

Our Lady of the Lake University 2020-2021 Student Health Plan

Group No: ST0891SH
Policy No: WI2021TXSHIP01

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

Who is Eligible to Enroll?

Registered domestic undergraduate students taking 7 or more credit hours; International students and student athletes taking 1 or more credit hours; PhD and graduate students taking 1 or more credit hours; and dependents of eligible students are eligible to enroll in this plan.

How Do I Enroll?

Domestic undergraduate, graduate and PhD students taking 7 or more credit hours and student athletes are automatically enrolled in the plan unless coverage is waived. International students are automatically enrolled in the plan. PhD and graduate students taking less than 7 credits may enroll voluntarily upon request to Health Services. Student premium is added to your tuition bill. Students may enroll eligible dependents on a voluntary basis.

How Do I Waive Coverage?

Domestic undergraduate, graduate and PhD students and student athletes can waive coverage by providing proof of other comparable medical insurance coverage. An online waiver form must be completed by the waiver period deadline dates below. International students cannot waive coverage.

Waiver Period Deadline Dates

Annual/Fall	August 31, 2020
Spring/Summer	January 25, 2021

Student Cost & Periods of Coverage*

	Annual 8/1/20 to 7/31/21	Fall 8/1/20 to 1/8/21	Spring/ Summer 1/9/21 to 7/31/21
Student	\$2,181	\$963	\$1,218
Spouse	\$2,181	\$963	\$1,218
Each Child	\$2,181	\$963	\$1,218
3 or More Children	\$6,543	\$2,889	\$3,654

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

The plan described in this Summary is awaiting approval by the Texas 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*

UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN
DEDUCTIBLE (IF APPLICABLE) WILL ALWAYS APPLY. See Certificate
For Details For Pediatric Dental Coverage

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Policy Year Deductible	\$500 Individual	\$1,000 Individual
Out-of-Pocket Maximum	\$6,350 Individual \$12,700 Family	No Maximum
Coinsurance	70% of NC**	50% of U&C**
Preventive Care	100% of NC Deductible Waived	50% of U&C
Hospital Room & Board (Inpatient)	\$1,000 copay per admission then plan pays 70% of NC	\$1,000 copay per admission then plan pays 50% of U&C
Surgery (Inpatient or Outpatient)	70% of NC	50% of U&C
Physician's Office Visits	\$50 copay per visit then plan pays 70% of NC	\$50 copay per visit then plan pays 50% of NC
Emergency Care Services	\$300 copay per visit then plan pays 70% NC	Paid Same as In-Network; provider subject to U&C
Urgent Care	\$50 copay per visit then plan pays 70% NC	\$50 copay per visit then plan pays 50% U&C
Imaging Services & Laboratory Procedures (Outpatient)	70% of NC	50% of U&C
Sports Accident Expense for Intercollegiate, Club, or Intramural Sports	70% of NC	50% of U&C
Outpatient Prescription Drugs (Copay per 30-day supply) Out-of-Network benefits provided on a reimbursement basis)	Generic: \$30 copay Preferred Brand: \$60 copay Non-Preferred Brand: \$60 copay Specialty: \$60 copay then plan pays 100% of NC; Deductible waived	Generic: \$30 copay Preferred Brand: \$60 copay Non-Preferred Brand: \$60 copay Specialty: \$60 copay then plan pays 50% of Actual Charge; after 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 TX SHIP CERT (2020). 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.

Underwritten By:
Wellfleet Insurance Company

Plan Administrator:
Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115
www.Wellfleetstudent.com
(877) 657-5030

Servicing Agent:
Paul Fisher
Pinnacle Student Insurance
2021 W State Hwy 46, Suite 101
New Braunfels, TX 78132
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Preauthorization is required for inpatient hospital, surgery and selected outpatient services. Pre-Authorization is not required for an Emergency Medical Condition or for a Life-Threatening 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. The phone number can be found on the back of the Insured's ID card. The call should be made prior to Hospital Confinement, surgery or procedure. In the case of an emergency, the call should take place as soon as reasonably possible.

Where Can I Obtain more Information about the Plan?	
Enroll Dependents Waive Coverage Insurance Benefits Claim Processing ID Cards	Wellfleet Group LLC www.wellfleetstudent.com
Find Network Provider	Cigna PPO www.cigna.com
Find Prescription Drug Provider	Wellfleet RX Pharmacy Network www.wellfleetstudent.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 Ask Mayo Clinic

Exclusions

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 the Student Health Center or 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 or as part of the Student Health Center benefits provided by this plan.
4. Professional services rendered by an Immediate Family Member or anyone who lives with You. This exclusion does not apply to Dental services.
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, 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

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- 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. Expenses for radial keratotomy.
 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, and the fitting or repair or replacement of hearing aids or cochlear implants except as specifically provided in the Certificate.
 27. 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.
 28. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma.
 29. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
 30. You are:
 - committing or attempting to commit a felony,
 - engaged in an illegal occupation, or
 - participating in a riot.
 31. Elective abortions.
 32. Custodial Care service and supplies.
 33. Charges for hot or cold packs for personal use.
 34. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
 35. Services of private duty Nurse except as provided in the Certificate.
 36. Expenses that are not recommended and approved by a Physician.
 37. 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.
 38. Sleep Disorders, except for the diagnosis and treatment of obstructive sleep apnea.
 39. Treatment of Acne unless Medically Necessary.
 40. 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.
 41. 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;

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

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