Bryant UNIVERSITY

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2024/2025

DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

BRYANT UNIVERSITY

Smithfield, RI

("the Policyholder")

Policy Number: WI2425RISHIP50

Group Number: ST2238SH

Effective: 8/15/2024 – 8/14/2025

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 2024 – 2025 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 RI SHIP Cert (2024). 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 bein 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. 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

Servicing Agent

Risk Strategies Education, University Health Plans
PO Box 818078
Cleveland, OH 44181
(833)251-1735
Email: info@univhealthplans.com

Plan Administration

Enrollment, Eligibility, & Waivers

Risk Strategies Education, University Health Plans
PO Box 818078
Cleveland, OH 44181
(833)251-1735
www.universityhealthplans.com
(833)251-1735

Benefits, Claim Status, & ID Cards

Wellfleet Group, 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

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

PPO Network

www.mycigna.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

Student Health Center

BRYANT UNIVERSITY HEALTH SERVICES
Barrington House
(401) 232-6220
bhs@bryant.edu
Hours: Mondays through Fridays
8:30 a.m. - 4:30 p.m.

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

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General Information

Am I Eligible?

Domestic Students
All full-time Domestic Students, taking 12+ credit hours, are eligible to enroll in this Student Health Insurance Plan on a voluntary basis. Eligible domestic students who wish to enroll must complete the enrollment process by the enrollment deadline date.

International Students
All International Students, taking 1+ credit hours, will be automatically enrolled in the Student Health Insurance Plan and the cost for the coverage will be added to the student's tuition fees unless proof of comparable coverage is submitted by the waiver deadline date.

International Student Athletes
Coverage is mandatory for international student athletes. All international student athletes will be automatically enrolled in and charged for the Student Health Insurance Plan and are not eligible to submit a waiver.

Dependents
Dependents are not eligible.

How Do I Waive/Enroll?

To Waive or enroll in coverage:
Domestic Students
Eligible domestic students who wish to enroll must complete the enrollment process by the enrollment deadline date. You will not be automatically enrolled. The annual enrollment deadline is **10/31/2024** and **02/15/2025** for newly eligible spring students.

To complete the online enrollment, visit https://www.universityhealthplans.com/bryant.

International Students
Eligible international students, other than international student athletes, are automatically enrolled in this insurance plan. If you have proof of comparable coverage that meets the waiver requirements, you may complete the online waiver process by the waiver deadline date. The annual waiver deadline is **10/31/2024** and **02/15/2025** for newly eligible spring students.

Students who waive the Student Health Insurance Plan in the fall, waive coverage for the entire policy year.

To complete the online waiver, visit https://www.universityhealthplans.com/bryant.

- **Please Note:** Waivers are required to be completed for each plan year.

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	Enrollment Deadline
Annual	08/15/2024	08/14/2025	10/31/2024	10/31/2024
Fall	08/15/2024	12/31/2024	10/31/2024	10/31/2024
Spring	01/01/2025	08/14/2025	02/15/2025	02/15/2025

Costs for Full-Time Undergraduate, Graduate and International Students

	Annual	Fall	Spring
Student*	$1,938	$738	$1,200

***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 Out-of-Network air Ambulance 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 (will not exceed the Out-of-Pocket Maximum) Individual	$0	$100
Out-of-Pocket Maximum Individual (including Deductibles)	$6,350	No Maximum

Cost sharing You incur for Covered Medical Expenses that is applied to the Out-of-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the In-Network Provider Out-of-Pocket Maximum and cost sharing You incur for Covered Medical expenses that is applied to the In-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the Out-of-Network Provider Out-of-Pocket Maximum.		
Coinsurance	90% of the Negotiated Charge (NC)	80% of Usual & Customary (U&C) Charge
Preventive Services	100% of the (NC) for Covered Medical Expenses	80% of (U&C) Charge after Deductible for Covered Medical Expenses Deductible, Coinsurance, and any Copayment are applicable
Physician's Office Visits/House Calls including Specialists/Consultants *Check below for additional copayments if applicable	$15 Copayment per visit then the plan pays 100% of the (NC) for Covered Medical Expenses	80% of (U&C) Charge after Deductible for Covered Medical Expenses
Emergency Services in an emergency department for Emergency Medical Conditions	$100 Copayment per visit then the plan pays 90% of the (NC) for Covered Medical Expenses Copayment waived if admitted	Paid the same as In-Network Provider; however, the benefit will be based on the Recognized Amount
Urgent Care Centers for non-life-threatening conditions	$100 Copayment per visit then the plan pays 90% of the (NC) for Covered Medical Expenses	$100 Copayment per visit after Deductible then the plan pays 90% of (U&C) Charge 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 SPECIFIED BELOW, ANY APPLICABLE COPAYMENTS ARE APPLIED AFTER DEDUCTIBLE IS MET.
6. 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 and 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	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Registered Nurse Services for private duty nursing while Confined	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physical Therapy, Speech Therapy, and Occupational Therapy while Confined (inpatient)	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
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.		

