BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2021/2022

DESIGNED EXCLUSIVELY FOR THE STUDENTS

SAINT AUGUSTINE'S UNIVERSITY

Raleigh, NC

("the Policyholder")

Policy Number: WI2122NCSHIP193
Group Number: ST0898SH
Effective: 8/1/2021 - 7/31/2022

UNDERWRITTEN BY:

Wellfleet Insurance Company | Fort Wayne, IN

("the Company")

ADMINISTERED BY:

Wellfleet Group, LLC

WELLFLEET STUDENT

Table of Contents (Click on section title below to go to section in "Benefits at a Glance.")

Welcome Students…

We are pleased to provide you with this summary of the 2021 – 2022 Student Health Insurance Plan ("Plan"), which is fully compliant with the Affordable Care Act. "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**. For questions about medical benefits or claims, please call Wellfleet Student at (877) 657-5030, TTY 711.

Where to Find Help

For Questions About:	Please Contact:
Insurance Benefits **Claims Processing** **ID Cards**	**Wellfleet Group, LLC** **PO Box 15369** **Springfield, Massachusetts 01115-5369** **(877) 657-5030, TTY 711** **www.wellfleetstudent.com**
Servicing Agent	**LAMB Insurance Services** **704-321-3905**
Preferred PPO Provider Listings **Cigna Claims**	**Wellfleet Student** **www.wellfleetstudent.com** or **Cigna PPO** **www.cigna.com** **Send Cigna claims to:** **CIGNA PPO** **PO Box 188061** **Chattanooga, TN 37422 – 8061** **Electronic Payor ID: 62308**
Prescription Drug Provider	**For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit www.wellfleetstudent.com** **Your plan includes Wellfleet Rx – offering over 40 generics at a $0 copay. Please ask your health care provider to review our formulary to see if these medications are right for you. Click here http://wellfleetrx.com/students/formularies/ for more information.**

Am I Eligible?

All registered full-time Undergraduate, Domestic, and International traditional students taking twelve (12) or more credits are required to have health insurance, either through this Plan or through another individual or family plan. Students are automatically enrolled in this Plan at registration and the premium is added to the student's tuition fees unless proof of comparable coverage is provided by completing a waiver. Early college students and Gateway/Extended Studies are not eligible and do not qualify for the Student Health Insurance.

How Do I Confirm Enrollment and/or Waive?

All registered students taking 12 or more credits will be required to confirm enrollment or waive the Saint Augustine University Student Health Insurance Plan by the deadline to make their selection. Students who would like to waive the school insurance will need to have their current insurance information available to provide proof of insurance coverage.

To Confirm Enrollment or submit a waiver:

1. Go to: https://www.studentinsurance.com/Client/898.
2. Next, please click on the Waive/Enroll button to proceed.
3. New students must first Create a New Account and Returning students can log into their existing account.
4. Follow the directions to complete and submit the online waiver or enrollment form by the deadline.

- **FALL WAIVER DEADLINE – 9/15/2021**

All eligibility will be confirmed after add/drop. Any student who accepts the insurance, but no longer meets the eligibility requirements will be removed. The Company has the right to request reimbursement for any paid claims.

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
Fall	8/1/2021	12/31/2021	09/15/2021
Spring	1/1/2022	7/31/2022	3/1/2022

Plan Costs for Domestic and International Undergraduate Students

	Annual	Fall	Spring
Student*	$995	$425	$570

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

Preferred Provider Organization (PPO) Network

…providing access to quality health care at discounted costs!

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

Saint Augustine University's Schedule of Benefits

This is only a brief description of coverage available under Certificate form NC SHIP CERT (2019). The Certificate will contain full details of coverage, coinsurance, limitations, exclusions, and termination provisions. If there are any conflicts between this document and the Certificate, the Certificate governs in all cases.

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

SCHEDULE OF BENEFITS

Preventive Services:
In-Network Provider: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of the Negotiated Charge when services are provided through an In-Network Provider.

Out-of-Network Provider: Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through an Out-of-Network Provider. Benefits are paid at 60% of the Usual and Customary Charge.

Medical Deductible

In-Network Provider	Individual: $250
Out-of-Network Provider	Individual: $500

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:

In-Network Provider	Individual: $6,600
Out-of-Network Provider	Individual: 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 Amounts:

In-Network Provider:	80% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below.
Out-of-Network Provider:	60% of the Usual and Customary Charge (U&C) for Covered Medical Expenses unless otherwise stated below.

