UCONN
UNIVERSITY OF CONNECTICUT

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2025/2026

DESIGNED EXCLUSIVELY FOR THE UNDERGRATUATE AND GRADUATE STUDENTS OF:

UNIVERSITY OF CONNECTICUT

Storrs, CT
("the Policyholder")

Policy Number: WI2526CTSHIP31

Group Number: ST0931SH

Effective: 8/1/2025 - 7/31/2026

UNDERWRITTEN BY:

Wellfleet Insurance Company | Fort Wayne, IN

("the Company")

ADMINISTERED BY:

Wellfleet Group, LLC

WELLFLEET STUDENT

Welcome Students…

We are pleased to provide you with this summary of the 2025 – 2026 Student Health Insurance Plan ("Plan"), which is fully compliant with the Affordable Care Act. This is only a brief description of the coverage(s) available under Certificate form CT SHIP Cert (2025). 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.

"Benefits at a Glance" includes effective dates and costs of coverage, as well as other helpful information. For additional details about the Plan, please consult the Plan Certificate and other materials at **www.wellfleetstudent.com**.

This is not an insurance Policy and your receipt of this document does not constitute the insurance or delivery of a policy of insurance. Any provisions of the Policy, as described in this Summary, that may be in conflict with the laws of the state where the school is located will be administered to conform with the requirements of that state's laws, including those relating to mandated benefits.

The information contained in this Summary is accurate at the time of publication but may change in accordance with state and federal insurance regulations during the course of the Policy year. The most current version of this document will be posted online. In the case of a discrepancy between two versions of the Summary, the most recent will apply.

PENDING STATE APPROVAL

The Plan described in "Benefits at a Glance" is awaiting approval by the Connecticut Department of Insurance. If the Plan is changed during the approval process, a revision of this document 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.

Student Health Center

UCONN STUDENT HEALTH AND WELLNESS (SHaW) - STORRS CAMPUS ONLY

234 Glenbrook Road, Storrs, CT 06269-4011
Phone (860) 486-4700
Emergencies call 911
Or
Campus Police (860) 486-4800

For hours of operation, please click on the link below:

Hours & Offices | UConn Student Health and Wellness (SHaW)

UConn SHaW is the University's on-campus health facility. Student Health and Wellness is staffed by physicians, nurse practitioners, registered nurses and Licensed mental health clinicians.

Any student who has paid the SHaW Fee on their current term fee bill is eligible to use SHaW. Students who are registered for credit-bearing courses at Storrs through the College of Continuing Studies are also eligible.

SHaW provides a wide variety of services. This includes primary care visits with doctors and nurse practitioners including gynecologic and gender-affirming care; appointments with nurses, nutritionists, and physical activity counselors; and individual and group therapy with licensed clinicians in addition to medication management visits. Additional charges may be incurred for laboratory testing, pharmacy items, X-rays, special medical procedures and visits with specialists. Many of the charges are reimbursable by this Plan or other private Health insurance.

For Students of the Storrs Campus who have purchased the Student Health Insurance coverage, the deductible and copayment will be waived when you use the UConn Student Health and Wellness (SHaW).

Important Contact Information & Resources

Contact Us

Wellfleet Group, LLC
PO Box 15369
Springfield, Massachusetts 01115-5369
(877) 657-5030, TTY 711

Servicing Agent

Smith Brothers Insurance
68 National Drive
Glastonbury, CT 06033
(860) 430-3338
StudentHealth@SmithBrothersUSA.com

Plan Administration

Enrollment, Eligibility, & Waivers

The University of Connecticut
Student Health and Wellness
234 Glenbrook Road, Unit 4011
Storrs, CT 06269-4011
(860) 486-4535
www.studenthealth.uconn.edu

Benefits, Claim Status, & ID Cards

Wellfleet Group, LLC
PO Box 15369
Springfield, Massachusetts 01115-5369
(877) 657-5030, TTY 711
www.wellfleetstudent.com
Monday–Thursday, 8:30 a.m. to 7:00 p.m. Eastern Time
Friday, 9:00 a.m. to 5:00 p.m.Eastern Time

Claims

Cigna OAP
PO Box 188061
Chattanooga, Tennessee 37422-8061
Electronic Payor ID: 62308

PPO Network

Cigna.

