St. Andrews University
24-25 Student Health Plan (SHIP)
Group No: ST2270SH
Policy No: WI2425NCSHIP235

Dear Students:
We are pleased to provide you with this summary of the **Student Health Insurance Plan (SHIP)** for **St. Andrews University**. This plan is fully compliant with the Affordable Care Act.

Who Is Eligible To Enroll?

Domestic Students: All Graduate students taking 6 or more credits and all Undergraduate students taking 12 or more credits are required to have health insurance and will automatically be billed by St. Andrews University unless a waiver is submitted with proof of active comparable insurance coverage.

International Students: All International students will automatically be enrolled and billed for the St. Andrews University Student Health Insurance Plan. The cost of the insurance will be added to the student's account.

How Do I Confirm Enrollment and/or Waive?

All domestic students will need to confirm enrollment or waive the St. Andrews University SHIP. Domestic students will be required to go to: https://www.studentinsurance.com/Client/2330 by the deadline to submit their enrollment or waiver. Students who would like to waive the insurance will need to have their current insurance information available to provide proof of comparable insurance coverage. Plans that are not comparable are as follows: Medicaid, Medicare or out-of-state HMO's. If it is found that your plan is not comparable, the waiver will be declined.

The enrollment / waiver deadline is **September 20, 2024**. Any student who does not make a selection or has a declined waiver will automatically be enrolled.

Enrollment / Waiver Period Deadline Dates	
Annual | Fall	9/20/2024
Spring (new Students)	2/1/2025

Student Cost and Periods of Coverage*	
Fall 8/1/2024 to 12/31/2024	Spring 1/01/2025 to 7/31/2025
$1,262.00	$1,262.00
Note: The total cost of the St. Andrews Student Health Insurance is $2,524.00. The premium for the insurance will be split and billed half in the fall term and half in the spring term.	
*The above rates include administrative service fee	

Where Can I Obtain More Information About The Plan?

Enroll/Waiver Process Insurance Benefits Claim Processing ID Cards	Wellfleet Group, LLC www.wellfleetstudent.com 877-657-5030
Find Network Provider	Cigna OAP www.cigna.com
Retail Prescriptions Drugs	WellfleetRX www.wellfleetrx.com

HEALTH INSURANCE BENEFIT SUMMARY*

Deductible applies unless otherwise indicated

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Policy Year Deductible	$1,250	$2,500
Out-of-Pocket Maximum	$5,500	$11,000
Coinsurance	70% of NC	50% of U&C
Preventive Services	100% of NC *(Deductible waived)*	70% of U&C
Hospital Care, includes Room & Board, and hospital miscellaneous expenses	70% of NC	50% of U&C
Surgical Expenses	70% of NC	50% of U&C
Physician Office Visits including Specialist and Consultant visits	$45 copay per visit then 100% of NC *(Deductible waived)*	70% of U&C
Emergency Services in an emergency department.	$500 copay per visit then 100% of NC *(Deductible waived)*	Paid the same as IN-Network Provider subject to U&C
Urgent Care Centers for non-life-threatening conditions	$70 copay per visit then 100% of NC *(Deductible waived)*	$140 copay per visit then 100% of U&C *(Deductible waived)*
Diagnostic X-ray & Laboratory	70% of NC	50% of U&C
Prescription Drugs Retail Pharmacy (30-day supply) *Deductible does not apply*	100% of PA after copay: Tier 1 - $45 Tier 2 - $100 Tier 3 - $250 Specialty drug - $250	100% of U&C after copay: Tier 1 - $45 Tier 2 - $100 Tier 3 - $250 Specialty drug - $250

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

***This is only a brief description of the coverage(s) available under the Plan.** 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.

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

- Teladoc Behavioral Health (800) 835-2362
- 24/7 Behavioral Health Hotline/Care Connect (888) 857-5462
- 24/7 Nurse Hotline (800) 634-7629
- Point of Sale Vision Discount Program through Davis Vision.
- Emergency Medical and Travel Assistance through Travel Guard.

Underwritten By:
Wellfleet Insurance Company

Plan Administrator:
Wellfleet Group LLC
P.O. Box 15369
Springfield, MA 01115-5369
www.wellfleetstudent.com
(877) 657-5030

Servicing Agent:
Acentria Insurance
1401 Forum Way
Suite 400
West Palm Beach, FL 33401

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The Plan described above is currently awaiting approval by the state's Department of Insurance. This is not an insurance policy, and your receipt of this document does not constitute the issuance or delivery of a policy of insurance.

These Exclusions and Limitations will vary by state. For a complete list of exclusions please refer to Your plan certificate.

