



UNIVERSITY OF  
**NORTHERN**  
**COLORADO**

# BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2023/2024

**DESIGNED EXCLUSIVELY FOR THE STUDENTS  
OF:**

**UNIVERSITY OF NORTHERN  
COLORADO**

Greeley, CO

("the Policyholder")

**UNDERWRITTEN BY:**

Wellfleet Insurance Company | Fort Wayne, IN

("the Company")

Policy Number: WI2324COSHIP03

Group Number: ST1554SH

Effective: 8/17/2023 – 8/16/2024

**ADMINISTERED BY:**

Wellfleet Group, LLC



**WELLFLEET**  
STUDENT

## Welcome Students...

We are pleased to provide you with this summary of the 2023 – 2024 Student Health Insurance Plan (“Plan”), which is fully compliant with the Affordable Care Act. This is only a brief description of the coverage(s) available under Certificate form CO SHIP Cert (2023). The Certificate will contain reductions, limitations, exclusions, and termination provisions. Full details of coverage are contained in the Certificate. If there are any conflicts between this document and the Certificate, the Certificate shall govern in all cases.

“Benefits at a Glance” includes effective dates and costs of coverage, as well as other helpful information. For additional details about the Plan, please consult the Plan Certificate and other materials at [www.wellfleetstudent.com](http://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.

### **PENDING STATE APPROVAL**

**The Plan described in “Benefits at a Glance” is awaiting approval by the CO Department of Insurance. If the Plan is changed during the approval process, a revision of this document will be provided. This is not an insurance policy and your receipt of this document does not constitute the issuance or delivery of a policy of insurance.**

## 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**  
Academic HealthPlans  
[unco.myahpcare.com](http://unco.myahpcare.com)

**Waivers**  
970-351-1915  
email [nicky.weglin@unco.edu](mailto:nicky.weglin@unco.edu).

### Benefits, Claim Status, & ID Cards

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

### Claims

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



### PPO Network



Cigna  
[www.mycigna.com](http://www.mycigna.com)



### Pharmacy Benefits Manager

For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit [www.wellfleetstudent.com](http://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**



### Student Health Center

**Cassidy Hall**  
1901 10<sup>th</sup> Ave.  
Greeley, CO 80639  
Phone: 970-351-2412  
Fax: 970-351-2427

It is recommended that students seek care first at the Student Health Center (SHC) where treatment for most issues can be handled. Simple visits and in house tests are covered at 100% with a \$20 copay. If lab work or other items are sent off campus, the \$500 deductible and co-insurance would apply.



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



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## General Information

### Am I Eligible

All degree seeking Domestic undergraduate students taking nine (9) or more credit hours regardless of the type of class (on campus, off campus or online) and all degree seeking Domestic graduate students taking six (6) or more credit hours regardless of the type of class (on campus, off campus or online) are required to have health insurance and are automatically enrolled and the premium will be added to the student's tuition fees. These students have the option to waive the insurance if they complete an on-line waiver in URSA by the 10th day of classes.

If you discover after the 10th day that you are not being billed for the insurance, you can complete an enrollment form. No back-dating of the coverage will be done. Coverage will begin on the date the insurance company receives the enrollment.

Domestic undergraduate students taking less than nine (9) credit hours and Domestic graduate students taking less than six (6) credit hours and Domestic graduate students that are not in a degree seeking program are not eligible to participate in the UNC Student Health Insurance Plan. They may, however contact Academic Health Plans at (855) 825-3985, who will assist then in finding individual coverage.

All international students with one (1) or more credit hours will be automatically enrolled in the Student Health Insurance Plan and the premium will be added to the student's tuition fees without the option to waive unless they are currently enrolled in a government sponsored US accepted insurance plan.

Students who waived the student insurance in a previous semester but want to be on the insurance for the current semester may complete a request for re-enrollment. If you request the re-enrollment and pay the required premium amount during the open enrollment period at the start of the semester (no later than the 10th class day), you will be insured with the student insurance beginning on the effective date of coverage for that semester. You must meet the other enrollment criteria as stated in this document.