Medical Benefit Payments for In-Network Providers and Out-of-Network Providers
The Certificate provides benefits based on the type of health care provider You select. The Certificate provides access to both In-Network Providers and Out-of-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by In-Network Providers versus Out-of-Network Providers, as shown in the Schedule of Benefits.

Dental and Vision Benefit Payments
For dental and vision benefits, You may choose any dental or vision provider.
For dental, different benefits may be payable based on the type of service, as shown in the Schedule of Benefits.

Preferred Provider Organization:
To locate an In-Network Provider in Your area, consult Your Provider Directory or call toll free 877-657-5030 or visit our website at www.wellfleetstudent.com.

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.**

NOTICE: YOUR ACTUAL EXPENSES FOR COVERED SERVICES MAY EXCEED THE STATED COINSURANCE PERCENTAGE OR COPAYMENT AMOUNT BECAUSE THE ACTUAL PROVIDER CHARGES MAY NOT BE USED TO DETERMINE THIS PLAN AND YOUR PAYMENT OBLIGATIONS.

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Inpatient Benefits		
Hospital Care Includes hospital room & board expenses and miscellaneous services and supplies. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined: Limited to 1 visit per day of Confinement per provider	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Surgery: Pre-Certification Required		
Surgeon Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Anesthetist	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Assistant Surgeon	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% 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	60% 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	60% 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	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Skilled Nursing Facility Benefit Maximum days per Policy Year	Unlimited	Unlimited
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
INPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
Mental Health Disorder and Substance Use Disorder Benefit Pre-Certification Required In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-certification requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Benefits		
Outpatient Surgery: Pre-Certification required Surgeon Services Anesthetist Assistant Surgeon	 80% of the Negotiated Charge after Deductible for Covered Medical Expenses 80% of the Negotiated Charge after Deductible for Covered Medical Expenses 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Surgery Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Office Visits	$20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	$20 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Specialist/Consultant Physician Services	$20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	$20 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telemedicine or Telehealth Services	$20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	$20 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Cardiac Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Cardiac Rehabilitation Maximum Visits per Policy Year	Unlimited	Unlimited

Pulmonary Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation Maximum Visits per Policy Year	Unlimited	Unlimited
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maximum Visits per Policy Year for Physical Therapy, Occupational Therapy and. Chiropractic Care Combined	Unlimited	Unlimited
Maximum Visits per Policy Year for Speech Therapy	Unlimited	Unlimited
Habilitative Services including, Physical Therapy, and Occupational Therapy and Speech Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitative Services Maximum Visits per Policy Year for Physical Therapy, Occupational Therapy and Chiropractic Care, Combined	Unlimited	Unlimited
Emergency Services in an emergency department (includes Urgent Care for Emergency Medical Conditions).	$250 Copayment per visit then the plan pays 80% 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	$50 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	$50 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diagnostic Imaging Services Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% 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	60% 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	60% 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	60% 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	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expense Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Home Health Care Expenses Maximum visits per Policy Year	Unlimited	Unlimited
Hospice Care Coverage	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maximum Hospice Care days per Policy Year	Unlimited	Unlimited
Maximum Social Services visits per lifetime	6 visits	6 visits
Maximum Bereavement visits per lifetime	2 visits	2 visits
Outpatient Private Duty Nursing Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
OUTPATIENT MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER		
Mental Health Disorder and Substance Use Disorder Benefit Pre-Certification Required except for office visits Physician's Office Visits including, but not limited to, physician visits; individual and group therapy; medication management All Other Outpatient Services including, but not limited to, Intensive Outpatient Programs (IOP); partial hospitalization; Electronic Convulsive Therapy (ECT); Repetitive Transcranial Magnetic Stimulation (rTMS); Medically Necessary biofeedback, psychiatric and neuropsych testing 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.	 $20 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	 $20 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy.		
TIER 1 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy	$10 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$10 Copayment then the plan pays 100% of Actual Charge for Covered Medical Expenses Deductible Waived

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.		
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$20 Copayment then the plan pays 100% 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 the Negotiated Charge for Covered Medical Expenses Deductible Waived	$30 Copayment then the plan pays 100% of the 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.	$25 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$25 Copayment then the plan pays 100% of the 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	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$50 Copayment then the plan pays 100% of the Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Retail pharmacy	$75 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$75 Copayment then the plan pays 100% of the 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.	$25 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$25 Copayment then the plan pays 100% of the 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	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$50 Copayment then the plan pays 100% of the Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60 day supply filled at a Retail pharmacy	$75 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$75 Copayment then the plan pays 100% of the Actual Charge for Covered Medical Expenses Deductible Waived
Zero Cost Generics		
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
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.	$25 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$25 Copayment then the plan pays 100% of the Actual Charge for Covered Medical Expenses Deductible Waived
More than a 30 day supply but less than a 61 day supply	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$50 Copayment then the plan pays 100% of the Actual Charge for Covered Medical Expenses Deductible Waived

