



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

Who Is Eligible To Enroll?

Full-time Students: Undergrads 12+ credits & Graduate Students 9+ Credits, **Part-time Students** registered for at least 6 credits and **Dependents** of enrolled students.

How Do I Enroll?

It is a requirement of UConn that all full-time students maintain health insurance coverage. The University will post, to the fee bill, the premium for the SHIP to *most* full-time students at the start of their first semester during each academic year. If the online waiver is not completed, the enrollment should happen automatically. All registered part-time students taking 6 credits or students who wish to enroll dependent(s) should contact Smith Brothers Insurance, at 860-430-3338 or email: kkruszezski@smithbrothersusa.com for more information.

How Do I Waive Coverage?

If after review of the SHIP a student wishes to decline the coverage, they must do so by completing the online waiver located in the UConn Student Administration system at: www.studentadmin.uconn.edu.

Waiver Period Deadline Dates

Annual	September 15, 2021
Spring	February 5, 2022

Cost and Periods of Coverage

	Annual 8/1/2021 –7/31/2022	Spring/Summer 1/1/2022-7/31/2022
Student	\$2,946*	\$1,733*
Spouse	\$2,896	\$1,683
Per Child	\$2,896	\$1,683

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

Where Can I Obtain More Information About The Plan?

Enroll Dependents Voluntary Enrollment	Smith Brothers Insurance 860-430-3338 kkruszezski@SmithbrothersUSA.com
Waive Coverage	UConn Student Administration www.studentadmin.uconn.edu
Insurance Benefits Claim Processing ID Cards	Wellfleet Group, LLC (413) 733-4540 or (877) 657-5030 www.wellfleetstudent.com
Find an In-Network Provider	Cigna Open Access Plus (OAP) www.Cigna.com
Find Prescription Drug Provider	WellfleetRX/ESI www.wellfleetr.com

HEALTH INSURANCE BENEFIT SUMMARY*
 Unless otherwise specified below,
 the Medical Plan Deductible will always apply

BENEFIT**	In-Network Provider	Out-of-Network Provider
Deductible	\$300 Individual \$900 Family	\$600 Individual \$1,800 Family
Out-of-Pocket Maximum	\$6,850 Individual \$13,700 Family	No Maximum
Coinsurance	80% of NC (amount paid by the plan)	60% of U&C (amount paid by the plan)
Preventive Care	100% of NC (Deductible waived)	60% of U&C
Hospital Room & Board (Inpatient)	80% of NC	60% of U&C
Physician Office Visits, Specialists/Consultants and Chiropractic Care	\$20 copay per visit, then 100% of NC (Deductible waived)	60% of U&C (Deductible waived)
Emergency Services rendered in a Hospital Emergency room	\$150 copay per visit then plan pays 100% of NC (Deductible waived)	Paid the same as In-Network Provider subject to U&C
Urgent Care Centers	\$20 copay per visit then 100% of NC (Deductible waived)	60% of U&C
SHaW	100% of Actual Charge for Covered Medical Expenses (Deductible Waived)	
Laboratory Procedures (Outpatient)	80% of NC (Deductible waived)	60% of U&C
Outpatient Prescription Drugs Copay per 30-day supply filled at a Retail pharmacy.	Tier 1: \$10 copay Tier 2: \$40 copay Tier 3: \$60 copay Tier 4: \$60 copay Then plans pays 100% of NC. (Deductible waived)	60% of U&C
Out-of-Network benefits provided on a reimbursement basis	60% of U&C (Deductible waived)	

NC= Negotiated Charge **U&C=Usual and Customary**

*This is only a brief description of the coverage(s) available under Certificate form CT SHIP Cert (2020). 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.

**Pre-certification is required for inpatient hospital, surgery, and selected outpatient services. Pre-Certification is not required for an Emergency Medical 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.

Underwritten By:
Wellfleet Insurance Company

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

Servicing Agent:
Smith Brothers Insurance
68 National Drive
Glastonbury, CT 06033
KKruszezski@SmithBrothersUSA.com
860-430-3338

The following Value-added Services are not part of the Policy and are not underwritten by Wellfleet Insurance Company. The services are provided by Independent vendors and are included if the student participates in the student health insurance plan:

- Vision Discount Program through Davis Vision
- Medical Travel Assistance services provided by Travel Guard.
- 24-hour nurse hotline through American Health Holdings
- 24/7 Behavioral Health Hotline through CareConnect.

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.

This Certificate does not cover loss nor provide benefits for any of the following, except as otherwise provided by the benefits of this Certificate and as shown in the Schedule of Benefits.

1. **International Students Only** -expenses incurred within Your Home Country or country of regular domicile, that exceed the benefit amount shown in the Schedule of Benefits.
2. Treatment, service or supply which is not Medically Necessary for the diagnosis, care or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended or approved by the Student Health Center or by Your attending Physician or dentist.
3. Medical services rendered by a provider employed for or contracted with the Policyholder, including team physicians or trainers, except as specifically provided in the Schedule of Benefits or as part of the Student Health Center benefits provided by this plan.
4. Professional services rendered by an Immediate Family Member or anyone who lives with You.
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 (except as otherwise specifically covered under this Certificate):
 - 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;
 - Costs for an ovum donor or donor sperm;
 - Sperm storage costs;
 - Cryopreservation and storage of embryos;
 - 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. subject to applicable law.
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 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 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.
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. Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.

21. 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.
22. Treatment for obesity. Surgery for removal of excess skin or fat.
23. Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
24. Expenses for radial keratotomy.
25. Adult Vision unless specifically provided in the Certificate.
26. 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.
27. Charges for hearing exams, hearing screening, the fitting or repair or replacement of hearing aids or cochlear implants except as specifically provided in the Certificate.
28. 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.
29. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma.
30. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
31. 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.
32. Custodial Care service and supplies except when provided in connection with Extended Day Treatment Programs.
33. Charges for hot or cold packs for personal use.
34. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
35. Services of private duty Nurse except as provided in the Certificate.
36. Expenses that are not recommended and approved by a Physician.
37. Routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal or artificial organs or tissues.
38. 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.
39. Sleep Disorders, except for the diagnosis and treatment of obstructive sleep apnea.
40. Treatment of Acne unless Medically Necessary.
41. 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.
42. 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;
 - 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.
43. Non-chemical addictions.
44. Non-physical, occupational, speech therapies (art, dance, etc.).
45. Modifications made to dwellings.
46. General fitness, exercise programs.
47. Hypnosis.
48. Rolwing.
49. Biofeedback.