



Washburn University
2019-2020 Domestic Student Health Plan
 Group No: ST0970SH
 Policy No: CCIC1920KSSHIP95

Dear Students:
 We are pleased to provide you with this summary of the Student Health Plan for Washburn University. This plan is fully compliant with the Affordable Care Act.

Who is Eligible to Enroll?

Domestic Washburn University and Washburn Institute of Technology registered full-time undergraduate students taking at least 5 or more credit hours, and graduate students pursuing a graduate degree are eligible to enroll in this insurance plan. Dependents of the student are also eligible to enroll.

How Do I Enroll?

Domestic students may enroll on a voluntary basis on the website www.wellfleetstudent.com. Search for your school's webpage and select the option to enroll online. Student must enroll by enrollment deadline dates. Credit card payment is required.

Enrollment Period Deadline Dates

| | |
|----------------------|--------------------|
| Annual/Fall Semester | September 28, 2019 |
| Spring/Summer | February 12, 2020 |
| Summer | June 30, 2020 |

Cost and Periods of Coverage*

| | Annual 8/1/19 to 7/31/20 | Fall 8/1/19 to 1/9/20 | Spring/ Summer 1/10/20 to 7/31/20 | Summer 5/31/20 to 7/31/20 |
|-------------------------|-----------------------------------|--------------------------------|---|------------------------------------|
| Student | \$1,797 | \$795 | \$1,002 | \$304 |
| Spouse | \$1,797 | \$795 | \$1,002 | \$304 |
| Each Dependent | \$1,797 | \$795 | \$1,002 | \$304 |
| 3 or More Dependents | \$5,391 | \$2,385 | \$3,006 | \$912 |

*The above rates include an administrative fee. Dependent rates are in addition to the student rate.

Where Can I Obtain more Information about the Plan?

| | |
|--|--|
| Enroll in the Student Plan | Wellfleet Student www.wellfleetstudent.com |
| Insurance Benefits Claim Processing ID Cards | Wellfleet Group, LLC www.wellfleetstudent.com |
| Find Network Provider | Wellfleet Student or Cigna PPO www.wellfleetstudent.com |

***The plan described in this Summary is awaiting approval by the Kansas Department of Insurance. If the plan is changed during the approval process, a revised Summary 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**

HEALTH INSURANCE BENEFIT SUMMARY FOR COVERED MEDICAL EXPENSES*
 Unless otherwise specified below the medical plan deductible will always apply

| BENEFIT | IN-NETWORK | OUT OF NETWORK |
|--|---|--|
| Policy Year I Deductible | \$500 Individual | \$1,500 Individual |
| Out-of-Pocket Maximum | \$6,600 Individual \$13,200 Family | \$6,600 Individual \$13,200 Family |
| Coinsurance | 70% of NC** | 50% of U&C** |
| Preventive Care | 100% of NC (deductible waived) | 70% of U&C |
| Hospital Room & Board (Inpatient) | 70% of NC | 50% of U&C |
| Surgery (Inpatient** or Outpatient) | 70% of NC | 50% of U&C |
| Physician Office Visit OR Consultant/Specialist | \$25 copay per visit then the plan pays 70% of NC | \$25 copay per visit then the plan pays 50% of U&C |
| Emergency Services Expense | \$100 copay per visit then the plan pays 70% of NC | Paid the same as In-Network; Provider subject to U&C |
| Urgent Care | \$75 copay per visit then the plan pays 70% of NC | \$75 copay per visit then the plan pays 50% of U&C |
| Imaging Services & Laboratory Procedures (Outpatient) | 70% of NC | 50% of U&C |
| Sports Accident Expense for Intercollegiate or club sports | 70% of NC | 50% of U&C |
| Outpatient Prescription Drugs Copay per 30-day supply Out-of-Network Provider benefits provided on a reimbursement basis. | Generic: \$25 copay per drug Preferred Brand: \$50 copay per drug Non-Preferred Brand: \$50 copay per drug Specialty: \$50 copay per drug Then the plan pays 80% of Actual Charge; after the deductible | |

**NC= Negotiated Charge for Covered Medical Expenses
 **U&C=Usual and Customary for Covered Medical Expenses

*This is only a brief description of the coverage(s) available under Certificate form KS SHIP CERT (2019). The Certificate will contain the 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.

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. The phone number can be found on the back of the Insured's ID card. The call should be made prior to Hospital Confinement. In the case of an emergency, the call should take place as soon as reasonably possible

Underwritten By:
 Commercial Casualty Insurance Company

Plan Administrator:
 Wellfleet Group, LLC
 2077 Roosevelt Ave.
 Springfield, MA 01104
www.wellfleetstudent.com
 (877) 657-5030

Servicing Agent:
 Dissinger Reed
 8700 Indian Creek Pkwy, Suite 320
 Overland, KS 66210
 (800) 386-9183
www.dissingerreed.com

The following Value-Added Services are not part of the Policy and are not underwritten by Commercial Casualty Insurance Company. The services are provided by Independent vendors and are included if the student participates in the student health plan.

- Vision discount program through Davis Vision
- Medical travel assistance through Scholastic Emergency Services
- 24-hour nurse line through AHH

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.
6. Infertility treatment (male or female)-this includes but is not limited to:
 - Procreative counseling;
 - Premarital examinations;
 - Genetic counseling and genetic testing;
 - Impotence, organic or otherwise;
 - Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
 - In vitro fertilization, in vivo fertilization or any other medically-aided insemination procedure, 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. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
8. 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.
9. Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
10. 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.
11. 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.
12. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
13. 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.
14. Services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
15. Expenses payable under any prior policy which was in force for the person making the claim.
16. 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.
17. 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.
18. Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
19. Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
20. 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.
21. Treatment for obesity. Surgery for removal of excess skin or fat.

22. Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
23. Refractive procedures including radial keratotomies, corneal relaxation, keratophakia, keratomileusis or any other procedure used to reshape the corneal curvature except for Medically Necessary procedures associated with severe anisometropia.
24. Adult Vision unless specifically provided in the Certificate.
25. 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.
26. Charges for hearing exams, hearing screening, hearing aids and the fitting or repair or replacement of hearing aids or cochlear implants except as specifically provided in the Certificate.
27. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma. For purposes of this provision, the term "cosmetic" means procedures and related services performed to reshape, structures of the body in order to alter the individual's appearance.
28. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
29. You are:
 - committing or attempting to commit a felony,
 - engaged in an illegal occupation.
30. Elective abortions.
31. Custodial Care service and supplies.
32. Charges for hot or cold packs for personal use.
33. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
34. Services of private duty Nurse except as provided in the Certificate.
35. Expenses that are not recommended and approved by a Physician.
36. 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.
37. Cosmetic procedures related to Gender Reassignment including but not limited to rhinoplasty, face lift, facial bone reduction, lip enhancement or reduction, blepharoplasty, breast augmentation, body contouring, reduction thyroid chondroplasty, hair removal, voice modification surgery, skin resurfacing, chin implants, nose implants.
38. Treatment of Acne unless Medically Necessary.
39. 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.
40. 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 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;
 - any drug or medicine for the purpose of weight control;
 - fertility drugs;
 - 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.
41. Non-chemical addictions.
42. Non-physical, occupational, speech therapies (art, dance, etc.).
43. Modifications made to dwellings.
44. General fitness, exercise programs.
45. Hypnosis.
46. Rolwing.
47. Biofeedback services and materials except for urinary incontinence in adults 18 years old and older.