Open Access Plus OAP
www.mycigna.com

Pharmacy Benefits Manager

For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit **www.wellfleetrx.com/students**

Your plan includes Wellfleet Rx – offering over 40 generics at a $0 copay. Please ask your health care provider to review our formulary to see if these medications are right for you. Click here **http://wellfleetrx.com/students/formularies/** for more information.

Member Pharmacy Help

(877) 640-7940

Student Health Center

UCONN STUDENT HEALTH AND WELLNESS (SHaW)
STORRS CAMPUS ONLY
234 Glenbrook Road,
Storrs, CT 06269-4011
Phone (860) 486-4700
Emergencies call 911
Or Campus Police (860) 486-4800

Telehealth Service

Your plan includes access to virtual healthcare advice by phone, video, or app.

- Scheduled mental health services – 7 days a week

Register at
https://www.teladoc.com/wellfleetstudent/

- In addition, your plan includes virtual physical therapy and other musculoskeletal services from Hinge Health
- Register at https://hinge.health/wellfleet

For further information about your plan please use the QR code below.

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General Information

Am I Eligible

UNDERGRADUATES

All registered full-time Undergraduate students taking 12 credits are required to have health insurance coverage, either through this Student Health Insurance Plan or through another individual or family plan. Students are automatically enrolled in the Student Health Insurance Plan at registration and the premium is added to the student's tuition

GRADUATES

All registered full-time Graduate students taking 9 credits are required to have health insurance coverage, either through this Student Health Insurance Plan or through another individual or family plan. Students are automatically enrolled in the Student Health Insurance Plan at registration and the premium is added to the student's tuition

PART TIME

All registered Part-time students taking 6 credits are eligible to enroll in this Student Health Insurance Plan on a voluntary basis. Please contact Smith Brothers Insurance

Note: Online Courses do not count toward eligibility.

DEPENDENTS

Insured Students who are enrolled in the Student Health Plan may also enroll their eligible Dependents.

How Do I Waive/Enroll?

To Waive Coverage:
Most full-time students will be automatically enrolled in the Student Health Insurance Plan, unless a waiver has been completed by the specified deadline dates listed. The premium for the Plan will be added to your tuition bill.

Exempt University Programs: While most full-time students are automatically billed for the UConn Student Health Insurance Plan, there are some university programs that are exempt from the health insurance requirement. Due to multiple changes of University Program classification it is advised that ALL students check their tuition fee bill to determine if the fee for the insurance has been posted. If the change has not been posted, you may still be eligible to voluntarily enroll in the student health insurance plan.

If after review of the coverage a student wants to formally decline (waive) the Wellfleet/UConn Student Health Insurance Plan, the online waiver must be completed. The online Waiver is accessed through the student administration (PeopleSoft) system at www.studentadmin.uconn.edu. Your UConn NetID number and unique password are needed to access the system. The only acceptable form of notification to decline the coverage is via the online waiver.

The deadline to waive coverage is

- **Fall Term 09/15/2025**
- **Spring Term 02/05/2026**

By submitting the waiver request, you agree that your current insurance plan may be contacted for confirmation that your coverage is in force for the applicable policy year and that it meets the school's waiver requirements

To Voluntarily Enroll yourself or Dependents:
Please Contact
Smith Brothers Insurance
68 National Drive
Glastonbury, CT 06033
(860) 430-3338

Effective Dates & Costs

All time periods begin at 12:00 A.M. local time and end at 11:59 P.M. local time at the Policyholder's address.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual Students	08/01/2025	07/31/2026	09/15/2025
Spring/Summer New/Transfer	01/01/2026	07/31/2026	02/05/2026

Plan Costs for Undergraduate and Graduate Students and their Dependents

	Annual Students	Spring/Summer New/Transfer Students
Student	$3,214	$1,897
Spouse	$3,144	$1,827
Each Child	$3,144	$1,827
3 or more Children	$9,432	$5,481

***The above plan costs include an administrative service fee.**
The plan costs for Dependents are in addition to the plan costs for student.

Open Access Plus (OAP) Network

…providing access to quality health care at discounted costs!

By enrolling in this Student Health Plan, you have the Cigna Open Access Plus (OAP) Network of participating Providers. To find a complete listing of the Network's participating Providers, go to **www.cigna.com,** or contact Wellfleet Student toll-free at (877) 657-5030, TTY 711, or **www.wellfleetstudent.com** for assistance.

Plan Benefits

UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE (IF APPLICABLE) WILL ALWAYS APPLY.

