FAITH BAPTIST BIBLE COLLEGE AND THEOLOGICAL SEMINARY (THE POLICYHOLDER)

STUDENT HEALTH INSURANCE PLAN (SHIP)

Effective Dates & Plan Costs

The plan costs and coverage terms are listed below. Coverage terms are effective at 12:00 a.m. and terminate at 11:59 p.m. Plan costs include the medical insurance premium and administrative fees.

	DEADLINE DATE	STUDENT
Annual 08/01/2022 to 07/31/2023	September 2, 2022	$ 1,897.00
Fall 08/01/2022 to 12/31/2022	September 2, 2022	$ 796.00
Spring / Summer 01/01/2023 to 07/31/2023	January 20, 2023	$ 1,101.00
Summer 05/11/2023 to 07/31/2023	May 4, 2023	$ 426.00

Coinsurance is the cost sharing between what the insurance pays and what you pay. This insurance plan pays 90% of the Negotiated Charge (NC) when you use **Cigna PPO** providers, and 70% of Usual & Customary (U&C) Charge when you use out-of-network providers.

This is only a brief description of the coverage(s) available under Certificate form IA SHIP Cert (2022). 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.

This is not an insurance policy and your receipt of this document does not constitute the issuance or delivery of a policy of insurance.

Underwritten By: Wellfleet Insurance Company

Questions

Eligibility & Enrollment
Relation Insurance Services
(800) 955-1991

Benefits
Wellfleet Group, LLC
(877) 657-5030, TTY 711

Plan Materials & Information
www.4studenthealth.com/faith

Insurance ID Card

Download your ID card from **www.wellfleetstudent.com**.

Carry your ID card with you at all times!

Getting Care

Visit **www.wellfleetstudent.com**, or call **(877) 657-5030, TTY 711** to find a provider in the Cigna PPO Network.

Prescription Drugs

Always use a Wellfleet Rx / ESI pharmacy. To locate a pharmacy, visit **www.wellfleetstudent.com** or call **(877) 640-7940**.

Servicing Agent

Relation Insurance Services

Rev: Jun 21, 2022

WI2223IASHIP145
Group Number: ST1073SH

Benefits

	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER[1]
Medical Deductible	$500 per Policy Year	$1,500 per Policy Year
Physician's Office Visits including Specialists / Consultants	$20 copay then the plan pays 100% of NC (deductible waived)	70% of U&C
Urgent Care Centers for Non-Life-Threatening Conditions	90% of NC	70% of U&C
Emergency Services in an Emergency Department for Emergency Medical Conditions	90% of NC	Paid the same as In-Network Provider subject to U&C
Hospital Care includes Hospital Room & Board Expenses and Miscellaneous Services & Supplies[2]	90% of NC	70% of U&C
Prescription Drugs[3]	$20 copay Generic $40 copay Preferred Brand $60 copay Non-Preferred Brand & Specialty (deductible waived)	70% of U&C
Out-of-Pocket Maximum	$7,500 per Policy Year	$22,500 per Policy Year

1. Using out-of-network providers will cost you more money! Coinsurance is payable for Usual and Customary (U&C) Charges, the most common charge for similar professional services, drugs, procedures, devices, supplies, or treatment within the area in which the charge is incurred. Some out-of-network providers charge more than U&C and you will be responsible for these excess amounts over the listed coinsurance.
2. Pre-Certification required for Inpatient Services Care, selected Outpatient Services, and Outpatient Surgery. For a complete list of these services, see the Plan Certificate.
3. At an out-of-network pharmacy, you must pay for prescriptions in full, then submit a claim for reimbursement.

Exclusions & 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. 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.
6. Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
7. 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.
8. Services that are duplicated when provided by both a licensed midwife and a Physician.
9. Expenses payable under any prior policy which was in force for the person making the claim.
10. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
11. 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.
12. Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
13. You are:
    - committing or attempting to commit a felony,
    - engaged in an illegal occupation, or
    - participating in a riot.
14. Custodial Care service and supplies.
15. Charges for hot or cold packs for personal use.
16. Services of private duty Nurse except as provided in the Certificate.
17. Expenses that are not recommended and approved by a Physician.
18. Experimental or Investigative drugs, devices, Treatments or procedures unless otherwise covered under Cancer Clinical Trials. See the Other Services and Supplies section for more information.
19. 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.
20. 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.
21. Non-chemical addictions.
22. Non-physical, occupational, speech therapies (art, dance, etc.).
23. Modifications made to dwellings.
24. General fitness, exercise programs.
25. Hypnosis.
26. Rolfing.
27. Biofeedback.
28. Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
29. Sleep Disorders, unless medically necessary, except for the diagnosis and Treatment of obstructive sleep apnea.
30. 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

1. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
2. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
3. 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 in excess of $1,000.00 per Intercollegiate or club sports Accident.
4. 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.

Weight management / Reduction

1. 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.
2. Treatment for obesity except surgery for morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat.

Family Planning

1. 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 Investigative, unless Our denial is overturned by an External Appeal Agent.

Vision

1. Expenses for radial keratotomy.
2. Adult Vision unless specifically provided in the Certificate.
3. 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

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

Hearing

1. Charges for hearing screening, hearing aids and the fitting or repair or replacement of hearing aids or cochlear implants except as specifically provided in the Certificate.

Cosmetic

1. Treatment of Acne unless Medically Necessary.
2. Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
3. 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

1. 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;
2. Drugs with over-the-counter equivalents except as specifically provided under Preventive Services;
3. Allergy sera and extracts administered via injection;
4. Vitamins, and minerals, except as specifically provided under Preventive Services;
5. Food supplements, dietary supplements; except as specifically provided in the Certificate;
6. Cosmetic drugs or medicines including, but not limited to, products that improve the appearance of wrinkles or other skin blemishes;
7. Refills in excess of the number specified or dispensed after 1 year of date of the prescription;
8. Drugs labeled, “Caution – limited by federal law to Investigational use” or Experimental Drugs;
9. Any drug or medicine purchased after coverage under the Certificate terminates;
10. Any drug or medicine consumed or administered at the place where it is dispensed;
11. 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;
12. Bulk chemicals;
13. Non-insulin syringes, surgical supplies, Durable Medical Equipment/medical devices, except as specifically provided in the Prescription Drug Benefit section of the Certificate;
14. Repackaged products;
15. Blood components except factors;
16. Any drug or medicine for the purpose of weight control;
17. Fertility drugs;
18. Sexual enhancements drugs;
19. Vision correction products.