If you want to enroll in the student insurance after the open enrollment period, you must show proof of your other coverage. Coverage will begin on the date the insurance company receives the enrollment form and required premium amount. Coverage will not be back-dated or pro-rated.

Summer Enrollment: Students enrolling for summer classes may purchase the Student Health Insurance, provided they meet the eligibility criteria. Students need to complete an enrollment form during the open enrollment period. No back dating or pro-rating of the coverage will be done. Coverage will begin on the date the insurance company approves the enrollment.

Students must attend classes for at least the first 31 days of the period for which he or she is enrolled unless he or she withdraws due to an Injury or Sickness during the first 31 days of the period for which he or she is enrolled, and the absence is an approved medical leave. The Company maintains its right to investigate student status and attendance records to verify that the eligibility requirements have been and continue to be met. If the Company discovers the eligibility requirements have not been met, its only obligation is refund of premium less any claims paid. Please contact the Student Health Insurance Office at (970) 351-1915 for additional details on eligibility.

If you no longer meet the eligibility requirements contact Academic Health Plans at [unco.myahpcare.com](http://unco.myahpcare.com) or at [help.ahpcare.com](http://help.ahpcare.com) prior to your termination date.

### Dependents

Dependents are not eligible.

### How Do I Waive?

To waive out of the Student Health Insurance Plan please complete the online student health insurance waiver in your URSA account prior to the deadline, which is always the 10<sup>th</sup> day of classes. If you have any questions please reach out to Nicky Weglin at 970-351-1915 or email [nicky.weglin@unco.edu](mailto:nicky.weglin@unco.edu).

## 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
Fall	08/17/2023	12/31/2023
Spring/Summer	01/01/2024	08/16/2024
Summer	05/11/2024	08/16/2024

### Plan Costs for Students

	Fall	Spring/Summer	Summer
Student*	\$1,560	\$1,560	\$838

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

## Plan Benefits

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

Pre-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
<b>Policy Year Deductible Individual (Deductible is waived if Covered Medical Expenses are incurred at the Student Health Center)</b>	\$500	\$1,000
<b>Prescription Drug Deductible</b> Combined In-network and Out of Network Provider	\$100 (The Prescription Drug Deductible does not apply toward the medical Deductible.)	
Cost sharing You incur for Covered Medical Expenses that is applied to the Out-of-Network Deductible will not be applied to satisfy the In-Network Deductible. Cost sharing You incur for Covered Medical Expenses that is applied to the In-Network Deductible will not be applied to satisfy the Out-of-Network Provider Deductible.		
<b>Out-of-Pocket Maximum Combined In-Network and Out-of-Network</b>	\$8,550	
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.		
<b>Coinsurance</b>	80% of The Negotiated Charge (NC)	50% of Usual & Customary Charge (U&C)
<b>Preventive Services</b>	100% of the NC Charge for Covered Medical Expenses Deductible Waived	50% of U&C Charge after Deductible for Covered Medical Expenses
<b>Physician Office Visits including specialist and consultant</b>	\$20 Copayment per visit then the plan pays 100% of the NC Charge for Covered Medical Expenses Deductible Waived	50% of U&C Charge after Deductible for Covered Medical Expenses
<b>Emergency Services</b> in an emergency department for Emergency Medical Condition	\$150 Copayment per visit after Deductible then the plan pays 80% of the NC Charge for Covered Medical Expenses	Paid the same as In-Network Provider subject to U&C. Charge
<b>Urgent Care Centers</b> for non-life-threatening conditions	80% of the NC Charge after Deductible for Covered Medical Expenses	50% of U&C Charge after Deductible for Covered Medical Expenses