When You receive Emergency Services, or Out-of-Network air Ambulance Services, or Urgent Crisis Center Services or certain non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, or clinical laboratory, You are protected from Surprise Billing. In these situations, Your cost sharing responsibility will be calculated as if the total amount that would be charged for the services by an In-Network Provider or facility were equal to the Recognized Amount for the services, which is generally defined either as an amount set by state law or the lesser of the billed charges and the Qualifying Payment Amount. Refer to the Preferred Provider Organization provision in the How The Plan Works And Description Of Benefits section for additional information.

Pre-Certification Requirement:
What types of Inpatient and Outpatient services or supplies require Pre-Certification?
Pre-Certification is required for the following:

1. All Inpatient admissions, including length of stay, to a Hospital, Skilled Nursing Facility, a facility established primarily for the Treatment of a Substance Use Disorder, or a residential Treatment facility, surgical procedures;
2. All Inpatient maternity care after the initial 48/96 hours;
3. Home Health Care;
4. Durable Medical Equipment over $500 per item;
5. Outpatient Surgical Procedures;
6. Transplant Services;
7. Diagnostic Testing and Radiology Services listed at www.wellfleetstudent.com/providers/. See Prior Authorization Requirements section;
8. Complex Imaging;
9. Biomarker Testing;
10. Chemotherapy/Radiation;
11. Fertility Preservation;
12. Infusions/Injectables;
13. Botox Injections;
14. Genetic Testing, except for BRCA;
15. Orthotics/Prosthetics;
16. Non-emergency Air Ambulance (fixed wing).

Pre-Certification is not required for an Emergency Medical Condition, or Urgent Care Center or Hospital Confinement for the initial 48/96 hours of maternity care.

Pre-Certification is not a guarantee that benefits will be paid.

Key Plan Benefits

BENEFIT	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Policy Year Deductible* Individual Family *Deductible is waived if Covered Medical Expenses are incurred at the Student Health Center.	$300 $900	$600 $1,800
Cost sharing You incur for Covered Medical Expenses that is applied to the Out-of-Network Deductible will not be applied to satisfy the In-Network Deductible. Cost sharing You incur for Covered Medical Expenses that is applied to the In-Network Deductible will not be applied to satisfy the Out-of-Network Provider Deductible.		
Out-of-Pocket Maximum Individual Family	$6,850 $13,700	No Maximum No Maximum
Cost sharing You incur for Covered Medical Expenses that is applied to the Out-of-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the In-Network Provider Out-of-Pocket Maximum and cost sharing You incur for Covered Medical Expenses that is applied to the In-Network Provider Out-of-Pocket Maximum will not be applied to satisfy the Out-of-Network Provider Out-of-Pocket Maximum.		
Coinsurance	80% of the Negotiated Charge (NC)	60% of the Usual and Customary (U&C) Charge

Preventive Services	100% of the (NC) for Covered Medical Expenses Deductible Waived	60% of the (U&C) Charge after Deductible for Covered Medical Expenses Subject to Deductible and any Copayment
Physician Office Visits including Specialists/Consultants *Check below for additional copayments if applicable	$20 Copayment per visit then the plan pays 100% of the (NC) for Covered Medical Expenses Deductible Waived	60% of (U&C) Charge for Covered Medical Expenses Deductible Waived
Emergency Services in an emergency department for Emergency Medical Conditions.	$150 Copayment per visit then the plan pays 100% of the (NC) for Covered Medical Expenses Deductible Waived	Paid the same as In-Network Provider subject to (U&C) Charge.
Urgent Care Centers for non-life-threatening conditions	$20 Copayment per visit then the plan pays 100% of the (NC) for Covered Medical Expenses Deductible Waived	$20 Copayment per visit then the plan pays 100% of (U&C) Charge for Covered Medical Expenses Deductible Waived

Schedule of Benefits

THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:

1. **THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
3. **DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY AN IN-NETWORK OR OUT-OF-NETWORK PROVIDER.**
4. **UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE WILL ALWAYS APPLY.**
5. **UNLESS SPECIFIED BELOW, ANY APPLICABLE COPAYMENTS ARE APPLIED AFTER DEDUCTIBLE IS MET.**
6. **UNLESS OTHERWISE SPECIFIED BELOW, ANY DAY OR VISIT LIMITS WILL BE APPLIED TO IN-NETWORK AND OUT-OF-NETWORK COMBINED.**

