



# BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2022/2023

DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

**SCHOOL OF VISUAL ARTS**  
New York, NY  
("the Policyholder")

Policy Number: WNY2223NYSHIP05

Group Number: ST0654SH

Effective: 8/25/2022 – 8/24/2023

**UNDERWRITTEN BY:**

Wellfleet New York Insurance Company | New York,  
NY  
("the Company")

**ADMINISTERED BY:**

Wellfleet Group, LLC



**WELLFLEET**  
STUDENT

## Welcome Students...

We are pleased to provide you with this summary of the 2022 – 2023 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 NYSHIP 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.

“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](http://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 at the website listed on the cover. In the case of a discrepancy between two versions of the Summary, the most recent will apply.

# Important Contact Information & Resources



## Contact Us

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

## Plan Administration

### Enrollment, Eligibility, & Waivers

### Servicing Agent

### University Health Plans, a division of Risk Strategies

15 Pacella Park Drive, Suite 130  
Randolph, MA 02368  
Phone: (833) 251-1138  
Fax: (617) 472-6419

[www.universityhealthplans.com](http://www.universityhealthplans.com)  
or email us at [info@univhealthplans.com](mailto:info@univhealthplans.com)

### Benefits, Claim Status, & ID Cards

Wellfleet Group, LLC  
PO Box 15369  
Springfield, Massachusetts 01115-5369  
**(877) 657-5030, TTY 711**  
[www.wellfleetstudent.com](http://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  
PO Box 188061  
Chattanooga, Tennessee 37422-8061  
Electronic Payor ID: 62308



## PPO Network



Cigna  
[www.mycigna.com](http://www.mycigna.com)



## Pharmacy Benefits Manager

For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit [www.wellfleetstudent.com](http://www.wellfleetstudent.com).

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**



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



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## General Information

### Am I Eligible

If you are a full-time or part-time student, School of Visual Arts (SVA) requires you to have health insurance that is comparable to the SVA Student Health Plan. To make sure you have sufficient coverage, you will be automatically enrolled in the Plan and billed by Student Accounts for the Health Plan Cost unless you waive coverage under the Plan, by the Waiver Deadline by providing proof that you have other health insurance coverage that meets this requirement. If you are a full-time or part-time student, enrolling in the Fall, you will be enrolled for the Annual Coverage Term. If you are a full-time or part-time student enrolling in the Fall but are not registered for Spring classes, You will be enrolled for the Fall Coverage Term only.

### Dependents

Dependents are not eligible.

### How Do I Waive?

If you have other health insurance coverage that is comparable to the SVA Student Health Plan and, therefore, you do not wish to be enrolled in the Plan, you must complete the online waiver form and provide proof of comparable health insurance coverage at [www.sva.edu/uhp](http://www.sva.edu/uhp) by the applicable waiver deadline date. If you do not complete a waiver form by the applicable waiver deadline date, 10/1/22 for Annual / Fall, you will be enrolled in the Plan and will be responsible for the Plan Cost.

If you have other comparable health insurance coverage but miss the Annual / Fall waiver deadline date, you may complete and submit an online waiver appeal form as proof of your comparable health insurance coverage by the Fall waiver appeal deadline, 12/19/22. If approved, the appeal form is for the Fall Coverage Term only. If you wish to waive coverage for the Spring Coverage Term, you must complete an online waiver form and provide proof of comparable health insurance coverage by the Spring waiver deadline date, 2/6/23. If you have other comparable health insurance coverage but miss the Spring waiver deadline date, you may complete and submit an online waiver appeal form as proof of your comparable health insurance coverage by the Spring waiver appeal deadline, 4/28/23. Waiver submissions may be audited by SVA, University Health Plans, and/or their contractors or representatives. You may be required to provide, upon request, any coverage documents and/or other records demonstrating that you meet the Policyholder's requirements for waiving coverage under the Plan. By submitting the waiver form, you agree that your current health insurance plan may be contacted for confirmation that your coverage is in force for the applicable Plan Year and that it meets the Policyholder's waiver requirements.