**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

## Schedule of Benefits

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK	OUT-OF-NETWORK
<b>INPATIENT SERVICES</b>		
Hospital Care Includes Hospital Room & Board Expenses and Hospital Miscellaneous Expenses. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary 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	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Registered Nurse Services for private duty nursing while Confined	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
<b>BEHAVIORAL, MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER BENEFITS</b>		
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.		
<b>Inpatient Behavioral Mental Health Disorder and Substance Use Disorder Benefit</b> Pre-Certification Required	Same as any other Covered Sickness	



<p><b>Outpatient Behavioral Mental Health Disorder and Substance Use Disorder Benefit</b></p> <p>Physician’s Office Visits including, but not limited to, Physician visits; individual and group therapy; medication management.</p> <p>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</p>	<p>Same as any other Covered Sickness</p> <p>Deductible Waived</p>	
<b>PROFESSIONAL AND OUTPATIENT SERVICES</b>		
<b><i>Surgical Expenses</i></b>		
<p><b>Inpatient and Outpatient Surgery includes:</b> Pre-Certification Required Surgeon Services Anesthetist Assistant Surgeon</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Outpatient Surgical Facility and Miscellaneous expenses for services &amp; supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood &amp; plasma.</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Bariatric Surgery Pre-Certification Required</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Organ Transplant Surgery travel and lodging expenses a maximum of \$2,000 per Policy Year or \$250 per day, whichever is less while at the transplant facility. Pre-Certification Required</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Organ Transplant- Donor Surgery</p>	<p>100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived</p>	<p>100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived</p>
<p>Reconstructive Surgery Pre-Certification Required</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>

<b>Other Professional Services</b>		
Gender Affirming Treatment Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Maximum hours per week	28	28
Hospice Care Coverage	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
<b>Office Visits</b>		
Physician's Office Visits including Specialists/Consultants	\$20 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telemedicine or Telehealth Services	\$20 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Acupuncture Services (Medically Necessary Treatment only)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Acupuncture Services Maximum visits per Policy Year	30	30
Allergy Testing and Treatment including injections	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Maximum visits per Policy Year	30	30
Shots and Injections unless considered Preventive Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Tuberculosis screening (TB), Titers, QuantiFERON B tests including shots (other than covered under Preventive Services)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses

<b>EMERGENCY SERVICES, AMBULANCE AND NON-EMERGENCY SERVICES</b>		
Emergency Services in an emergency department for Emergency Medical Conditions.	\$150 Copayment per visit after Deductible then the plan pays 80% of the Negotiated Charge for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Urgent Care Centers for non-life-threatening conditions	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	70% 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 Expenses ground and/or air(fixed wing) transportation Pre-Certification Required for non-emergency air Ambulance (fixed wing)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
<b>DIAGNOSTIC LABORATORY, TESTING AND IMAGING SERVICES</b>		
Diagnostic Imaging Services Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% 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	50% 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	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
<b>REHABILITATION AND HABILITATION THERAPIES</b>		
Cardiac Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Rehabilitation Therapy Maximum Visits for each therapy per Policy Year for Physical Therapy, Occupational Therapy and Speech Therapy Combined with Habilitation Services Therapy.  The Maximum Visits do not apply to Rehabilitation Therapy for a Mental Health Disorder or Substance Use Disorder.	60	60
Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitation Services Maximum Visits for each therapy per Policy Year for Physical Therapy, Occupational Therapy and Speech Therapy Combined with Rehabilitation Services  The Maximum Visits do not apply to Habilitation Therapy for a Mental Health Disorder or Substance Use Disorder	60	60
<b>OTHER SERVICES AND SUPPLIES</b>		
Covered Clinical Trials	Same as any other Covered Sickness	
Diabetic Services and Supplies (including equipment and training)  Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Durable Medical Equipment Pre-certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% 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	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hearing Aids for Minors (to the end of the month in which the Insured Person turns age 18)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Initial and replacement hearing aids Limited to 1 pair of hearing aids per 48-month period.  A new hearing aid will be a covered service when alterations to Your existing hearing aid cannot adequately meet Your needs or be repaired.		
Infertility Treatment including Standard Fertility Preservation Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% 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	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Student Health Center/Infirmary Expense Benefit	\$20 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	
Sports Accident Expense Benefit - incurred as the result of the play or practice of Intercollegiate sports Up to \$5,000 per Accident	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Non-emergency Care While Traveling Outside of the United States	50% of Actual Charge after Deductible for Covered Medical Expenses Subject to \$10,000 maximum per Policy Year	
<b>PEDIATRIC AND ADULT DENTAL AND VISION CARE</b>		
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)  Preventive Dental Care Limited to 2 dental exams every 12 months  The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care:  Emergency Dental  Routine Dental Care  Endodontic Services  Prosthodontic Services	See the Pediatric Dental Care Benefit description in the Certificate for further information.  100% of Usual and Customary Charge for Covered Medical Expenses  50% of Usual and Customary Charge for Covered Medical Expense  50% of Usual and Customary Charge for Covered Medical Expenses  50% of Usual and Customary Charge for Covered Medical Expenses  50% of Usual and Customary Charge for Covered Medical Expenses	