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK	OUT-OF-NETWORK
INPATIENT SERVICES		
Hospital Care Includes Hospital Room and Board Expenses and Hospital Miscellaneous Expenses. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	Cost sharing based on facility where service is rendered	
Physician's Visits while Confined	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Registered Nurse Services for private duty nursing while Confined	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER BENEFITS In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, and any Pre-Certification requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness. Day or visit limits do not apply to Mental Health Disorder and Substance Use Disorder Benefits.		
Inpatient Mental Health Disorder and Substance Use Disorder Benefits Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Mental Health Disorder and Substance Use Disorder Benefits		
Physician's Office Visits including, but not limited to, Physician visits; individual and group therapy; medication management (For Treatment rendered at the Student Health Center/Infirmary, refer to the Student Health Center/Infirmary Expense Benefit section of this Schedule of Benefits for benefit information.)	$20 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived
All Other Outpatient Services (All Other Outpatient Services does not include Emergency Services in an emergency department, Urgent Care Centers, and Emergency Ambulance Service and Prescription Drugs. Refer to the Emergency Services, Ambulance and Non-Emergency Services, and Prescription Drugs sections of this Schedule of Benefits for benefit information.) Pre-Certification may be required for certain All Other Outpatient Services. To see if Pre-Certification is required, refer to the Pre-Certification Requirement listing and specific benefit listed in this Schedule of Benefits.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Mental Health Wellness Exams limited to 2 exams per Policy Year Pre-Certification is not required	Paid at 100% of the Negotiated Charge Deductible Waived if applicable	Paid at 100% of Usual and Customary Charge Deductible waived if applicable
PROFESSIONAL AND OUTPATIENT SERVICES		
Surgical Expenses		
Inpatient Surgery includes: Pre-Certification required for Surgery only Surgeon Services Anesthetist Assistant Surgeon	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Surgery includes: Pre-Certification Required For Surgeon Services, Assistant Surgeon, and Anesthetist charges. This also includes outpatient miscellaneous– expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma charges.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Abortion Expense	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Organ Transplant Surgery travel and lodging expenses limited to: Lodging 10 nights up to the average standard room rate (assumes double occupancy). Meals- 2 meals per person a day up to a 10 day maximum while at the transplant facility. Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Bone Marrow Testing Benefit	Based on site of service not to exceed 20% of Actual Charge for Covered Medical Expenses Deductible Waived	Based on site of service not to exceed 20% of Actual Charge for Covered Medical Expenses Deductible Waived
Reconstructive Surgery Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Other Professional Services		
Gender Affirming Services Benefit Pre-Certification Required for gender affirming surgery	Same as any other Mental Health Disorder	

Home Health Care Expenses Pre-Certification required This benefit is not subject to the plan Deductible.	80% of the Negotiated Charge for Covered Medical Expenses	80% of Usual and Customary Charge for Covered Medical Expenses
Home Health Care Expenses Maximum visits per Policy Year	100	100
Hospice Care Coverage	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Office Visits		
Physician's Office Visits including Specialists/Consultants	$20 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived
Telemedicine or Telehealth Services Benefit	$20 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived
Telemedicine or Telehealth Services Program Behavioral Health Musculoskeletal	$0 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived $0 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	
Allergy Testing and Treatment, including injections performed at a Physician's or specialists office	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit	$20 Copayment per visit after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Maximum visits per Policy Year	30	30
Tuberculosis screening (TB), Titers, QuantiFERON B tests including shots (other than covered under Preventive Services)	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