Inpatient Mental Health Disorder and Substance Use Disorder Benefit Pre-Certification Required for all inpatient admissions, including length of stay, to a Hospital, Skilled Nursing Facility, a facility established primarily for the Treatment of a Substance Use Disorder, or a residential Treatment facility	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Mental Health Disorder and Substance Use Disorder Benefit		
Physician's Office Visits including, but not limited to, Physician visits; individual and group therapy; medication management	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
All Other Outpatient Services (except Emergency Services in an emergency department for Emergency Medical Conditions and Prescription Drugs) 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; and community residential care services for Substance Use Disorder.	90% of the Negotiated Charge for Covered Medical Expenses	80% 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	90% of the Negotiated Charge for Covered Medical Expenses	80% 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	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Abortion Expense	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Bariatric Surgery Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	80% of 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 while at the transplant facility. Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Reconstructive Surgery Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Other Professional Services		
Gender Affirming Treatment Benefit Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Pre-Certification required	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hospice Care Coverage	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Office Visits		
Physician's Office Visits/House Calls including Specialists/Consultants	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	80% of 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	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telemedicine or Telehealth Services by a contracted Provider (Behavioral Health)	$0 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	

Allergy Testing and Treatment, including injections	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	$15 Copayment per visit after Deductible then the plan pays 80% of Usual and Customary Charge for Covered Medical Expenses
Chiropractic Care Benefit Maximum visits per Policy Year	30	30
Tuberculosis screening (TB), Titers, QuantiFERON B tests including shots (other than covered under Preventive Services)	90% of the Negotiated Charge for Covered Medical Expenses	80% of 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	$100 Copayment per visit then the plan pays 90% of the Negotiated Charge for Covered Medical Expenses Copayment waived if admitted	Paid the same as In-Network Provider; however, the benefit will be based on the Recognized Amount
Urgent Care Centers for non-life-threatening conditions	$100 Copayment per visit then the plan pays 90% of the Negotiated Charge for Covered Medical Expenses	$100 Copayment per visit after Deductible then the plan pays 90% of Usual and Customary Charge for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	$50 Copayment per trip then the plan pays 100% of the Negotiated Charge 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)	90% of the Negotiated Charge for Covered Medical Expenses	Ground Ambulance transportation: 80% of Usual and Customary Charge after Deductible for Covered Medical Expenses Air Ambulance transportation: Paid the same as In-Network Provider subject to Usual and Customary Charge
DIAGNOSTIC LABORATORY, TESTING AND IMAGING SERVICES		
Diagnostic Imaging Services Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	80% of 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 for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Chemotherapy and Radiation Therapy Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
REHABILITATION AND HABILITATION THERAPIES		
Cardiac Rehabilitation	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	$15 Copayment per visit after Deductible then the plan pays 80% of Usual and Customary Charge for Covered Medical Expenses
Pulmonary Rehabilitation	$15 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	$15 Copayment per visit after Deductible then the plan pays 80% of Usual and Customary Charge for Covered Medical Expenses
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	100% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	100% of the Negotiated Charge for Covered Medical Expenses	80% of 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 for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Durable Medical Equipment Pre-Certification Required	100% of the Negotiated Charge for Covered Medical Expenses	90% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Enteral Formulas and Nutritional Supplements	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses

See the Prescription Drug section of this Schedule when purchased at a pharmacy.		
Hearing Aids	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infertility Treatment Pre-Certification Required • For Diagnosis, Treatment of Infertility and/or Standard Fertility-Preservation Services when a Medically Necessary medical Treatment may directly or indirectly cause iatrogenic infertility to an Insured Person • For Tests/Procedures attendant to the diagnosis and Treatment of infertility when the sole purpose is the Treatment of Infertility	Same as any other Covered Sickness 90% of the Negotiated Charge for Covered Medical Expenses	Same as any other Covered Sickness 80% 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	100% of the Negotiated Charge for Covered Medical Expenses	90% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Private Duty Nursing Pre-Certification Required	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hemophilia Services Outpatient/In a Physician's Office	Same as any other Covered Sickness	
Asthma Education	Same as any other Covered Sickness	
Sports Accident Expense Benefit- incurred as the result of the play or practice	90% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses

of Intercollegiate sports or club sports Pre-Certification not Required		
Non-emergency Care While Traveling Outside of the United States	80% of Actual Charge after Deductible for Covered Medical Expenses	
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	
DENTAL AND VISION CARE		
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)	See the Pediatric Dental Care Benefit description in the Certificate for further information.	
Preventive Dental Care Limited to 2 dental exams every 12 months (twice per Policy Year)	100% of Usual and Customary Charge for Covered Medical Expenses	
The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care:		
Emergency Dental	50% of Usual and Customary Charge for Covered Medical Expenses	
Routine Dental Care	50% of Usual and Customary Charge for Covered Medical Expenses	
Endodontic Services	50% of Usual and Customary Charge for Covered Medical Expenses	
Prosthodontic Services	50% of Usual and Customary Charge for Covered Medical Expenses	
Periodontic Services	50% of Usual and Customary Charge for Covered Medical Expenses	
Medically Necessary Orthodontic Care	50% of Usual and Customary Charge for Covered Medical Expenses	
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 Examination Benefit (to the end of the month in which the Insured Person turns age 19) Limited to 1 vision examination per Policy Year A second vision care exam will be covered (if prescription changes) for Insured Persons that have the following conditions: Diabetes, Hypertension, Kidney Disease, Dementia, Pregnancy, HNCRT (head and neck cancer patients with radiation therapy). 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 after Deductible for Covered Medical Expenses
Pediatric Vision Care Hardware Benefit (to the end of the month in which the Insured Person turns age 19) Limited to 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year A second set of frames with lenses will be covered (if prescription changes) for Insured Persons that have the following conditions: Diabetes, Hypertension, Kidney Disease, Dementia, Pregnancy, HNCRT (head and neck cancer patients with radiation therapy). Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision	100% of Usual and Customary Charge after Deductible for Covered Medical Expenses