<p>Periodontic Services</p> <p>Medically Necessary Orthodontic Care</p> <p>Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.</p>	<p>50% of Usual and Customary Charge for Covered Medical Expenses</p> <p>50% of Usual and Customary Charge for Covered Medical Expenses</p>	
<p>Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19)</p> <p>Limited to 1 vision examination per Policy Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year</p> <p>Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.</p>	<p>100% of Usual and Customary Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	
<p>Adult Vision Care (age 19 and older)</p> <p>Routine Eye Examination once every 12 months</p> <p>Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions</p>	<p>100% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>	
<p><b>MISCELLANEOUS DENTAL SERVICES</b></p>		
<p>Accidental Injury Dental Treatment</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Sickness Dental Expense Benefit Subject to \$500 per Tooth</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p>Treatment for Temporomandibular Joint (TMJ) Disorders</p>	<p>80% of the Negotiated Charge after Deductible for Covered Medical Expenses</p>	<p>50% of Usual and Customary Charge after Deductible for Covered Medical Expenses</p>
<p><b>PRESCRIPTION DRUGS</b></p>		
<p><b>Prescription Drugs Retail Pharmacy</b></p> <p>No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy or Student Health Center.</p> <p>UNLESS OTHERWISE SPECIFIED BELOW THE PRESCRIPTION DRUG DEDUCTIBLE WILL ALWAYS APPLY. PLEASE NOTE: IF THE PRESCRIPTION DRUG DEDUCTIBLE APPLIES, THE MEDICAL DEDUCTIBLE WILL NOT APPLY. THE PRESCRIPTION DRUG</p>		

<p>DEDUCTIBLE <b>DOES NOT APPLY</b> TOWARDS ANY APPLICABLE MEDICAL DEDUCTIBLE AND THE MEDICAL DEDUCTIBLE DOES NOT APPLY TOWARD ANY APPLICABLE PRESCRIPTION DRUG DEDUCTIBLE</p> <p>Your benefit is limited to a 30 day supply. Coverage for more than a 30 day supply only applies if the smallest package size exceeds a 30 day supply. See “Retail Pharmacy Supply Limits” section for more information.</p>		
<p>TIER 1 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy</p> <p>Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.</p> <p>See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.</p>	<p>\$20 Copayment after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p>	<p>\$20 Copayment after Deductible then the plan pays 50% of Actual Charge for Covered Medical Expenses</p>
<p>More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy</p>	<p>\$40 Copayment after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p>	<p>\$40 Copayment after Deductible then the plan pays 50% of Actual Charge for Covered Medical Expenses</p>
<p>More than a 60 day supply filled at a Retail pharmacy</p>	<p>\$60 Copayment after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p>	<p>\$60 Copayment after Deductible then the plan pays 50% of Actual Charge for Covered Medical Expenses</p>
<p>TIER 2 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy</p> <p>Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.</p> <p>See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.</p>	<p>\$50 Copayment after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p>	<p>\$50 Copayment after Deductible then the plan pays 50% of Actual Charge for Covered Medical Expenses</p>
<p>More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy</p>	<p>\$100 Copayment after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses</p>	<p>\$100 Copayment after Deductible then the plan pays 50% of Actual Charge for Covered Medical Expenses</p>