EMERGENCY SERVICES, AMBULANCE AND NON-EMERGENCY SERVICES		
Emergency Services in an emergency department for Emergency Medical Conditions	$150 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Urgent Care Centers for non-life-threatening conditions	$20 Copayment per visit then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	$20 Copayment per visit then the plan pays 100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived
Emergency Ambulance Service ground and/or air, water transportation	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Paid the same as In-Network Provider subject to Usual and Customary Charge.
Non-Emergency Ambulance Expenses ground and/or air (fixed wing) transportation Pre-Certification Required for non-emergency air Ambulance (fixed wing)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	Ground Ambulance transportation: 60% of Usual and Customary Charge after Deductible for Covered Medical Expenses Air Ambulance transportation: Paid the same as In-Network Provider subject to Usual and Customary Charge
DIAGNOSTIC LABORATORY, RADIOLOGY, TESTING AND IMAGING SERVICES		
Diagnostic Complex Imaging Services Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Diagnostic Laboratory, Radiological Services and Testing (Outpatient) Pre-Certification may be required. See Prior Authorization Requirements section listed at www.wellfleetstudent.com/providers/	80% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
REHABILITATION AND HABILITATION THERAPIES		
Cardiac Rehabilitation	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Rehabilitation Therapy Maximum Visits for each therapy per Policy Year for Physical Therapy, and Occupational Therapy and Speech Therapy Combined with Habilitation Services Therapy	40	40
Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy	100% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitation Services Maximum Visits for each therapy per Policy Year for Physical Therapy, and Occupational Therapy and Speech Therapy Combined with Rehabilitation Therapy	40	40
OTHER SERVICES AND SUPPLIES		
Covered Clinical Trials	Same as any other Covered Sickness	
Diabetic Services and Supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Durable Medical Equipment Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Enteral Formulas and Nutritional Supplements (Treatment of Inherited Metabolic Diseases including cystic fibrosis and Medically Necessary Specialized Formulas) See the Prescription Drug section of this Schedule when purchased at a pharmacy.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hearing Aids Limited to 1 hearing aid per ear within a 24 month period	Paid the same as Durable Medical Equipment	
Infertility Treatment Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Fertility Preservation Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
Prosthetic and Orthotic Devices Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Lyme Disease	Same as any other Covered Sickness subject to the limits described in the benefit	
Mobile Field Hospital	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Student Health Center/Infirmary Expense Benefit	100% of the Usual and Customary Charge for Covered Medical Expenses Deductible Waived	
Sports Accident Expense Benefit - incurred as the result of the play or practice of club sports Pre-Certification not Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Non-emergency Care While Traveling Outside of the United States	60% of Actual Charge after Deductible for Covered Medical Expenses Subject to $10,000 maximum per Policy Year	
Bedside Visits (International Students and their Dependents)	100% of Actual Charge for Covered Expenses Deductible Waived Subject to $5,000 maximum per Policy Year	
Medical Treatment Received in Home Country (International Students and their Dependents Only)	60% of Actual Charge after Deductible for Covered Medical Expenses	
Medical Evacuation Expense (International Students, and Domestic Students and their Dependents)	100% of Actual Charge for Covered Medical Expenses Deductible Waived	
Repatriation Expense (International Students, and Domestic Students and their Dependents)	100% of Actual Charge for Covered Medical Expenses Deductible Waived	
PEDIATRIC AND ADULT DENTAL AND VISION CARE		
Pediatric Dental Care Benefit (thru age 26 subject to the termination date provision. Please refer to the Termination Date section of the Certificate for further information.) Preventive Dental Care Limited to 2 dental exams every 12 months The benefit payable amount for the following services is different from the benefit payable amount for	See the Pediatric Dental Care Benefit description in the Certificate for further information. 100% of Usual and Customary Charge for Covered Medical Expenses	

Preventive Dental Care: Emergency Dental Routine Dental Care Endodontic Services Prosthodontic Services Periodontic Services Medically Necessary Orthodontic Care Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived	
Pediatric Vision Care Benefit (thru age 26 subject to the termination date provision. Please refer to the Termination Date section of the Certificate for further information.) Limited to 1 vision examination per Policy Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of Usual and Customary Charge after Deductible for Covered Medical Expenses	
Annual Adult Vision Care Includes an annual retina exam for an existing condition of the eye, such as glaucoma or diabetic retinopathy.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
MISCELLANEOUS DENTAL SERVICES		
Accidental Injury Dental Treatment Subject to $250 per tooth	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Sickness Dental Expense Benefit	80%of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hospital Dental Services Benefit	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses

PRESCRIPTION DRUGS		
Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy. Your benefit is limited to a 30-day supply. Coverage for more than a 30-day supply only applies if the smallest package size exceeds a 30-day supply. See "Retail Pharmacy Supply Limits" section for more information.		
TIER 1 (Including Enteral Formulas) For each fill up to a 30-day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$10 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 30-day supply but less than a 61-day supply filled at a Retail pharmacy	$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60-day supply filled at a Retail pharmacy	$30 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual Charge for Covered Medical Expenses Deductible Waived
TIER 2 (Including Enteral Formulas) For each fill up to a 30-day supply filled at a Retail pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual Charge for Covered Medical Expenses Deductible Waived