**NOTE:** Paper copies of the waiver form are available from the School of Visual Art.

## 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	Waiver Deadline
Annual	8/25/2022	8/24/2023	10/1/2022
Fall	8/25/2022	2/23/2023	10/1/2022
Spring (for new students to the School in the Spring Semester only)	1/1/2023	8/24/2023	2/6/2023

### Insurance Premiums

	Annual	Fall	Spring
Student	\$2,751	\$1,379	\$1,779

### Broker Fees

	Annual	Fall	Spring
Student*	\$64	\$32	\$32

### School Administrative Fees

	Annual	Fall	Spring
Student*	\$15	\$4	\$4

### Total Plan Costs (Premiums + Fees)

	Annual	Fall	Spring
Student*	\$2,830	\$1,415	\$1,815

\*The above plan costs include an administrative service fee.

## Plan Benefits

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

Preauthorization is required for inpatient hospital, surgery and selected outpatient services. For inpatient hospital, preauthorization is not required for emergency admissions or services provided in a neonatal intensive care unit of a hospital certified pursuant to Article 28 of the Public Health Law.

### Key Plan Benefits

BENEFIT	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
<b>Plan Year Deductible Individual Combined Participating and Non-Participating Providers</b>	\$300	\$300
<b>Out-of-Pocket Limit Individual</b>	\$6,350	None
<b>Coinsurance</b>	10% of the Allowed Amount	40% of the Allowed Amount
<b>Preventive Care</b>	Covered in full	30% Coinsurance not subject to Deductible
<b>Primary Care Office Visits (or Home Visits) including Specialist Office Visits *Check below for additional copayments</b>	\$10 Copayment per visit then 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible
<b>Emergency Department</b>	\$250 Copayment per visit then 10% Coinsurance after Deductible	\$250 Copayment per visit then 10% Coinsurance after Deductible
<b>Urgent Care Center</b>	0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible

## Schedule of Benefits

**SCHOOL OF VISUAL ARTS SCHEDULE OF BENEFITS**  
**Platinum Metal Level**  
**Actuarial Value: 90.06%**  
**School of Visual Arts**

**Policy Number:** WNY2223NYSHIP05  
**Group/Plan Number:** ST0654SH  
**Policyholder Effective Date:** August 25, 2022  
**Policyholder Termination Date:** August 24, 2023

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Medical Deductible</b> <ul style="list-style-type: none"> <li>• Individual</li> </ul>	\$300	\$300	
<b>Out-of-Pocket Limit</b> <ul style="list-style-type: none"> <li>• Individual</li> </ul>	\$6,350	None	
<b>Accidental Death and Dismemberment Benefits</b> <b>\$10,000 Annual Maximum.</b>		See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how We calculate the Allowed Amount. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount.	
<b>OFFICE VISITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Primary Care Office Visits (or Home Visits)	\$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	\$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	See benefit for description



PREVENTIVE CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<ul style="list-style-type: none"> <li>Well Child Visits and Immunizations*</li> </ul>	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Adult Annual Physical Examinations*</li> </ul>	Covered in full	30% Coinsurance not subject to Deductible	
<ul style="list-style-type: none"> <li>Adult Immunizations*</li> </ul>	Covered in full	30% Coinsurance not subject to Deductible	
<ul style="list-style-type: none"> <li>Routine Gynecological Services/Well Woman Exams*</li> </ul>	Covered in full	30% Coinsurance not subject to Deductible	
<ul style="list-style-type: none"> <li>Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer</li> </ul>	Covered in full	30% Coinsurance not subject to Deductible	
<ul style="list-style-type: none"> <li>Sterilization Procedures for Women*</li> </ul>	Covered in full	30% Coinsurance not subject to Deductible	
<ul style="list-style-type: none"> <li>Vasectomy</li> </ul>	Covered in full	30% Coinsurance not subject to Deductible	
<ul style="list-style-type: none"> <li>Bone Density Testing*</li> </ul>	Covered in full	30% Coinsurance not subject to Deductible	
<ul style="list-style-type: none"> <li>Screening for Prostate Cancer</li> </ul>	Covered in full	30% Coinsurance not subject to Deductible	
<ul style="list-style-type: none"> <li>All other preventive services required by USPSTF and HRSA.</li> </ul>	Covered in full	30% Coinsurance not subject to Deductible	
<p>*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.</p>	Use Cost-Sharing for appropriate service (Primary Care Office Visit Specialist Office Visit Diagnostic Radiology Services Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit Specialist Office Visit Diagnostic Radiology Services Laboratory Procedures and Diagnostic Testing)	

