BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2025/2026

DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

CARLETON COLLEGE

Northfield, MN
("the Policyholder")

Policy Number: WI2526MNSHIP30

Group Number: ST1268SH

Effective: 8/15/2025 – 8/14/2026

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 2025 – 2026 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 MN SHIP Cert (2025). 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. In the case of a discrepancy between two versions of the Summary, the most recent will apply.

PENDING STATE APPROVAL

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

Important Contact Information & Resources

Contact Us

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

Plan Administration

Enrollment, Eligibility, Waivers, 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

Cigna

Cigna
www.mycigna.com

Pharmacy Benefits Manager

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

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

Telehealth Service

Your plan includes access to virtual healthcare advice by phone, video, or app.

- Scheduled mental health services – 7 days a week

Register at https://www.teladoc.com/wellfleetstudent/

- In addition, your plan includes virtual physical therapy and other musculoskeletal services from Hinge Health
- Register at https://hinge.health/wellfleet

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

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General Information

Am I Eligible

Domestic Students

All registered Full-Time Undergraduate Domestic students taking 6 or more credits are required to have health insurance coverage, either through this Student Health Insurance Plan or through another individual or family plan. Students are automatically enrolled in the Student Health Insurance Plan at registration and the premium is added to the student's tuition fees unless proof of comparable coverage is provided by completing the waiver.

International Students

All registered International students taking 6 or more credits are required to have health insurance coverage, either through this Student Health Insurance Plan or through another individual or family plan. Students are automatically enrolled in the Student Health Insurance Plan at registration and the premium is added to the student's tuition fees unless proof of comparable coverage is provided by completing the waiver.

Dependents

Insured Students who are enrolled in the Student Health Plan may also enroll their eligible Dependents.

How Do I Waive/Enroll?

To Waive:

- Go to **www.wellfleetstudent.com.**
- Search **Carleton College**
- Click the waiver tab and proceed as directed. You must fill in all of the required information on the waiver form. If any information is missing, your waiver will not be accepted.
- Click submit and review the information being provided is accurate.
- When your online waiver form is successfully submitted you will receive a confirmation e-mail.
- **Please Note:** Waivers are required to be completed for each plan year.

The deadline to waive coverage for Annual coverage is 8/15/2025.

To Purchase coverage and Enroll your dependents:

- Go to **www.wellfleetstudent.com**.
- Select **Carleton College**
- Click the "Enroll" tab and proceed as directed to enroll in and purchase the Student Health Insurance Plan.

The deadline to enroll and purchase coverage for Annual coverage is 8/15/2025.

Effective Dates & Costs

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

Coverage Period	Coverage Start Date	Coverage End Date	Waiver Deadline Date/ Dependent Enrollment Deadline Date
Annual	08/15/2025	08/14/2026	08/15/2025

Plan Costs for Students and their Dependents

	Annual
Student*	$2,707
Spouse*	$2,707
Each Child*	$2,707
3 or more Children*	$8,121

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

Plan Benefits

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

When the Insured Person receives 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, the Insured Person is 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.

Pre-Certification Requirement:
What types of Inpatient and Outpatient services or supplies require Pre-Certification?
Pre-Certification is required for the following:

1. 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, surgical procedures;
2. All Inpatient maternity care after the initial 48/96 hours;
3. Home Health Care;
4. Durable Medical Equipment over $500 per item;
5. Outpatient Surgical Procedures;
6. Transplant Services;
7. Diagnostic Testing and Radiology Services listed at www.wellfleetstudent.com/providers/. See Prior Authorization Requirements section;
8. Complex Imaging;
9. Biomarker Testing;

10. Chemotherapy/Radiation;
11. Infusions/Injectables;
12. Botox Injections;
13. Genetic Testing, except for BRCA;
14. Orthotics/Prosthetics;
15. Non-emergency Air Ambulance (fixed wing)
16. Outpatient Private Duty Nursing.

Pre-Certification is not required for an Emergency Medical Condition, or Urgent Care Center or Hospital Confinement for the initial 48/96 hours of maternity care.

Pre-Certification is not a guarantee that benefits will be paid.

