Deductible Waived

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% of Actual Charge for Covered Medical Expenses	
Tobacco cessation prescription drugs beyond the coverage above. Additional regiments of over-the-counter drugs are excluded.	Paid the same as any other Retail Pharmacy Prescription Drug Fill	
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)		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill	
Additional Benefits		
Abortion Expense	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Adult Vision Care for Insured Persons beyond the end of the month they turn 19 Routine Eye Exam 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 Charge after Deductible for Covered Medical Expenses	
Adult Vision Hardware 1 pair of prescribed lenses and frames or contact lenses in lieu of lenses and frames per 12 month period 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 Charge after Deductible for Covered Medical Expenses	

Gender Transition Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
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 Policy Year	
Registered Nurse Services for private duty nursing while Confined	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Sickness Dental Expense beyond the end of the month the Insured Person turns 19.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Tuberculosis screening, Titers, Quantiferon B tests including shots (other than covered under preventive services)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary 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 Policy Year	
Repatriation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $25,000 maximum per Policy Year	
Student Health Center Expense	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	
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		

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 the Insured Person's 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 the Insured Person could be eligible.
- Which are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

- Received from an individual or entity that is not a Provider, as defined in this Certificate, or recognized by Us.
- Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, subject to the internal and external review process. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.
- For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to an Insured Person, then this Exclusion does not apply. This exclusion applies if the Insured Person receives the benefits in whole or in part. This exclusion also applies whether or not the Insured Person claims the benefits or compensation.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
- For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
- For court ordered testing or care unless Medically Necessary.
- For which an Insured Person has no legal obligation to pay in the absence of this or like coverage.
- For the following:
    - Physician or Other Practitioners' charges for consulting with Insured Persons by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Insured Person except as otherwise described in this Certificate.
    - Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with Providers not directly responsible for an Insured Person's care.
    - Charges that are not documented in Provider records.
    - Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
    - For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
- Received from a dental or medical department maintained by or on behalf of a School, mutual benefit association, labor union, trust or similar person or group, or as part of the Student Health Center benefits provided by this plan.
- Prescribed, ordered or referred by or received from a member of an Insured Person's immediate family, including an Insured Person's spouse, child, brother, sister, parent, in-law, or self.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For mileage, lodging and meals costs, and other Insured Person travel related expenses, except as specifically stated as a Covered Service.
- For which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if an Insured Person had applied for Parts A, B and/or D, except, as specified elsewhere in this Certificate or as otherwise prohibited by federal law, as addressed in the section titled "Medicare" in General Provisions. For the purposes of the calculation of benefits, if the Insured Person has not enrolled in Medicare Part B, We will calculate benefits as if they had enrolled.
- Charges in excess of Our Maximum Usual and Customary.
- Incurred prior to an Insured Person's Effective Date.
- Incurred after the termination date of this coverage except as specified elsewhere in this Certificate.
- For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves an Insured Person's present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

- For the following:
  - Custodial Care, convalescent care or rest cures.
  - Domiciliary care provided in a residential institution, (except for Mental Health Disorder and Substance Use Disorder treatment), treatment center, halfway house, or school because an Insured Person's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
  - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
  - Care provided or billed by a residential facility (except for Mental Health Disorder and Substance Use Disorder treatment), including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
  - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
  - Wilderness camps.
- For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
  - cleaning and soaking the feet.
  - applying skin creams in order to maintain skin tone.
  - other services that are performed when there is not a localized illness, injury or symptom involving the foot.
- For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.
- For marital counseling.
- For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- For services to reverse voluntarily induced sterility.
- For personal hygiene, environmental control, or convenience items including but not limited to:
  - Air conditioners, humidifiers, air purifiers;
  - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
  - charges for non-medical self-care except as otherwise stated;
  - Purchase or rental of supplies for common household use, such as water purifiers;
  - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
  - Infant helmets to treat positional plagiocephaly;
  - Safety helmets for Insured Persons with neuromuscular diseases; or
  - Sports helmets.
- Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
- For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or as otherwise described in this Certificate.
- For care received in an emergency room which is not Emergency Care, except as specified in this Certificate. This includes, but is not limited to suture removal in an emergency room.
- For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
- For self-help training and other forms of non-medical self-care, except as otherwise provided in this Certificate.
- For examinations relating to research screenings.
- For stand-by charges of a Physician.
- Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes except as required under Preventive Services.