<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Pre-Hospital Emergency Medical Services (Ambulance Services)	0% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services	0% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Emergency Department	\$250 Copayment 10% Coinsurance after Deductible  Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	\$250 Copayment 10% Coinsurance after Deductible  Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	See benefit for description
Urgent Care Center	0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	See benefit for description
<b>PROFESSIONAL SERVICES and OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Acupuncture	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Advanced Imaging Services <ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Radiology Facility</li> <li>Performed as Outpatient Hospital Services</li> </ul> <b>Preauthorization Required</b>	\$10 Copayment 0% Coinsurance not subject to Deductible  \$10 Copayment 10% Coinsurance after Deductible  10% Coinsurance after Deductible	30% Coinsurance not subject to Deductible  \$10 Copayment 30% Coinsurance after Deductible  40% Coinsurance after Deductible	See benefit for description
Allergy Testing and Treatment <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> </ul>	\$10 Copayment 0% Coinsurance not subject to Deductible  \$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible  30% Coinsurance not subject to Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

<p>Cardiac and Pulmonary Rehabilitation</p> <ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> <li>Performed as Inpatient Hospital Services</li> </ul>	<p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>10% Coinsurance after Deductible</p> <p>Included as part of inpatient Hospital service Cost-Sharing</p>	<p>30% Coinsurance not subject to Deductible</p> <p>40% Coinsurance after Deductible</p> <p>Included as part of inpatient Hospital service Cost-Sharing</p>	<p>See benefits for description</p>
<p>Chemotherapy and Immunotherapy</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Preauthorization Required</b></p>	<p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p> <p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Chiropractic Services</p> <p><b>Preauthorization Required</b></p>	<p>\$10 Copayment 0% Coinsurance not subject to Deductible</p>	<p>30% Coinsurance not subject to Deductible</p>	<p>See benefit for description</p>
<p>Clinical Trials</p>	<p>Use Cost-Sharing for appropriate service</p>	<p>Use Cost-Sharing for appropriate service</p>	<p>See benefit for description</p>
<p>Diagnostic Testing</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p> <p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p>

<p>Dialysis</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Center</li> <li>Performed as Outpatient Hospital Services</li> <li>Performed at Home</li> </ul>	<p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$10 Copayment 0% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p> <p>\$10 Copayment 30% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p><b>Preauthorization Required</b></p>	<p>10% Coinsurance after Deductible</p>	<p>40% Coinsurance after Deductible</p>	<p>60 visits per condition, per Plan Year combined therapies</p>
<p>Home Health Care</p> <p><b>Preauthorization Required</b></p>	<p>10% Coinsurance after Deductible</p>	<p>40% Coinsurance after Deductible</p>	<p>40 visits per Plan Year</p>
<p>Infertility Services</p> <p><b>Preauthorization Required</b></p>	<p>Use Cost-Sharing for appropriate service (Office Visit Diagnostic Radiology Services Surgery Laboratory &amp; Diagnostic Procedures)</p>	<p>Use Cost-Sharing for appropriate service (Office Visit Diagnostic Radiology Services Surgery Laboratory &amp; Diagnostic Procedures)</p>	<p>See benefit for description</p>

<p>Infusion Therapy</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> <li>Home Infusion Therapy</li> </ul> <p><b>Preauthorization Required</b></p>	<p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p> <p>Home infusion counts toward home health care visit limits</p>
<p>Inpatient Medical Visits</p>	<p>10% Coinsurance after Deductible</p>	<p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Interruption of Pregnancy</p> <ul style="list-style-type: none"> <li>Medically Necessary Abortions</li> <li>Elective Abortions</li> </ul>	<p>Covered in full</p> <p>10% Coinsurance after Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>40% Coinsurance after Deductible</p>	<p>Unlimited</p> <p>One (1) procedure per Plan Year</p>
<p>Laboratory Procedures</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Laboratory Facility</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>0% Coinsurance not subject to Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p> <p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p>