Key Plan Benefits

BENEFIT	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Policy Year Deductible* Combined In-Network and Out-of-Network Individual	$200	
Cost sharing the Insured Person incurs for Covered Medical Expenses that is applied to the Out-of-Network Deductible will be applied to satisfy the In-Network Deductible. Cost sharing the Insured Person incurs for Covered Medical Expenses that is applied to the In-Network Deductible will be applied to satisfy the Out-of-Network Provider Deductible. *When Treatment is rendered at or the Insured Person is referred by the Student Health Center, the Deductible will be waived. No authorization or referral requirement will apply to obstetrical or gynecological care provided by In-Network Providers.		
Out-of-Pocket Maximum *Combined In-Network and Out-of-Network Individual Family	$7,900 $15,800	
Cost sharing the Insured Person incurs for Covered Medical Expenses that is applied to the Out-of-Network Provider Out-of-Pocket Maximum will be applied to satisfy the In-Network Provider Out-of-Pocket Maximum and cost sharing the Insured Person incurs for Covered Medical Expenses that is applied to the In-Network Provider Out-of-Pocket Maximum will be applied to satisfy the Out-of-Network Provider Out-of-Pocket Maximum. *The combined amount will never exceed the federal maximum.		
Coinsurance	80% of the Negotiated Charge (NC)	50% of Usual & Customary (U&C) Charge
Preventive Services	100% of the (NC) Deductible Waived	60% of (U&C) Charge Deductible, Coinsurance, and any Copayment are applicable
Physician's Office Visits including Specialist and Consultants visits *Check below for additional copayments if applicable	80% of the (NC) after Deductible for Covered Medical Expenses	50% of (U&C) Charge after Deductible for Covered Medical Expenses

Emergency Services in an emergency department for Emergency Medical Conditions.	$250 Copayment per visit after Deductible then the plan pays 100% of the (NC) for Covered Medical Expenses Copayment waived if admitted	The same cost sharing requirements that apply to an In-Network Provider.
Urgent Care Centers for non-life-threatening conditions	100% of the (NC) after Deductible for Covered Medical Expenses	100% of (U&C) 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 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	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Skilled Nursing Facility Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
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, 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. Day to visit limits do not apply to Mental Health Disorder and Substance Use Disorder Benefits.		
Inpatient Mental Health Disorder and Substance Use Disorder Benefits Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Mental Health Disorder and Substance Use Disorder Benefits Physician's Office Visits including, but not limited to, Physician visits; individual and group therapy; medication management (For Treatment rendered at the Student Health Center/Infirmary, refer to the Student Health Center/Infirmary Expense Benefit section of this Schedule of Benefits for benefit information.) All Other Outpatient Services (All Other Outpatient Services does not include Emergency Services in an emergency department, Urgent Care Centers, and Emergency Ambulance Service and Prescription Drugs. Refer to the Emergency Services, Ambulance and Non-Emergency Services, and Prescription Drugs sections of this Schedule of Benefits for benefit information.) Pre-Certification may be required for certain All Other Outpatient Services. To see if Pre-Certification is required, refer to the Pre-Certification	90% of the Negotiated Charge after Deductible for Covered Medical Expenses 90% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses 80% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Requirement listing and specific benefit listed in this Schedule of Benefits.		
PROFESSIONAL AND OUTPATIENT SERVICES		
Surgical Expenses		
Inpatient and Outpatient Surgery includes: Pre-Certification required for Surgery only Surgeon Services Anesthetist Assistant Surgeon	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Surgical Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% 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	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% 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	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Other Professional Services		
Gender Affirming Services Benefit Pre-Certification Required for gender affirming surgery	Same as any other Mental Health Disorder	
Home Health Care Expenses Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Maximum visits per Policy Year	120	120
Hospice Care Coverage	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Office Visits		
Physician's Office Visits including Specialists/Consultants	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telehealth Services Benefit	Same as any other Physician's Office Visits including Specialists/Consultants	