- For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the ”Covered Services” section.
- For Manipulation Therapy services rendered in the home as part of Home Care Services.
- Services and supplies for sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
- For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bio energetic synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
- For surgical treatment of gynecomastia.
- Complications directly related to a service or treatment that is a non- Covered Service under this Certificate because it was determined by Us to be Experimental/Investigational or non- Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non- Medically Necessary service.
- Treatment of telangiectatic dermal veins (spider veins) by any method.
- Reconstructive services except as specifically stated in the **Covered Services** section of this Certificate, or as required by law.
- Human Growth Hormone for children born small for gestational age.
- 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.
- 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.
- Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
- Expenses that are not recommended and approved by a Physician.
- 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.
- 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.
- Sleep Disorders, except for the diagnosis and Treatment of obstructive sleep apnea.
- Charges for hot or cold packs for personal use.

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.
- 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.

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.
- Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

Family Planning:

- Cloning; or
- Medical and surgical procedures that are Experimental or Investigative, unless Our denial is overturned by an External Appeal Agent.

Vision

- Adult Vision unless specifically provided in the Certificate.
- 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.
- Prescriptions, fitting, or purchase of eyeglasses or contact lenses, except for benefits provided under Pediatric Vision, and except in the case of Injury or as otherwise provided and unless covered elsewhere in this Certificate.
- Vision correction surgery, Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision (including LASIK, radial keratotomy or keratomileusis), except as provided herein or when due to a disease process. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery for treatment of cataract or aphakia, contact lenses or glasses following lens implantation.

Dental

- Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
- Dental Implants, except for the benefit covered under the Pediatric Dental benefit, unless covered elsewhere in this Certificate.

Hearing

- Charges for hearing exams, hearing screening, hearing aids 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;
- 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;
- Any drug or medicine for the purpose of weight control;
- Fertility drugs;
- Sexual enhancements drugs;
- Vision correction products;
- For Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply, except as required for Preventive Care Services;
- Nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

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.

How to Access Services

If you require medical assistance or you need assistance with a non-medical situation, such as lost luggage, lost documents or other travel issues, follow these steps:

- Inside the U.S. and Canada:Dial toll-free **(877) 305-1966**
- Outside the U.S. and Canada:
  - **a)** Request an international operator.
  - **b)** Request the operator to place a collect call to the U.S. at **+1 (715) 295-9311**.

Please provide the following information when you call:

- Policy number or school name
- Nature of your call and/or emergency
- Current location
- Contact phone number and email address
- Secondary point of contact
- Date of birth

24 Hour Nurseline

Students who enroll and maintain medical coverage in this insurance plan have access to the 24 Hour Nurseline. This 24-Hour Nurseline program provides:

- Phone-based, reliable health information in response to health concerns and questions; and
- Assistance in decisions on the appropriate level of care for an injury or sickness.

Appropriate care may include:

- self-care at home
- a call to a physician
- or a visit to the emergency room.

Calls are answered 24 hours a day, 365 days a year by experienced registered nurses who have been specifically trained to handle telephone health inquiries.

This program is not a substitute for doctor visits or emergency response systems. The Nurseline does not answer health plan benefit questions. Health benefit questions should be referred to the Plan Administrator. The 24 Hour Nurseline toll free number will be on the ID card.
(800) 634-7629

CareConnect
Integrated Behavioral Health from Wellfleet Student

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.