Exclusions and Limitations

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

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

General Exclusions

- **International Students Only -** Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible.
- Treatment, service or supply which is not Medically Necessary for the diagnosis, care or Treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended or approved by Your attending Physician or dentist.
- Medical services rendered by a provider employed for or contracted with the Policyholder, including team Physicians or trainers, except as specifically provided in the Schedule of Benefits.
- Professional services rendered by an Immediate Family Member or anyone who lives with You.
- Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance, except tax supported institutions or services covered by Student Health Fees.
- Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
- Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which You are required to pay.
- Services that are duplicated when provided by both a certified Nurse midwife and a Physician.
- Expenses payable under any prior policy which was in force for the person making the claim.
- Loss resulting from war or any act of war, whether declared or not, or Loss sustained while in the armed forces of any country or international authority.
- 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.
- Expenses covered under any public assistance program or government plan, except Medicaid.
- Expenses incurred after:
  - The date insurance terminates as to an Insured Person, except as specified in the extension of benefits provision; and The end of the Policy Year specified in the Policy.
  - Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
- You are:
  - committing or attempting to commit a felony,
  - engaged in an illegal occupation, or
  - participating in a riot.
- Custodial Care service and supplies.
- Charges for hot or cold packs for personal use.
- Services of private duty Nurse when provided by a close relative or a member of Your household except as provided in the Certificate.
- Expenses that are not recommended and approved by a Physician.
- Experimental or Investigative drugs, devices, Treatments or procedures unless otherwise covered under Covered Clinical Trials. See the Other Benefits section for more information.
- Routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal or artificial organs or tissues.
- Loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
- Non-chemical addictions.
- Outpatient non-physical, occupational, speech therapies (art, dance, etc.).
- Modifications made to dwellings.
- General fitness, exercise programs.
- Hypnosis.
- Rolfing.
- Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.

- Sleep Disorders, except for a sleep study performed in the Insured Person's home, the diagnosis, and Treatment of obstructive sleep apnea.
- Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary because of Injury, infection or disease.

Activities Related
- Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
- 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.
- Racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles).

Weight Management/Reduction
- Weight management. Weight reduction. Nutrition programs. This does not apply to nutritional counseling, or any screening or assessment specifically provided under the Preventive Services benefit, or otherwise specifically covered under the Certificate.
- Treatment for obesity except surgery for Morbid Obesity (bariatric surgery). Surgery for removal of excess skin or fat.

Family Planning
- Infertility Treatment (male or female) - except as provided under the Infertility Treatment benefit-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 Insured Persons acting as surrogate mothers);
    - Cloning; or
    - Medical and surgical procedures that are Experimental or Investigative, unless Our denial is overturned by an External Appeal Agent.
    - Elective abortions.

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 except as provided under the Pediatric Vision Care Benefit or Adult Vision Care, duplicate spare eyeglasses, lenses or frames, non-prescription lenses or contact lenses that are for cosmetic purposes.

Dental
- Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.

Hearing
- Charges for hearing screening or cochlear implants.

Cosmetic
- Treatment of Acne unless Medically Necessary.
- Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
- Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma.

Prescription Drugs

- Any drug or medicine which does not, by federal or state law, require a prescription order, i.e. over-the-counter drugs, even if a prescription is written, except as specifically provided under Preventive Services or in the Prescription Drug Benefit section of this Certificate. Insulin and OTC preventive medications required under ACA are exempt from this exclusion;
- Drugs with over-the-counter equivalents except as specifically provided under Preventive Services;
- Allergy sera and extracts administered via injection;
- Vitamins, and minerals, except as specifically provided under Preventive Services;
- Food supplements, dietary supplements; except as specifically provided in the Certificate;
- Cosmetic drugs or medicines including, but not limited to, products that improve the appearance of wrinkles or other skin blemishes;
- Refills in excess of the number specified or dispensed after 1 year of date of the prescription;
- Drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
- Any drug or medicine purchased after coverage under the Certificate terminates;
- Any drug or medicine consumed or administered at the place where it is dispensed;
- If the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
- Prescription digital therapeutics;
- Bulk chemicals;
- Non-insulin syringes, surgical supplies, Durable Medical Equipment/medical devices, except as specifically provided in the Prescription Drug Benefit section of the Certificate;
- Repackaged products;
- Blood components except factors;
- Any drug or medicine for the purpose of weight control;
- Vision correction products.

Definitions | Commonly used terms

Effective Date means the time the Covered Person's coverage Period Begins. This is often the beginning of the Plan Year.

Deductible means the dollar amount You must pay before benefits are payable under this Plan. The deductible amount is shown in the above schedule. The deductible is included in the Out-of-Pocket Maximum. Note: The deductible applies to all services unless the benefit specifies, "deductible does not apply."

Coinsurance means the percentage of Covered Medical Expenses that We (Wellfleet) will pay. The Coinsurance percentage is stated in the Schedule of Benefits. The Coinsurance is separate and not part of any Deductible and/or copayment.

Copayment means a specified dollar amount You must pay for specified Covered Medical Expenses. Any copayment amounts are shown in the Schedule. The copayment is separate from the deductible and is calculated towards the Out-of-Pocket Maximum.

Out-of-Pocket Maximum means the most You will incur during a Policy Year before the coverage begins to pay at 100% of the allowed amount. This includes deductibles, copayments (medical and prescriptions) and any Coinsurance paid by you. This limit will never include Premium, balanced-billed charges or health care this plan does not cover.

In-Network Providers are Physicians, Hospitals and other healthcare providers that agree to Participate in a Preferred Provider Organization (PPO) Network and accept a negotiated fee for their services. In-Network Providers are not allowed to bill above the negotiated fee. Any balance remaining after the negotiated fee, not paid by the Plan, is the member's responsibility (deductible and coinsurance).

Out-of-Network Providers are Physicians, Hospitals and other health care providers that DO NOT agree to Participate in a Preferred Provider Organization (PPO) network. The Coinsurance paid to an Out-of-Network is less than In-Network providers.

Pre-certification of Care means contacting the Claims Administrator, Wellfleet, prior to Inpatient treatment to obtain prior approval. This may be done by your doctor or hospital administrator.