More than a 30-day supply but less than a 61-day supply filled at a Retail pharmacy	$80 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60-day supply filled at a Retail pharmacy	$120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual Charge for Covered Medical Expenses Deductible Waived
TIER 3 (Including Enteral Formulas) For each fill up to a 30-day supply filled at a Retail Pharmacy Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions. See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 30-day supply but less than a 61-day supply filled at a Retail pharmacy	$120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60-day supply filled at a Retail pharmacy	$180 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual Charge for Covered Medical Expenses Deductible Waived
Specialty Prescription Drugs		
For each fill up to a 30-day supply Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual Charge for Covered Medical Expenses Deductible Waived

More than a 30-day supply but less than a 61-day supply	$120 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual Charge for Covered Medical Expenses Deductible Waived
More than a 60-day supply	$180 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	60% of Actual Charge for Covered Medical Expenses Deductible Waived
Zero Cost Drugs		
Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	100% of Actual Charge for Covered Medical Expenses Deductible Waived
Orally administered anti-cancer Prescription Drugs (including Specialty Drugs)		
Benefit	If the cost share for the Prescription Drug's Tier is greater than the Chemotherapy Benefit or Infusion Therapy Benefit, the cost share will be calculated as follows: Greater of: • Chemotherapy Benefit; or • Infusion Therapy Benefit	
Diabetic Supplies (for prescription supplies purchased at a pharmacy)		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill except that the Insured Person's out-of-pocket costs shall not exceed the amounts below and the deductible is waived: • Covered insulin drugs will not exceed $25 per each 30-day supply; • Covered non-insulin drugs will not exceed $25 per each 30-day supply; and • Covered diabetes devices or diabetic ketoacidosis devices will not cumulatively exceed $100 per 30-day supply regardless of the number of devices dispensed in a 30-day period, so long as the devices can be prescribed and dispensed in a 30-day supply. The out-of-pocket caps described above only apply when: • Prescribed to the Insured by a prescribing practitioner; or • Prescribed and dispensed by a pharmacist once during a policy year.	
MANDATED BENEFITS		
Colorectal Cancer Screening	Same as any other Preventive Service	
Early Intervention Services Benefit	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived if applicable	100% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived if applicable
Epidermolysis Bullosa Treatment Benefit	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Mammography, Breast and Ovarian Cancer Screening	Paid at 100% of the Negotiated Charge Deductible Waived if applicable	Paid at 100% of Usual and Customary Charge Deductible waived if applicable

Neuropsychological Testing Benefit for dependent children diagnosed with cancer. Pre-Certification is not required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pain Management Benefit	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	60% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Surgical Removal of Tumors and Treatment of Leukemia	Same as any other Covered Sickness	
Prostate Cancer Screening and Treatment	Same as any other Covered Sickness, unless considered a Preventive Service.	
Accidental Death and Dismemberment		
Principal Sum	$10,000	
Loss must occur within 365 days of the date of a covered Accident. Only one benefit will be payable under this provision, that providing the largest benefit, when more than one (1) loss occurs as the result of any one (1) Accident. This benefit is payable in addition to any other benefits payable under this 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 –** Covered Medical Expenses within Your Home Country or country of origin that are covered under Your governmental or national health plan.
- 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.
- 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.
- 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 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 a national government or any of its agencies, except when a charge is made which You are required to pay or by a Veteran's Administration.
- 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.
- 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.
- Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid, subject to applicable law.
- 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.
- Participation in a riot, civil disorder or a felony, except when Injury occurs when the Insured Person has an elevated blood alcohol content or when under the influence of intoxicating liquor or any drug or both. Participation means to voluntarily take a part or share with others assembled together in some activity. Riot means a violent public disturbance of the peace by a number of persons assembled together.
- Custodial Care service and supplies, except when provided in connection with Extended Day Treatment Programs.
- Charges for hot or cold packs for personal use.
- Services of private duty Nurse except as provided in the Certificate.
- Expenses that are not recommended and approved by a Physician.
- Experimental or Investigational 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.
- Biofeedback.
- Sleep Disorders, except for the diagnosis and Treatment of obstructive sleep apnea including testing performed in a home or outpatient setting.
- Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
- 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 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. Surgery for removal of excess skin or fat.