More than a 60 day supply	$75 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$75 Copayment then the plan pays 100% of the Actual Charge for Covered Medical Expenses Deductible Waived
Orally administered anti-cancer prescription drugs (including specialty drugs)		
Benefit	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	
Other Benefits		
Allergy Testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Allergy Injections/Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	Paid the same as In-Network Provider subject to Usual and Customary Charge
Non-Emergency Ambulance Service ground and/or air, water transportation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Bariatric Surgery Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Covered Clinical Trials	Same as any other Covered Sickness	
Durable Medical Equipment Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diabetic services and supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hearing Aids for Insured Persons who are age 22 and under Limited to one (1) hearing aid per impaired ear, and replacement hearing aids for Insured's under the age of 22. Once every 36 months.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
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	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Prosthetic Devices Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Reconstructive Surgery Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
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 Periodontic Services 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 Benefit description in the Certificate for further information. 100% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge 50% of Usual and Customary Charge	
Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19) Limited to 1 visit(s) per Policy Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year Claim forms must be submitted to us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of Usual and Customary Charge after Deductible for Covered Medical Expenses per Policy Year	
Low Vision Evaluation	100% of Usual and Customary Charge after Deductible for Covered Medical Expense per Policy Year	
Low Vision Maximum	One comprehensive low vision evaluation every 5 years 4 follow-up visits in any 5-year period	
Accidental Injury Dental Treatment	$75 Copayment per visit then the plan pays 80% of the Negotiated Charge after Deductible for Covered Medical Expenses	$75 Copayment per visit then the plan pays 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Chiropractic Care Benefit Maximum visits per Policy Year combined with occupational therapy and physical therapy for Rehabilitation and Habilitation	Unlimited	Unlimited
Infertility Treatment Infertility Treatment limited to 3 Treatments per Insured Person per lifetime Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Organ Transplant Surgery - Transplant surgery and donor search expenses - Travel and lodging expenses while at the transplant facility. - Donor travel and lodging and meal expenses while at the transplant facility Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Shots and Injections unless considered Preventive Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Sexual Dysfunction Services	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Tuberculosis screening, Titers, Quantiferon B tests including shots (other than covered under preventive services)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Bedside Visits (International Students)	80% of Actual Charge for Covered Medical Expenses Subject to $1,000 maximum per Policy Year. The maximum dollar benefit limits will only apply to benefits that are not considered essential health benefits	
Non-emergency Care While Traveling Outside of the United States	60% of Actual Charge for Covered Medical Expenses	
Medical Evacuation Expense	100% of Actual Charge for Covered Medical Expenses Subject to $100,000 maximum per Policy Year. Deductible Waived The maximum dollar benefit limits will only apply to benefits that are not considered essential health benefits	
Repatriation Expense	100% of Actual Charge for Covered Medical Expenses Subject to $100,000 maximum per Policy Year. Deductible Waived The maximum dollar benefit limits will only apply to benefits that are not considered essential health benefits	
Mandated Benefits		
Anesthesia and Hospitalization for Dental Procedures Benefit	Same as any other Covered Sickness	
Colorectal Cancer Screening Benefit	Same as any other Preventive Service	

Congenital Anomaly Including Cleft Lip/Cleft Palate Benefit	Same as any other Covered Sickness
Diagnosis and Treatment of Lymphedema	Same as any other Covered Sickness
Mammography and Cervical Cancer Screening	Same as any other Covered Sickness, unless considered a Preventive Service
Mastectomy Benefit and Reconstructive Breast Surgery	Same as any other Covered Sickness
Newborn Hearing Screening Coverage	Same as any other Covered Sickness
Osteoporosis Coverage/Bone Mass Measurement Benefit	Same as any other Preventive Service
Ovarian Cancer Surveillance Tests	Same as any other Preventive Service
Prostate Cancer Benefit	Same as any other Preventive Service
Treatments of Bones and Joints of the Jaw, Face, or Head Benefit	Same as any other Covered Sickness

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Principal Sum $10,000

Loss must occur within 365 days of the date of a covered Accident.