<p>Maternity and Newborn Care</p> <ul style="list-style-type: none"> <li>• Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> <li>• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> <li>• Inpatient Hospital Services and Birthing Center</li> <li>• Physician and Midwife Services for Delivery</li> <li>• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps</li> <li>• Postnatal Care</li> </ul>	<p>Covered in full</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)</p> <p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p> <p>Covered in full</p> <p>\$10 Copayment 0% Coinsurance not subject to Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p>	<p>See benefit for description</p> <p>One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early</p> <p>Covered for duration of breast feeding</p>
<p>Outpatient Hospital Surgery Facility Charge</p>	<p>10% Coinsurance after Deductible</p>	<p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Preadmission Testing</p>	<p>10% Coinsurance after Deductible</p>	<p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Prescription Drugs Administered in Office or Outpatient Facilities</p> <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in Specialist Office</li> <li>• Performed in Outpatient Facilities</li> </ul>	<p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>0% Coinsurance not subject to Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p>	<p>See benefit for description</p>

<p>Diagnostic Radiology Services</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Radiology Facility</li> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Preauthorization Required</b></p>	<p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p> <p>\$10 Copayment 30% Coinsurance not subject to Deductible</p> <p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Therapeutic Radiology Services</p> <ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Radiology Facility</li> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Preauthorization Required</b></p>	<p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>\$10 Copayment 30% Coinsurance not subject to Deductible</p> <p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p><b>Preauthorization Required</b></p>	<p>10% Coinsurance after Deductible</p>	<p>40% Coinsurance after Deductible</p>	<p>60 visits per condition, per Plan Year combined therapies</p>
<p>Second Opinions on the Diagnosis of Cancer, Surgery and Other</p>	<p>\$10 Copayment 0% Coinsurance not subject to Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.</p>	<p>See benefit for description</p>

<p>Surgical Services (including Oral Surgery Reconstructive Breast Surgery Other Reconstructive and Corrective Surgery; and Transplants</p> <ul style="list-style-type: none"> <li>Inpatient Hospital Surgery</li> <li>Outpatient Hospital Surgery</li> <li>Surgery Performed at an Ambulatory Surgical Center</li> <li>Office Surgery</li> </ul> <p><b>Preauthorization Required</b></p>	<p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p> <p>\$10 Copayment 0% Coinsurance not subject to Deductible</p>	<p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>30% Coinsurance not subject to Deductible</p>	<p>See benefit for description</p>
<b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
ABA Treatment for Autism Spectrum Disorder	\$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	See benefit description
Assistive Communication Devices for Autism Spectrum Disorder	\$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education			See benefit for description
<ul style="list-style-type: none"> <li>Diabetic Equipment, Supplies and Insulin (up to a 90 day supply)</li> <li>Diabetic Education</li> </ul>	<p>See the Prescription Drug Cost-Sharing but not more than \$100 for a 30-day supply of insulin</p> <p>\$10 Copayment 0% Coinsurance not subject to Deductible</p>	<p>See the Prescription Drug Cost-Sharing but not more than \$100 for a 30-day supply of insulin</p> <p>30% Coinsurance not subject to Deductible</p>	See Prescription Drug benefit
<p>Durable Medical Equipment and Braces</p> <p><b>Preauthorization Required</b></p>	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description



External Hearing Aids	10% Coinsurance after Deductible	40% Coinsurance after Deductible	Single purchase once every 3 years
Cochlear Implants <b>Preauthorization Required</b>	10% Coinsurance after Deductible	40% Coinsurance after Deductible	One per ear per time Covered
Hospice Care			210 days per Plan Year
<ul style="list-style-type: none"> <li>Inpatient</li> <li>Outpatient</li> </ul>	10% Coinsurance after Deductible	40% Coinsurance after Deductible	Five (5) visits for family bereavement counseling
Medical Supplies	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Prosthetic Devices			
<ul style="list-style-type: none"> <li>External</li> <li>Internal</li> </ul>	10% Coinsurance after Deductible	40% Coinsurance after Deductible	One (1) prosthetic device, per limb, per lifetime
<b>Preauthorization Required</b>	10% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited See benefit for description
<b>INPATIENT SERVICES and FACILITIES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Autologous Blood Banking	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefits for description
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)  <b>Preauthorization Required. However, Preauthorization is not required for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.</b>	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Observation Stay	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)  <b>Preauthorization Required</b>	10% Coinsurance after Deductible	40% Coinsurance after Deductible	200 days per Plan Year  See benefit for description

