BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2022/2023

DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

UNIVERSITY OF LA VERNE

La Verne, CA
("the Policyholder")

Policy Number: WI2223CASHIP144

Group Number: ST1828SH

Effective: 08/15/2022 – 08/14/2023

UNDERWRITTEN BY:

Wellfleet Insurance Company | Fort Wayne, IN

("the Company")

ADMINISTERED BY:

Wellfleet Group, LLC dba Wellfleet Administrators, 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 CA 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
dba Wellfleet
Administrators, LLC
PO Box 15369
Springfield, Massachusetts 01115-5369
(877) 657-5030, TTY 711

Plan Administration

Enrollment, Eligibility, & Waivers

Gallagher Student Health
500 Victory Road
Quincy, MA 02171
(617) 770-9889

Benefits, Claim Status, & ID Cards

Wellfleet Group, LLC
dba Wellfleet
Administrators, LLC
PO Box 15369
Springfield, Massachusetts 01115-5369
(877) 657-5030, TTY 711
www.wellfleetstudent.com

Monday–Thursday, 8:30 a.m. to 7:00 p.m.
Eastern Time

Friday, 9:00 a.m. to 5:00 p.m.
Eastern Time

Claims

Wellfleet Group, LLC
dba Wellfleet
Administrators, LLC
PO Box 15369
Springfield, Massachusetts 01115-5369
Electronic Payor ID: 62308

PPO Network

First Health
www.firsthealthbp.com

Pharmacy Benefits Manager

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

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

Member Pharmacy Help

(877) 640-7940

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

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General Information

Am I Eligible

All students enrolled in and attending classes on the main campus of the University are eligible to enroll in the Plan. Traditional full-time (taking at least 12 or more credits) domestic undergraduate students, all international undergraduate students, and international graduate students taking at least three (3) or more credits are required to enroll in the Plan. Part-time domestic undergraduate students (taking at least six (6) or more credits), full-time domestic graduate students, (taking at least nine (9) or more credits) and part-time domestic graduate students (taking at least three (3) or more credits) may enroll in the Plan on a voluntary basis by the Enrollment Deadline Date.

Dependents

Dependents are not eligible.

Effective Dates & Costs

All time periods begin at 12:00 A.M. local time and end at 11:59 P.M. local time at the Policyholder's address.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline Date
Fall	08/15/2022	01/02/2023	08/31/2022
Spring/Summer	01/03/2023	08/14/2023	02/08/2023

Plan Costs for Full-time and Part-time Domestic Undergraduate and all International Undergraduate Students

	Fall	Spring/Summer
Student*	$490	$490

Plan Costs for International Graduate Students

	Fall	Spring/Summer
Student*	$765	$765

Plan Costs for and all Domestic Graduate Students

	Fall	Spring/Summer
Student*	$765	$765

***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-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 (Medical **Deductible** is waived if Covered Medical Expenses are incurred at the Student Health Center)	$250	$750
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.		
Out-of-Pocket Maximum Individual	$7,500	$22,500
Cost sharing You incur for Covered Medical Expenses that is applied to the Out-of-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the In-Network Provider Out-of-Pocket Maximum and cost sharing You incur for Covered Medical expenses that is applied to the In-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the Out-of-Network Provider Out-of-Pocket Maximum.		
Coinsurance	90% of Negotiated Charge (NC)	70% of Usual & Customary (U&C)
Preventive Services	100% of NC Deductible Waived	70% of U&C Subject to Deductible and any Copayments
Physician Office Visits including specialist and consultant visits ***Check below for additional copayments if applicable**	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	70% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Services in an emergency department for Emergency Medical Conditions.	90% of the Negotiated Charge after Deductible 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	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of Usual and Customary Charge 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	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Maximum days per Policy Year	100	100
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Registered Nurse Services for private duty nursing while Confined	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses

MENTAL HEALTH 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 and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.		
Inpatient Mental Health and Substance Use Disorder Benefits Pre-Certification Required Inpatient Treatment for Mental Health, including Gender Dysphoria and Behavioral Health Treatment for Pervasive Developmental Disorder or Autism and Substance Use Disorders. This includes inpatient Psychiatric and Residential Treatment Centers	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Mental Health and Substance Use Disorder Benefit For the Treatment of Mental Health, including Gender Dysphoria and Behavioral Health Treatment for Pervasive Developmental Disorder or Autism and Substance Use Disorders. Outpatient Office Visits (including but not limited to the following: Physician visits, individual and group therapy, hormone therapy, medication management) Outpatient Services, other than Office Visits. Outpatient services includes, but not limited to the following: Intensive Outpatient Programs (IOP); Partial Hospitalization, Electronic Convulsive Therapy (ECT), Repetitive Transcranial Magnetic Stimulation (rTMS); Psychiatric and Neuro Psychiatric testing; and *Gender Transition surgery. *Pre-Certification Required	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived 90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses 70% of the 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	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the 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	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Abortion Expense	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Bariatric Surgery Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Organ Transplant Surgery travel and lodging expenses a maximum of $2,000 per Policy Year or $250 per day, whichever is less	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Reconstructive Surgery Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Other Professional Services		
Gender Transition Benefit	See benefits for Mental Health Disorder and Substance Use Disorder	
Home Health Care Expenses Pre-Certification required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Hospice Care Coverage	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Office Visits		
Physician's Office Visits including Specialists/Consultants For Mental Health and Substance Use Disorder benefit see the Mental Health and Substance Use Disorder Benefit section	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Telemedicine or Telehealth Services	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Acupuncture Services (Medically Necessary Treatment) only	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses

Allergy Testing and Treatment including injections	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Shots and Injections unless considered Preventive Services	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Tuberculosis (TB) screening, Titers, QuantiFERON B tests including shots (other than covered under preventive services)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Services, Ambulance And Non-Emergency Services		
Emergency Services in an emergency department for Emergency Medical Conditions.	90% of the Negotiated Charge after Deductible 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	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	90% 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 transportation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Diagnostic Laboratory, Testing and Imaging Services		
Diagnostic Imaging Services Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses

Rehabilitation and Habilitation Therapies		
Cardiac Rehabilitation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
OTHER SERVICES AND SUPPLIES		
Covered Clinical Trials	Same as any other Covered Sickness	
Diabetic services and supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Durable Medical Equipment Pre-Certification Required	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the 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.	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the 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	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Student Health Center/Infirmary Expense Benefit	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	
Non-emergency Care While Traveling Outside of the United States	70% of Actual Charge after Deductible for Covered Medical Expenses	

Bedside Visits	100% of Actual Charge after Deductible for Covered Medical Expenses Subject to $1,000 maximum per Policy Year
Medical Evacuation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived
Repatriation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived
Pediatric and Adult Dental and Vision Care	
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19) Preventive Dental Care Limited to 1 dental exams every 6 months The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care: Type A services: Diagnostic and Preventive care Type B services: Basic Restorative Care Type C services: Major Restorative care Medically Necessary Orthodontic Care Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	See the Pediatric Dental Care Schedule of Benefits below and Pediatric Dental Care Benefit description for further information. 100% of Usual and Customary Charge after Deductible for Covered Medical Expenses 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pediatric Vision Care Benefit (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.	See the Pediatric Vision Care Benefit description for further information. 100% of Usual and Customary Charge after Deductible for Covered Medical Expenses per Policy Year

Adult Vision Care (age 19 and older) 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	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived	
Miscellaneous Dental Services		
Accidental Injury Dental Treatment	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the Usual and Customary Charge after Deductible for Covered Medical Expenses
Surgical Services Directly Affecting the Upper or Lower Jawbone Benefit	90% of the Negotiated Charge after Deductible for Covered Medical Expenses	70% of the 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 or Student Health Center.		
TIER 1 (Including Enteral Formulas) For each fill up to a 30-day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$10 Copayment then the plan pays 100% of Negotiated Charge for Covered Medical Expenses Deductible Waived Copayment waived for Generic Contraceptive Prescription Drugs and Brand Name Contraceptive Prescription Drugs for which there are no therapeutic equivalent. Up to a 12-month supply of contraceptives may be dispensed with a single prescription order.	70% of Actual Charge for Covered Medical Expenses Deductible Waived Copayment waived for Generic Contraceptive Prescription Drugs and Brand Name Contraceptive Prescription Drugs for which there are no therapeutic equivalent. Up to a 12-month supply of contraceptives may be dispensed with a single prescription order.
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 Negotiated Charge for Covered Medical Expenses Deductible Waived	70% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60-day supply filled at a Retail pharmacy	$30 Copayment then the plan pays 100% of Negotiated Charge for Covered Medical Expenses Deductible Waived	70% of Actual Charge for Covered Medical Expenses Deductible Waived