Telehealth Services Program Behavioral Health Musculoskeletal	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	
Allergy Testing and Treatment, including injections	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Maximum visits per Policy Year	Unlimited	30
Tuberculosis screening (TB), Titers, QuantiFERON B tests including shots (other than covered under Preventive Services)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
EMERGENCY SERVICES, AMBULANCE AND NON-EMERGENCY SERVICES		
Emergency Services in an emergency department for Emergency Medical Conditions.	$250 Copayment per visit after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Copayment waived if admitted	The same cost sharing requirements that apply to an In-Network Provider.
Urgent Care Centers for non-life-threatening conditions	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	100% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	The same cost sharing requirements that apply to an In-Network Provider.
Non-Emergency Ambulance Expenses ground and/or air (fixed wing) transportation Pre-Certification Required for non-emergency air Ambulance (fixed wing)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	Ground Ambulance transportation: 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses Air Ambulance transportation: The same cost sharing requirements that apply to an In-Network Provider.
DIAGNOSTIC LABORATORY, RADIOLOGY, TESTING AND IMAGING SERVICES		
Diagnostic Complex Imaging Services Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Diagnostic Laboratory, Radiological Services and Testing (Outpatient) Pre-Certification may be required. See Prior Authorization Requirements section listed at www.wellfleetstudent.com/providers/.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
REHABILITATION AND HABILITATION THERAPIES		
Cardiac Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy Maximum Visits for each therapy per Policy Year for Physical Therapy, Occupational Therapy and Speech Therapy Combined with Habilitation Services Therapy	Unlimited	30
Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitation Services Maximum Visits for each therapy per Policy Year for Physical Therapy, Occupational Therapy and Speech Therapy Combined with Rehabilitation Therapy	Unlimited	30
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.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Durable Medical Equipment Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Enteral Formulas and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hearing Aids (Medically Necessary) Limited to 1 hearing aid for each ear every 3 years	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infertility Treatment Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
Prosthetic and Orthotic Devices Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Private Duty Nursing Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Student Health Center/Infirmary Expense Benefit	80% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	
Sports Accident Expense Benefit - incurred as the result of the play or practice of Intercollegiate sports or club sports Up to $89,500 per Accident Pre-Certification not Required	Intercollegiate, or club sports payable at 100% of the Negotiated Charge up to $500 then payable as any other Covered Injury.	Intercollegiate, or club sports payable at 100% of Usual and Customary Charge up to $500 then payable as any other Covered Injury.
Non-emergency Care While Traveling Outside of the United States	50% of Actual Charge after Deductible for Covered Medical Expenses Subject to $10,000 maximum per Policy Year	

Medical Evacuation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $50,000 maximum per Policy Year
Repatriation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to $50,000 maximum per Policy Year
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 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 provision in the Certificate for further information. 100% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived
Adult Dental Care Benefit (age 19 and older) Preventive Dental Care Limited to 2 dental exams 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.	See the Adult Dental Care Benefit provision in the Certificate for further information. 100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived

Adult Dental Care (age 19 and older) Maximum benefit per Policy Year	$1,000	
Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19) Limited to 1 vision examination per Policy Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year 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	
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	80% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived	
MISCELLANEOUS DENTAL SERVICES		
Accidental Injury Dental Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Sickness Dental Expense Benefit	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Anesthesia and Hospital Charges for Dental Care	Same as any other Covered Injury, Covered Sickness or Pediatric/Adult Dental Care	
PRESCRIPTION DRUGS		
Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy. The Insured Person's 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	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered

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	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	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 Deductible Waived	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.	$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$100 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 60 day supply filled at a Retail pharmacy	$150 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	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.	$70 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$140 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered

More than a 60 day supply filled at a Retail pharmacy	$210 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
Specialty Prescription Drugs		
For each fill up to a 30 day supply.	$70 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 30 day supply but less than a 61 day supply	$140 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 60 day supply	$210 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
Specialty Prescription Drugs with Copayment Assistance Program Copayment Assistance Program - Prior Authorization May Be Required: Amounts the Insured Person pays 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 the Insured Person for certain Specialty Prescription Drugs when the Insured Person's prescription is filled at a participating network pharmacy. Visit www.wellfleetrx.com/students 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 the Insured Person 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 Deductible Waived	Not Covered
Zero Cost Drugs		
	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	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 The Insured Person's responsibility will not exceed the Prescription Drug Benefit.	

Diabetic Supplies (for prescription supplies purchased at a pharmacy)	
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill. The Insured Person's responsibility for a prescription insulin drug will not exceed the Net Price of the prescription insulin drug.
MANDATED BENEFITS	
Cleft Lip and Cleft Palate Benefits for Dependent Children	Same as any other Covered Sickness
Lyme Disease	Same as any other Covered Sickness
Port-wine Stain	Same as any other Covered Sickness
Prostate Cancer Screening	Same as any other Covered Sickness
Routine Cancer Screenings	Same as any other Preventive Service
PANDAS and PANS Coverage	Same as any other Covered Sickness
Anesthesia and Hospital Charges for Dental Care	Same as any other Covered Injury, Covered Sickness, or Pediatric/Adult Dental Care
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 the Insured Person.

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 –** Covered Medical Expenses received incurred within the Insured Person's Home Country that are covered under the Insured Person's governmental or national health plan.
- Treatment, service or supply which is not Medically Necessary for the diagnosis, care or Treatment of the Sickness or Injury involved.
- 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 the Insured Person.
- 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.
- Expenses for a single service that is duplicated by both a certified Nurse midwife and a Physician.
- Loss resulting from war or any act of war sustained while in the armed forces of any country or international authority, whether declared or not.