<p>Inpatient Habilitation Services (Physical Speech and Occupational Therapy)</p> <p><b>Preauthorization Required</b></p>	<p>10% Coinsurance after Deductible</p>	<p>40% Coinsurance after Deductible</p>	<p>60 days per Plan Year</p> <p>See benefit for description</p>
<p>Inpatient Rehabilitation Services (Physical Speech and Occupational Therapy)</p> <p><b>Preauthorization Required</b></p>	<p>10% Coinsurance after Deductible</p>	<p>40% Coinsurance after Deductible</p>	<p>60 days per Plan Year</p> <p>See benefit for description</p>
<p><b>MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES</b></p>	<p><b>Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Non-Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Limits</b></p>
<p>Inpatient Mental Health for a continuous confinement when in a Hospital (including Residential Treatment)</p> <p><b>Preauthorization Required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH-licensed Facilities for Members under 18.</b></p>	<p>10% Coinsurance after Deductible</p>	<p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)</p> <ul style="list-style-type: none"> <li>• Office Visits</li> <li>• All Other Outpatient Services</li> </ul> <p><b>Except for Office Visits, Preauthorization Required for ambulatory surgical center facility fee, and outpatient hospital surgery facility charge.</b></p>	<p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>0% Coinsurance after Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>See benefit for description</p>

<p>Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)</p> <p><b>Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions or for Participating OASAS-certified Facilities.</b></p>	<p>10% Coinsurance after Deductible</p>	<p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)</p> <ul style="list-style-type: none"> <li>Office Visits</li> <li>All Other Outpatient Services</li> </ul>	<p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>0% Coinsurance after Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>Up to 20 visits per Plan Year may be used for family counseling</p> <p>See benefit for description</p>
<p><b>PRESCRIPTION DRUGS</b></p> <p>*Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF</p>	<p><b>Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Non-Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Limits</b></p>
<p><b>Retail Pharmacy</b></p>			
<p>30-day supply</p> <p>Tier 1</p> <p>Tier 2</p>	<p>\$10 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$30 Copayment 0% Coinsurance not subject to Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p>	<p>See benefit for description</p>

<p>Tier 3</p> <p>Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.</p>	<p>\$50 Copayment 0% Coinsurance not subject to Deductible</p>	<p>30% Coinsurance not subject to Deductible</p>	
<p>Up to a 90-day supply for Maintenance Drugs</p> <p>Tier 1</p> <p>Tier 2</p> <p>Tier 3</p>	<p>\$30 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$60 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$90 Copayment 0% Coinsurance not subject to Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p>	<p>See benefit for description</p>
<p><b>Mail Order Pharmacy</b></p>			
<p>Up to a 90-day supply</p> <p>Tier 1</p> <p>Tier 2</p> <p>Tier 3</p>	<p>\$25 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$50 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$75 Copayment 0% Coinsurance not subject to Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p>	<p>See benefit for description</p>
<p>Enteral Formulas</p> <p>Tier 1</p> <p>Tier 2</p>	<p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p>	<p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p>