contained in the General Provisions.		
Adult Vision Care (age 19 and older) Routine Eye Examination 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	90% of Usual and Customary Charge after Deductible for Covered Medical Expenses	
MISCELLANEOUS DENTAL SERVICES		
Accidental Injury Dental Treatment	100% of the Negotiated Charge for Covered Medical Expenses	100% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Sickness Dental Expense Benefit	100% of the Negotiated Charge for Covered Medical Expenses	100% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	90% of the Negotiated Charge for Covered Medical Expenses	80% 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. 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.		
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	Not Covered
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	Not Covered

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	Not Covered
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.	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 30-day supply but less than a 61-day supply filled at a Retail pharmacy	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 60-day supply filled at a Retail pharmacy	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
TIER 3 (Including Enteral Formulas) For each fill up to a 30-day supply filled at a Retail Pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 30-day supply but less than a 61-day supply filled at a Retail pharmacy	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 60-day supply filled at a Retail pharmacy	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
Specialty Prescription Drugs		
For each fill up to a 30-day supply	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered

More than a 30-day supply but less than a 61-day supply	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
More than a 60-day supply	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
Specialty Prescription Drugs with Copayment Assistance Program Copayment Assistance Program - Prior Authorization May Be Required: Amounts You pay out-of-pocket for covered Specialty Prescription Drugs will not exceed the applicable Tier's cost share per 30 day supply and will be applied towards the Deductible (if applicable) and Out-of-Pocket Maximum. Copayment Assistance may be available to You for certain Specialty Prescription Drugs when Your prescription is filled at a participating network pharmacy. Visit www.wellfleetstudent.com for the applicable Specialty Prescription Drugs. Copayment Assistance dollars paid by the drug manufacturer for covered Specialty Prescription Drugs will not be applied towards the Deductible (if applicable) or Out-of-Pocket Maximum. Any amounts paid by You for a covered Specialty Prescription Drug after Copayment Assistance will be applied to the deductible (if applicable) and Out-of-Pocket Maximum. For details, contact the Copayment Assistance Program at 636-271-5280.		
For each fill up to a 30 day supply.	75% of the Negotiated Charge for Covered Medical Expenses	Not Covered
Zero Cost Drugs		
	100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
Orally administered anti-cancer Prescription Drugs (including Specialty Drugs)		
Benefit	If the cost share for the Prescription Drug's Tier is greater than the Chemotherapy Benefit or Infusion Therapy Benefit, the cost share will be calculated as follows: Greater of: • Chemotherapy Benefit; or • Infusion Therapy Benefit	
Diabetic Supplies (for prescription supplies purchased at a pharmacy)		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill except, that the Insured Person's out-of-pocket costs for covered prescription insulin drugs will not exceed $40 per 30-day supply regardless of the amount or type of insulin that is needed to fill the Insured Person's prescription. Coverage for prescription insulin drugs shall not be subject to the Deductible, if applicable.	
Epinephrine Auto-Injectors and Cartridges		
Limited to two (2) pack of the epinephrine auto-injectors or cartridges per Policy Year	100% of the Negotiated Charge for Covered Medical Expenses	Not Covered
MANDATED BENEFITS		
Lyme Disease Treatment	Same as any other Covered Sickness	
Mammograms	Same as any other Covered Sickness, unless considered a Preventive Service	
Prostate and Colorectal Examinations	100% of Negotiated Charge for Covered Medical Expenses Deductible Waived, if applicable	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses

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 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.
- 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.
- Outpatient non-physical, occupational, speech therapies (art, dance, etc.).
- Modifications made to dwellings.
- General fitness, exercise programs.
- Hypnosis.
- Rolfing.
- Biofeedback.
- Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
- 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.
- 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;
    - Cryopreservation and storage of embryos;
    - Ovulation induction and monitoring;
    - Artificial insemination;
    - 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.

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, the 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

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

Teladoc

By phone or internet, **Teladoc** gives you 24/7 access to board-certified physicians for Behavioral Health services. Whether you are at school, home or traveling, Teladoc can diagnose and treat most minor medical conditions wherever and whenever you need treatment.

Register your account today and request a visit at https://www.teladoc.com/wellfleetstudent or call (800)-Teladoc (835-2362).

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.