SNAPSHOT

2021–2022

UNIVERSITY OF REDLANDS
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.

	WAIVER DEADLINE DATE	STUDENT PLAN COST
Annual 08/10/2021 to 8/09/2022	09/20/2021	$ 1,713.00
Fall 08/10/2021 to 12/31/2021	09/20/2021	N/A
Spring / Summer 01/01/2022 to 8/09/2022	01/17/2022	N/A

Coinsurance is the cost sharing between what the insurance pays and what you pay. This insurance plan pays 80% of the Negotiated Charge when you use **Cigna Open Access Plus (OAP) PPO** providers, and 60% of Usual & Customary (U&C) Charge when you use out-of-network providers.

CareConnect provides you with immediate access to licensed behavioral health clinicians where and when you need them most.

An integrated behavioral health program, CareConnect offers easy access to licensed behavioral health clinicians 24/7/365 via telephone. Please visit **www.4studenthealth.com/redlands** for more information.

This is only a brief description of the coverage(s) available under Certificate form CA SHIP Cert (2019). 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.

Questions

Enrollment & Eligibility
Relation Insurance Services
(800) 537-1777

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

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

Insurance ID Card

You will receive an email when your insurance ID card is available. Download your ID card from **www.wellfleetstudent.com**.

Carry your ID card with you at all times!

Getting Care

Go to the campus health center. If you need to access care away from campus, visit **www.wellfleetstudent.com** or call **(877) 657-5030**, **TTY 711** to find a provider in the **Cigna OAP** Network.

Prescription Drugs

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

Revised August 11, 2021 1:10 PM

Relation™
EDUCATION SOLUTIONS

Relation Insurance Services
CA License No. 0G55426

Benefits

	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER[1]
Medical Deductible	$250 per Policy Year	
Physician's Office Visits	$20 copay per visit then the plan pays 100% of NC	60% of U&C
Urgent Care Centers for Non-Life-Threatening Conditions	80% of NC	60% of U&C
Emergency Services in an Emergency Department (includes Urgent Care for Emergency Medical Conditions)	$50 copay per visit (copay waived if admitted) then the plan pays 100% of NC	Paid the same as In-Network Provider subject to U&C
Hospital Care includes Hospital Room & Board Expenses and Miscellaneous Services & Supplies. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care.[2]	80% of NC	60% of U&C
Prescription Drugs	$20 copay Generic $50 copay Preferred Brand $75 copay Non-Preferred Brand $75 copay Specialty (deductible waived)	$20 copay Generic $50 copay Preferred Brand $75 copay Non-Preferred Brand $75 copay Specialty then the plan pays 60% of Actual Charges[3] (deductible waived)
Out-of-Pocket Maximum	$6,350 per Policy Year	No maximum

1. Using out-of-network providers will cost you more money! Coinsurance is payable for Usual and Customary (U&C) Charges. 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. You must pay for prescriptions in full, then submit a claim for reimbursement.

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 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 paid by Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medi-Cal.
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. 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.
11. Services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
12. Expenses payable under any prior policy which was in force for the person making the claim.
13. 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.
14. Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
15. 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.
16. Treatment for obesity except surgery for morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat.
17. Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
18. Expenses for radial keratotomy.
19. Adult Vision unless specifically provided in the Certificate.
20. 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.
21. 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.
22. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma, or for gender dysphoria.
23. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
24. Extraction of impacted wisdom teeth or dental abscesses.
25. You are:
    - committing or attempting to commit a felony,
    - engaged in an illegal occupation, or
    - participating in a riot.
26. Custodial Care service and supplies.
27. Charges for hot or cold packs for personal use.
28. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
29. Services of private duty Nurse except as provided in the Certificate.
30. Expenses that are not recommended and approved by a Physician.
31. 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.
32. Sleep Disorders, unless medically necessary, except for the diagnosis and treatment of obstructive sleep apnea.
33. Treatment of Acne unless Medically Necessary.

34. 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.
35. 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 the 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;
    - 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;
36. Non-chemical addictions.
37. Non-physical, occupational, speech therapies (art, dance, etc.).
38. Modifications made to dwellings.
39. General fitness, exercise programs.
40. Hypnosis.
41. Rolfing.
42. Biofeedback.

Wellfleet Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

(Arabic)
إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. تصل برقم +1 (877) 657-5030, TTY 711.

(Chinese-S)
如果您说中文，您可以免费获得语言援助服务。请致电 +1 (877) 657-5030, TTY 711.。

(Chinese-T)
如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 +1 (877) 657-5030, TTY 711.。

(French)
Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le +1 (877) 657-5030, TTY 711.

(French Creole-Haitian)
Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele +1 (877) 657-5030, TTY 711.

(German)
Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer +1 (877) 657-5030, TTY 711.

(Italian)
In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero +1 (877) 657-5030, TTY 711.

(Japanese)
日本語を話される場合、無料の言語支援をご利用いただけます。+1 (877) 657-5030, TTY 711 まで、お電話にてご連絡ください。

(Korean)
한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. +1 (877) 657-5030, TTY 711 번으로 전화해 주십시오.

(Persian-Farsi)
اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با +1 (877) 657-5030, TTY 711 بگیرید.

(Polish)
Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer +1 (877) 657-5030, TTY 711.

(Portuguese)
Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para +1 (877) 657-5030, TTY 711.

(Russian)
Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните +1 (877) 657-5030, TTY 711.

(Spanish)
Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al +1 (877) 657-5030, TTY 711.

(Tagalog)
Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa +1 (877) 657-5030, TTY 711.

(Vietnamese)
Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số +1 (877) 657-5030, TTY 711.