Family Planning

- Infertility Treatment (male or female)-this includes but is not limited to (except as otherwise specifically covered under this Certificate):
  - Genetic counseling and genetic testing;
  - Impotence, organic or otherwise;
  - Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
  - Costs for an ovum donor or donor sperm;
  - Sperm storage costs;
  - Cryopreservation and storage of eggs or embryos;
  - Ovulation predictor kits;
  - Reversal of tubal ligations;
  - Reversal of vasectomies;
  - Costs for and relating to surrogate motherhood if the individual is not an Insured Person under the Certificate;
  - Cloning; or
  - Medical and surgical procedures that are Experimental or Investigational, unless Our denial is overturned by an External Appeal Agent.

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, 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 exams and replacement of hearing aids or cochlear implants except as specifically provided in the Certificate.

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, or prescribed as Medically Necessary;
- Allergy sera and extracts administered via injection;
- Vitamins, and minerals, except as specifically provided under Preventive Services; or prescribed as Medically Necessary;

- 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;
- Medical marijuana, cannabis, or other supplies and/or services rendered at a cannabis dispensary. This does not include synthetic pharmaceutical products approved by the FDA and included on the Formulary. When prescribed as Medically Necessary Treatment for a pain management diagnosis, the Insured Person may submit a claim for reimbursement under the medical benefits;
- Any drug or medicine for the purpose of weight control;
- Sexual enhancements drugs;
- Vision correction products.

VALUE ADDED SERVICES

The following are not affiliated with Wellfleet Insurance Company and the services are not part of the Plan Underwritten by Wellfleet Insurance Company. These value-added options are provided by Wellfleet Student.

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

Wellfleet Student provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Wellfleet Student at (877) 657-5030, TTY 711.

If you are traveling and need assistance in North America, call the Assistance Center toll-free at: (877) 305-1966 or if you are in a foreign country, call collect at: (715) 295-9311.

When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

How to Access Services

If you require medical assistance or you need assistance with a non-medical situation, such as lost luggage, lost documents or other travel issues, follow these steps:

- Inside the U.S. and Canada: Dial toll-free **(877) 305-1966**
- Outside the U.S. and Canada:
  - **a)** Request an international operator.
  - **b)** Request the operator to place a collect call to the U.S. at **+1 (715) 295-9311**.

Please provide the following information when you call:

- Policy number or school name
- Nature of your call and/or emergency
- Current location
- Contact phone number and email address
- Secondary point of contact
- Date of birth

24/7 Nurseline

Students who enroll and maintain medical coverage in this insurance plan have **free** access to the 24/7 Nurseline by calling (800) 634-7629. This program provides:

- Phone-based, reliable health information in response to health concerns and questions; and
- Assistance in decisions on the appropriate level of care for an injury or sickness.

Appropriate care may include:

- Self-care at home
- an office or telehealth visit with a healthcare provider

- Or a visit to an urgent care center or emergency room.

Calls are answered 24/7/365 by experienced registered nurses who have been specifically trained to handle telephone health inquiries.

This program is not a substitute for doctor visits or emergency response systems. The Nurseline does not answer health plan benefit questions. Health benefit questions should be referred to the Plan Administrator.

Contracted Providers for Telemedicine/Telehealth

The right care when you need it most
Your Wellfleet health plan gives you access to virtual healthcare by phone, video, or app.

Teladoc gives you access to board-certified physicians for **Mental Health (at no additional cost to you)** services. Whether you are at school, home or traveling, Teladoc can diagnose and treat most minor medical conditions wherever and whenever you need treatment.

Register your account today and request a visit at https://www.teladochealth.com/benefits/wellfleetstudent or call (800)-Teladoc (835-2362).

Hinge Health gives you access to licensed physical therapists and health coaches for personalized musculoskeletal services including **virtual physical therapy** to help alleviate pain concerns.

Whether you are at school, home, or traveling, Hinge Health can assist in providing exercise therapy wherever and whenever you need treatment at **no additional cost to you**.

Register your account today and start your exercise therapy at https://hinge.health/wellfleet.

CareConnect
BY WELLFLEET

24/7 Telehealth Counseling for Mental Health

CareConnect is an integrated behavioral health program offering students easy access to licensed mental health clinicians 24/7/365 via telephone (888) 857-5462 and website access to expert mental health and emotional wellbeing resources.

The CareConnect hotline is available at **no additional cost to you**, and you also have free access to courses, articles, and short videos that support mental health and wellbeing by visiting https://careconnect.mysupportportal.com/welcome.