TIER 2 (Including Enteral Formulas) For each fill up to a 30-day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. 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 Negotiated Charge for Covered Medical Expenses Deductible Waived	70% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 30-day supply but less than a 61-day supply filled at a Retail pharmacy	$60 Copayment then the plan pays 100% of Negotiated Charge for Covered Medical Expenses Deductible Waived	70% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60-day supply filled at a Retail pharmacy	$90 Copayment then the plan pays 100% of Negotiated Charge for Covered Medical Expenses Deductible Waived	70% of Actual Charge for Covered Medical Expenses Deductible Waived
TIER 3 (Including Enteral Formulas) For each fill up to a 30-day supply filled at a Retail Pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$50 Copayment then the plan pays 100% of Negotiated Charge for Covered Medical Expenses Deductible Waived	70% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 30-day supply but less than a 61-day supply filled at a Retail pharmacy	$100 Copayment then the plan pays 100% of Negotiated Charge for Covered Medical Expenses Deductible Waived	70% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60-day supply filled at a Retail pharmacy	$150 Copayment then the plan pays 100% of Negotiated Charge for Covered Medical Expenses Deductible Waived	70% of Actual Charge for Covered Medical Expenses Deductible Waived

Specialty Prescription Drugs		
Specialty Prescription Drugs For each fill up to a 30-day supply. 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.	$50 Copayment then the plan pays 100% of Negotiated Charge for Covered Medical Expenses Deductible Waived	70% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 30-day supply but less than a 61-day supply	$100 Copayment then the plan pays 100% of Negotiated Charge for Covered Medical Expenses Deductible Waived	70% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60-day supply	$150 Copayment then the plan pays 100% of Negotiated Charge for Covered Medical Expenses Deductible Waived	70% of Actual Charge for Covered Medical Expenses Deductible Waived
Zero Cost Medications		
Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	100% of Actual Charge for Covered Medical Expenses Deductible Waived
Orally administered anti-cancer prescription drugs (including specialty drugs)		
Benefit	Same as any other Prescription Drug. The total amount of Copayments and Coinsurance an Insured Person must pay will not exceed $250 for an individual prescription of up to a 30-day supply.	
Diabetic Supplies (for Prescription supplies purchased at a pharmacy)		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill	
Mandated Benefits		
AIDS Vaccine	Same as any other Preventive Service	
Alzheimer's Disease Coverage	Same as any other Covered Sickness	
Behavioral Health Treatment for Pervasive Developmental Disorder or Autism	See benefits for Mental Health and Substance Use Disorder	
Dental Anesthesia	Same as any other Covered Sickness	
Diethylstilbestrol (DES) Coverage	Same as any other Covered Sickness	
Mastectomy Benefit	Same as any other Covered Sickness	
Osteoporosis	Same as any other Preventive Service	
Special Shoe Benefit	Same as any other Covered Sickness	

Accidental Death and Dismemberment	
Principal Sum	$10,000
Loss must occur within 365 days of the date of a covered Accident.	
Only one benefit will be payable under this provision, that providing the largest benefit, when more than one (1) loss occurs as the result of any one (1) Accident. This benefit is payable in addition to any other benefits payable under this Certificate.	

Exclusions and Limitations

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

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

General Exclusions

- **International Students Only -** Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible.
- Treatment, service or supply which is not Medically Necessary for the diagnosis, care or Treatment of the sickness or injury involved. This applies even if they are prescribed, recommended or approved by the Student Health Center or 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 licensed midwife and a Physician.
- Expenses payable under any prior policy which was in force for the person making the claim.
- Expenses paid by Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medi-Cal.
- 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 Services and Supplies 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.
- Non-chemical addictions.
- Non-physical, occupational, speech therapies (art, dance, etc.).
- Modifications made to dwellings.
- General fitness, exercise programs.
- Hypnosis.
- Rolfing.
- Biofeedback.
- Sleep Disorders, unless medically necessary, except for 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.

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 Members 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.

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.
- Extraction of impacted wisdom teeth or dental abscesses.

Hearing

- Charges for hearing screening, hearing aids 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.

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

VALUE ADDED SERVICES

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

VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:
www.wellfleetstudent.com

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.