



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

**Who Is Eligible?**

Colby College requires all registered full-time students have health insurance coverage, either through this Student Health Insurance Plan or through another individual or family plan.

**How to Accept / Waive?**

All eligible students are required to accept the insurance or complete an online waiver showing proof of comparable coverage. To accept or waive the school insurance go to: <https://www.studentinsurance.com/Client/1481>. Next select, Enroll or Waiver. Students submitting a waiver must have their current insurance information available. This information will be needed to submit your waiver. **The deadline to waive is August 1, 2020.**

Those students who make no selection, failed to submit a waiver or have an unapproved waiver after August 1, 2020, will automatically be enrolled in the insurance and the fee will remain on your bill.

**Cost and Periods of Coverage**

|         | Annual<br>8/1/2020 - 7/31/2021 | Spring/Summer<br>(New Students)<br>1/1/2021 - 7/31/2021 |
|---------|--------------------------------|---|
| Student | \$1,960                        | \$1,139   |

\*The above rates include an administrative fee.

**Where Can I Obtain More Information About The Plan?**

|   |   |
|---|---|
| Insurance Benefits Eligibility  | Cross Benefit Solutions<br>150 Mill Street, Suite 4<br>Lewiston, ME 04240<br>1-800-537-6444<br><a href="http://www.crossagency.com">www.crossagency.com</a>   |
| Insurance Benefits Benefits at a Glance<br>Policy Certificate<br>Claim Processing<br>ID Cards<br>Waive/Accept | <br><a href="http://www.wellfleetstudent.com">www.wellfleetstudent.com</a>  |
| Colby College Health Center   | Garrison-Foster Building 2 <sup>nd</sup> Floor<br>P: 207-859-4460 or F: 207-859-4475<br><a href="mailto:www.healthservices@colby.edu">www.healthservices@colby.edu</a><br>Mon.– Fri., 8:00 a.m.– 4:30 p.m.<br>Sat.– Sun., Noon– 5:00 p.m. |
| Colby College Counseling Center   | Garrison-Foster Building, Room 205<br>P: 207-859-4490 or F: 207-859-4495<br><a href="mailto:www.counseling@colby.edu">www.counseling@colby.edu</a><br>Mon. – Fri., 8:30 a.m. – 12:00 p.m. and<br>1:00 p.m. – 5:00 p.m.                    |

**HEALTH INSURANCE BENEFIT SUMMARY\***

| BENEFIT   | In-Network Provider   | Out-of-Network Provider              |
|---|---|--------------------------------------|
| Deductible  | \$0   | \$0                                  |
| Out-of-Pocket Maximum                                       | \$2,350 Individual  | \$5,000 Individual                   |
| Coinsurance   | 80% of PA   | 60% of U&C                           |
| Preventive Care   | 100% of PA  | 80% of U&C                           |
| Hospital Room & Board (Inpatient)**                         | 80% of PA   | 60% of U&C                           |
| Surgery (Inpatient** or Outpatient)                         | 80% of PA   | 60% of U&C                           |
| In Office Physician Visit including Specialist/ Consultants | 80% of PA   | 60% of U&C                           |
| Urgent Care Centers or Facilities                           | 80% of PA   | 60% of U&C                           |
| Emergency Services Expense                                  | 80% of PA   | Paid the same as In-Network Provider |
| Diagnostic X-ray & Laboratory                               | 80% of PA   | 60% of U&C                           |
| Prescription Drugs Retail Pharmacy<br>Up to 30-day supply   | 100% of PA after copay:<br>Tier 1 - \$10<br>Tier 2 - \$30<br>Tier 3 - \$50<br>Specialty drug - \$50 | 60% of Actual Charge                 |

PA= Preferred Allowance U&C=Usual and Customary

\*This is only a brief description of coverage available under Certificate form ME. SHIP CERT (2020). The Certificate will contain full details of coverage, coinsurance, limitations, exclusions, and termination provisions. If there are any conflicts between this document and the Certificate, the Certificate governs in all cases.

\*\*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.

Find Network PPO Provider: Cigna PPO Choice Fund  
<https://www.cigna.com/hcpdirectory/>

Find Prescription Drug Provider: Wellfleet RX/ESI  
[www.wellfleetrx.com](http://www.wellfleetrx.com)

**The following Value-Added Services are not part of the Policy and are not underwritten by Wellfleet Insurance Company. The services are:**

- Vision discount program through Davis Vision
- Medical travel assistance through Travel Guard

**Underwritten By:**  
 Wellfleet Insurance Company

**Plan Administrator:**  
 Wellfleet Group, LLC  
 PO Box 15369  
 Springfield, MA 01115  
[www.wellfleetstudent.com](http://www.wellfleetstudent.com)  
 1-877-657-5030

**Servicing Agent:**  
 Cross Benefit Solutions  
 150 Mill Street, Suite 4  
 Lewiston, ME 04240  
 800-537-6444  
[www.crossagency.com](http://www.crossagency.com)



## Exclusions and Limitations

**Exclusion Disclaimer:** Any exclusion in conflict with the Patient Protection and Affordable Care Act will be administered to comply with the requirements of the Act.

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, 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 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
13. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
14. 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.
15. Services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
16. Expenses payable under any prior policy which was in force for the person making the claim.
17. 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.
18. 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.
19. Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
  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 except surgery for morbid obesity (bariatric surgery). 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, or cochlear implants except as specifically provided in the Certificate.
  27. Racing or speed contests, skin diving or sky diving, 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. Extraction of impacted wisdom teeth or dental abscesses.
  31. Treatment of Temporomandibular Joint Dysfunction (TMJ) other than a surgical procedure for those covered conditions affecting the upper or lower jawbone or associated bone joints. Such a procedure must be considered Medically Necessary based on the Certificate definition of same.
  32. You are:
    - committing or attempting to commit a felony,
    - engaged in an illegal occupation, or
    - participating in a riot.
  33. Custodial Care service and supplies.
  34. Charges for hot or cold packs for personal use.
  35. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
  36. Services of private duty Nurse except as provided in the Certificate.
  37. Expenses that are not recommended and approved by a Physician.
  38. 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.
  39. 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.
  40. Sleep Disorders, except for the diagnosis and treatment of obstructive sleep apnea.
  41. Treatment of Acne unless Medically Necessary.
  42. 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.
  43. 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.

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