More than a 60 day supply filled at a Retail pharmacy	\$150 Copayment after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	\$150 Copayment after Deductible then the plan pays 50% of Actual Charge for Covered Medical Expenses
<p>TIER 3 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail Pharmacy</p> <p>Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.</p> <p>See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.</p>	\$70 Copayment after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	\$70 Copayment after Deductible then the plan pays 50% of Actual Charge for Covered Medical Expenses
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	\$140 Copayment after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	\$140 Copayment after Deductible then the plan pays 50% of Actual Charge for Covered Medical Expenses
More than a 60 day supply filled at a Retail pharmacy	\$210 Copayment after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	\$210 Copayment after Deductible then the plan pays 50% of Actual Charge for Covered Medical Expenses
<b>Specialty Prescription Drugs</b>		
<p>For each fill up to a 30 day supply.</p> <p>Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.</p>	\$70 Copayment after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	\$70 Copayment after Deductible then the plan pays 50% of Actual Charge for Covered Medical Expenses
More than a 30 day supply but less than a 61 day supply	\$140 Copayment after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	\$140 Copayment after Deductible then the plan pays 50% of Actual Charge for Covered Medical Expenses
More than a 60 day supply	\$210 Copayment after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	\$210 Copayment after Deductible then the plan pays 50% of Actual Charge for Covered Medical Expenses
<b>Zero Cost Drugs</b>		
Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer	<p>100% of the Negotiated Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>	<p>100% of Actual Charge for Covered Medical Expenses</p> <p>Deductible Waived</p>



to Proof of Loss provision contained in the General Provisions.		
<b>Orally administered anti-cancer Prescription Drugs (including Specialty Drugs)</b>		
Benefit	Greater of: Chemotherapy Benefit; or Infusion Therapy Benefit	
<b>Diabetic Supplies (for prescription supplies purchased at a pharmacy)</b>		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill except that the Insured Person's out-of-pocket costs for covered prescription insulin drugs will not exceed \$100 per 30- day supply per supply of insulin and \$300 per 90- day supply of insulin	
<b>Prescription eye drops</b>		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill	
<b>Mandated Benefits</b>		
Cleft Lip and Cleft Palate	Same as any other Covered Sickness	
Autism Spectrum Disorders Benefit	Same as any other Covered Sickness	

## Exclusions and Limitations

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

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

### General Exclusions

- **International Students Only** - Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible.
- Treatment, service or supply which is not Medically Necessary for the diagnosis, care or Treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended or approved by the Student Health Center or by Your attending Physician or dentist.
- Medical services rendered by a provider employed for or contracted with the Policyholder, including team Physicians or trainers, except as specifically provided in the Schedule of Benefits or as part of the Student Health Center benefits provided by this plan.
- Professional services rendered by an Immediate Family Member or anyone who lives with You.
- Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services covered by Student Health Fees.
- Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
- Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which You are required to pay.
- Services that are duplicated when provided by both a certified Nurse midwife and a Physician.
- Expenses payable under any prior policy which was in force for the person making the claim.
- Loss resulting from war or any act of war, whether declared or not, or Loss sustained while in the armed forces of any country or international authority.
- Injury sustained as the result of Your operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle Accident takes place.

- Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
- Expenses incurred after:
  - The date insurance terminates as to an Insured Person, except as specified in the extension of benefits provision; and
  - The end of the Policy Year specified in the Policy.
- Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
- You are:
  - committing or attempting to commit a felony,
  - engaged in an illegal occupation, or
  - participating in a riot.
- Custodial Care service and supplies.
- Charges for hot or cold packs for personal use.
- Services of private duty Nurse except as provided in the Certificate.
- Expenses that are not recommended and approved by a Physician.
- Experimental or Investigative drugs, devices, Treatments or procedures unless otherwise covered under Covered Clinical Trials. See the Other Benefits section for more information.
- Routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal 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 a sleep study performed in the Insured Person's home, the diagnosis and Treatment of obstructive sleep apnea.
- Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary because of Injury, infection or disease.