- 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 as defined in Section III unless considered a Preventive Service.
- The Insured Person is:
    - committing or attempting to commit a felony, or
    - engaged in an illegal occupation.
- Custodial Care service and supplies. Examples include routine patient care such as changing dressings; administering oral medications; help with walking, grooming, bathing, dressing; and services that can be performed by a person without any medical or paramedical training.
- Charges for hot or cold packs for personal use.
- Services of private duty Nurse except as provided for Outpatient Private Duty Nursing. This does not apply to a home care nurse or personal care assistant to a ventilator dependent Insured Person in the Insured Person's home pursuant to Minn. Statute 62A.155.
- Expenses that are not recommended and approved by a Physician. Physician includes a Physician Assistant (PA), or Advanced Practice Nurse Practitioner (APRN), or other health care professional practicing within the scope of his or her license.
- Experimental or Investigational drugs, devices, Treatments or procedures.
- 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.
- Non-chemical addictions such as gambling, spending, shopping, working.
- Outpatient non-physical and/or occupational therapies (art, dance, etc.).
- Modifications made to dwellings.
- General fitness, exercise programs.
- Hypnosis.
- Rolfing.
- Biofeedback.
- Charges incurred for acupuncture, in any form.
- Sleep Disorders, except for the diagnosis and Treatment of obstructive sleep apnea,, including testing performed in a home or outpatient setting.
- 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.
- Conversion Therapy.

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 or Enteral Formulas and Nutritional Supplements benefits, or medical nutritional therapy for the Treatment of diabetes.
- Treatment for obesity. Surgery for removal of excess skin or fat.

Family Planning

- Infertility Treatment (male or female)-this includes but is not limited to:
    - 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;
  - Ovulation predictor kits;
  - Reversal of tubal ligations;
  - Reversal of vasectomies;
  - Costs for and relating to surrogate motherhood if the individual is not an Insured Person under the Policy;
  - Cloning; or
  - Medical and surgical procedures that are Experimental or Investigational, unless Our denial is overturned by an External Appeal Agent.
- Elective abortions, except when the life of the Insured Person upon whom the abortion is performed is at stake. Elective abortion means an elective, non-therapeutic, abortion including those resulting from rape or incest.

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 and Adult Dental Care Benefit.

Hearing
- Charges for hearing exams, the fitting or repair or replacement of hearing aids except as specifically provided under the Hearing Aids benefit.

Cosmetic
- Treatment of Acne unless Medically Necessary.
- Charges for hair removal unless Medically Necessary Treatment of gender dysphoria; or hair growth.
- Surgery or related services for cosmetic purposes to improve appearance, except as provided under the Reconstructive Surgery benefit, or to restore bodily function or correct deformity resulting from disease, or trauma, or for port-wine stain removal. Emergency Services in connection with emergency complications related to cosmetic surgery are exempt from this exclusion.

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 under Preventive Services and the Enteral Formulas and Nutritional Supplements benefit;
- Cosmetic drugs or medicines including, but not limited to, products that improve the appearance of wrinkles or other skin blemishes, except in relation to the coverage for the elimination or maximum feasible Treatment of an Insured Person's port-wine stain;
- 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 a Physician's office or outpatient Hospital or while Hospital Confined. This does not apply to products (e.g., vaccines) administered at a retail pharmacy;
- 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, except as specifically provided under Diabetic Supplies in the Prescription Drug Benefit section of the Certificate;
- Repackaged products;
- 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.

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

24/7 Nurseline

Students who enroll and maintain medical coverage in this insurance plan have **free** access to the 24/7 Nurseline by calling (800) 634-7629. This 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

- an office or telehealth visit with a healthcare provider
- or a visit to an urgent care center or emergency room.

Calls are answered 24/7/365 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.

Contracted Providers for Telemedicine/Telehealth

The right care when you need it most
Your Wellfleet health plan gives you access to virtual healthcare by phone, video, or app.

Teladoc gives you access to board-certified physicians for **Mental Health (at no additional cost to you)** 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.teladochealth.com/benefits/wellfleetstudent or call (800)-Teladoc (835-2362).

Hinge Health gives you access to licensed physical therapists and health coaches for personalized musculoskeletal services including **virtual physical therapy** to help alleviate pain concerns.

Whether you are at school, home, or traveling, Hinge Health can assist in providing exercise therapy wherever and whenever you need treatment at **no additional cost to you**.

Register your account today and start your exercise therapy at https://hinge.health/wellfleet.

CareConnect
BY WELLFLEET

24/7 Telehealth Counseling for Mental Health

CareConnect is an integrated behavioral health program offering students easy access to licensed mental health clinicians 24/7/365 via telephone (888) 857-5462 and website access to expert mental health and emotional wellbeing resources.

The CareConnect hotline is available at **no additional cost to you**, and you also have free access to courses, articles, and short videos that support mental health and wellbeing by visiting https://careconnect.mysupportportal.com/welcome.