Only one benefit will be payable under this provision, that providing the largest benefit, when more than one (1) loss occurs as the result of any-one (1) Accident. This benefit is payable in addition to any other benefits payable under the Certificate.

Pre-Certification

Pre-certification is required for inpatient hospital, surgery and selected outpatient services. Pre-Certification is not required for an Emergency Medical Condition or Urgent Care or Hospital Confinement for the initial 48/96 hours of maternity care.
Additionally, no authorization requirement will apply to obstetrical or gynecological care provided by In-Network Providers.

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.

1. **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.

2. 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.
3. 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.
4. Professional services rendered by an Immediate Family Member or anyone who lives with You.
5. 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 (such as diabetes).
6. Infertility treatment (male or female)-except as provided in the Infertility Treatment provision this includes but is not limited to:
    - Procreative counseling;
    - Premarital examinations;
    - Genetic counseling and genetic testing;
    - Impotence, organic or otherwise;
    - Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
    - In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
    - Costs for an ovum donor or donor sperm;
    - Sperm storage costs;
    - Cryopreservation and storage of embryos;
    - Ovulation induction and monitoring;
    - Artificial insemination;
    - Hysteroscopy;
    - Laparoscopy;
    - Laparotomy;
    - Ovulation predictor kits;
    - Reversal of tubal ligations;
    - Reversal of vasectomies;
    - Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
    - Cloning; or
    - Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.
7. Services or supplies for the Treatment of an occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or Workers' Compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
8. Expenses covered under any public assistance program or government plan, except Medicaid.
9. Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance, except tax supported institutions or services covered by Student Health Fees.
10. Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
11. 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.
12. 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.
13. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate or 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.
14. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
15. 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.

16. Services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
17. Expenses payable under any prior policy which was in force for the person making the claim.
18. 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.
19. 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.
20. Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
21. Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
22. 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.
23. Treatment for obesity except surgery for morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat.
24. Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
25. Expenses for radial keratotomy.
26. Adult Vision unless specifically provided in the Certificate.
27. 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.
28. Charges for hearing exams, or cochlear implants except as specifically provided in the Certificate.
29. Racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles) or other hazardous sport or hobby.
30. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma.
31. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
32. You are:
    - committing or attempting to commit a felony,
    - engaged in an illegal occupation, or
    - participating in a riot.
33. Elective abortions.
34. Custodial Care service and supplies.
35. Charges for hot or cold packs for personal use.
36. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
37. Services of private duty Nurse when provided by a close relative or a member of your household.
38. Expenses that are not recommended and approved by a Physician.
39. 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.
40. Cosmetic procedures related to Gender Reassignment including but not limited to rhinoplasty, face lift, facial bone reduction, lip enhancement or reduction, blepharoplasty, body contouring, reduction thyroid chondroplasty, hair removal, voice modification surgery, skin resurfacing, chin implants, nose implants.
41. Sleep Disorders, except for the diagnosis and treatment of obstructive sleep apnea.
42. Treatment of Acne unless Medically Necessary.
43. Experimental or Investigational drugs, devices, treatments or procedures unless otherwise covered under Covered Clinical Trials or covered under clinical trials (routine patient costs). See the Other Benefits section for more information.
44. Under the Prescription Drug Benefit shown in the Schedule of Benefits:
    - any drug or medicine which does not, by federal or state law, require a prescription order, i.e. over-the-counter drugs, even if a prescription is written, except as specifically provided under Preventive

Services or in the Prescription Drug Benefit section of the 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;
- any drug or medicine for the purpose of weight control;
- sexual enhancements drugs;
- 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;
- 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;
- immunology products.

45. Non-chemical addictions.
46. Non-physical, occupational, speech therapies (art, dance, etc.).
47. Modifications made to dwellings.
48. General fitness, exercise programs.
49. Hypnosis.
50. Rolfing.
51. Biofeedback.

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

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

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.

CareConnect

Integrated Behavioral Health from Wellfleet Student

With CareConnect from Wellfleet Student, students have 24/7 access to professional assistance to help manage personal concerns, emotional issues, transition and adjustment concerns, academic stress, career development, and the demands of daily and family obligations.

Members in need of assistance simply call the behavioral health hotline on their ID card, **(888) 857-5462**, or via the Wellfleet Student mobile app for immediate access to a masters-level mental health professional. Students are run through a clinical assessment to determine if CareConnect counseling, health center referral, or other treatment is necessary. To access mobile features, students simply download their school's app in their device's app store.