#### **Activities Related:**

- Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any club sports for which benefits are paid under another Sports Accident policy issued to the Policyholder; or for which coverage is provided by the National Collegiate Athletic Association (NCAA), National Association of Intercollegiate Athletic (NAIA) or any other sports association in excess of \$5,000.00 per Intercollegiate sports Accident.
- Racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles).

#### **Weight Management/Reduction**

- Weight management. Weight reduction. Nutrition programs. This does not apply to nutritional counseling or any screening or assessment specifically provided under the Preventive Services benefit, or otherwise specifically covered

under the Certificate.

- Treatment for obesity except surgery for morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat.

#### **Family Planning:**

- Infertility Treatment (male or female)-this includes but is not limited to:
  - Procreative counseling;
  - Premarital examinations;
  - Genetic counseling and genetic testing;
  - Impotence, organic or otherwise;
  - Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
  - In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
  - Costs for an ovum donor or donor sperm;
  - Sperm storage costs;
  - Cryopreservation and storage of embryos;
  - Ovulation induction and monitoring;
  - Artificial insemination;
  - Hysteroscopy;
  - Laparoscopy;
  - Laparotomy;
  - Ovulation predictor kits;
  - Reversal of tubal ligations;
  - Reversal of vasectomies;
  - Costs for and relating to surrogate motherhood (maternity services are covered for Insured Persons acting as surrogate mothers);
  - Cloning; or
  - Medical and surgical procedures that are Experimental or Investigative, unless Our denial is overturned by an External Appeal Agent.
- Elective abortions.

#### **Vision**

- Expenses for radial keratotomy.
- Adult Vision unless specifically provided in the Certificate.
- Charges for 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.

#### **Dental**

- Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.

#### **Hearing**

- Charges for hearing exams, hearing screening, hearing aids for adult and the fitting or repair or replacement of hearing aids or cochlear implants except as specifically provided in the Certificate.

#### **Cosmetic**

- Treatment of Acne unless Medically Necessary.
- Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
- Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma.

**Prescription Drugs**

- Any drug or medicine which does not, by federal or state law, require a prescription order, i.e. over-the-counter drugs, even if a prescription is written, except as specifically provided under Preventive Services or in the Prescription Drug Benefit section of this Certificate. Insulin and OTC preventive medications required under ACA are exempt from this exclusion;
- Drugs with over-the-counter equivalents except as specifically provided under Preventive Services;
- Allergy sera and extracts administered via injection;
- Vitamins, and minerals, except as specifically provided under Preventive Services;
- Food supplements, dietary supplements; except as specifically provided in the Certificate;
- Cosmetic drugs or medicines including, but not limited to, products that improve the appearance of wrinkles or other skin blemishes;
- Refills in excess of the number specified or dispensed after 1 year of date of the prescription;
- Drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
- Any drug or medicine purchased after coverage under the Certificate terminates;
- Any drug or medicine consumed or administered at the place where it is dispensed;
- If the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
- Prescription digital therapeutics;
- Bulk chemicals;
- Non-insulin syringes, surgical supplies, Durable Medical Equipment/medical devices, except as specifically provided in the Prescription Drug Benefit section of the Certificate;
- Repackaged products;
- Blood components except factors;
- Any drug or medicine for the purpose of weight control;
- Sexual enhancements drugs;
- Vision correction products.

## VALUE ADDED SERVICES

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

### VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:

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

### 24 Hour Nurseline

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

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

Appropriate care may include:

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

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

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

(800) 634-7629



### 24/7 Behavioral Telehealth and Nurseline Access

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

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