Tier 3	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
<b>WELLNESS BENEFITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Exercise Facility Reimbursement</b>	Up to \$200 per six (6) month period	Up to \$200 per six (6) month period	See Benefit description
<b>PEDIATRIC DENTAL and VISION CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Pediatric Dental Care for Members through the end of the month in which the Member turns 19 years of age</b> <ul style="list-style-type: none"> <li>• Preventive Dental Care</li> <li>• Routine Dental Care</li> <li>• Major Dental (Endodontics, Periodontics, Oral Surgery and Prosthodontics)</li> <li>• Orthodontics</li> </ul> <b>Orthodontics and Major Dental Require Preauthorization</b>	<ul style="list-style-type: none"> <li>• Preventive Dental Care: \$35 Copayment, 0% Coinsurance not subject to Deductible</li> <li>• Routine Dental Care: 0% Coinsurance not subject to Deductible</li> <li>• Major Dental (Endodontics, Periodontics, Oral Surgery and Prosthodontics): 0% Coinsurance not subject to Deductible</li> <li>• Orthodontics: 50% Coinsurance not subject to Deductible</li> </ul>	<ul style="list-style-type: none"> <li>• Preventive Dental Care: \$35 Copayment, 0% Coinsurance not subject to Deductible</li> <li>• Routine Dental Care: 0% Coinsurance not subject to Deductible</li> <li>• Major Dental (Endodontics, Periodontics, Oral Surgery and Prosthodontics): 0% Coinsurance not subject to Deductible</li> <li>• Orthodontics: 50% Coinsurance not subject to Deductible</li> </ul>	<p>Two (2) dental exams and cleanings per Plan Year</p> <p>Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at six (6) month intervals</p>
<b>Pediatric Vision Care for Members through the end of the month in which the Member turns 19 years of age</b> <ul style="list-style-type: none"> <li>• Exams</li> <li>• Lenses and Frames</li> <li>• Contact Lenses</li> </ul>	<ul style="list-style-type: none"> <li>• Exams: 10% Coinsurance after Deductible</li> <li>• Lenses and Frames: 10% Coinsurance after Deductible</li> <li>• Contact Lenses: 10% Coinsurance after Deductible</li> </ul>	<ul style="list-style-type: none"> <li>• Exams: 10% Coinsurance after Deductible</li> <li>• Lenses and Frames: 10% Coinsurance after Deductible</li> <li>• Contact Lenses: 10% Coinsurance after Deductible</li> </ul>	<p>One (1) exam per Plan Year</p> <p>One (1) prescribed lenses and frames per Plan Year</p>

<b>Non-emergency Care While Traveling Outside of the United States</b>	30% coinsurance of - Actual Cost after Deductible		Unlimited
<b>Emergency Medical Evacuation</b>	0% coinsurance of - Actual Cost not subject to Deductible		Unlimited
<b>Repatriation of Remains</b>	0% coinsurance of - Actual Cost not subject to Deductible		Unlimited
<b>Accidental Death and Dismemberment Benefits</b>	N/A	N/A	\$10,000 Annual Maximum

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**

If, as the result of a covered Accident, You sustain any of the following losses, We will pay the benefit shown. The loss must occur within 365 days of the Accident.

	Percentage of Maximum Amount
Loss of Life.....	100%
Loss of Hand .....	50%
Loss of Foot .....	50%
Loss of either one hand, one foot or sight of one eye.....	50%
Loss of more than one of the above losses due to one Accident.....	100%

**Accident** means a sudden, unforeseeable external event which directly and from no other cause, results in loss of life, hand, foot or sight.

Loss of hand or foot means the complete severance through or above the wrist or ankle joint. Loss of eye means the total permanent loss of sight in the eye. The maximum amount is the largest amount payable under this benefit for all losses resulting from any one Accident.

**Exclusions and Limitations**

No coverage is available under this Certificate for the following:

**A. Aviation.**

We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

**B. Convalescent and Custodial Care.**

We do not Cover services related to rest cures, custodial care or transportation. “Custodial care” means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

**C. Conversion Therapy.**

We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support and understanding of an individual or the facilitation of an individual’s coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

**D. Cosmetic Services.**

We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

**E. Dental Services.**

We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services and Pediatric Dental Care sections of this Certificate.

**F. Experimental or Investigational Treatment.**

We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

**G. Felony Participation.**

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

**H. Foot Care.**

We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, We will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

**I. Government Facility.**

We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

**J. Medically Necessary.**

In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

**K. Medicare or Other Governmental Program.**

We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

**L. Military Service.**

We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

**M. No-Fault Automobile Insurance.**

We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

**N. Services Not Listed.**

We do not Cover services that are not listed in this Certificate as being Covered.

**O. Services Provided by a Family Member.**

We do not Cover services performed by Your immediate family member. "Immediate family member" means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

**P. Services Separately Billed by Hospital Employees.**

We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

**Q. Services With No Charge.**

We do not Cover services for which no charge is normally made.

**R. Vision Services.**

We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Pediatric Vision Care section of this Certificate.

**S. War.**

We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

**T. Workers' Compensation.**

We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.



## VALUE ADDED SERVICES

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

### VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:

[www.wellfleetstudent.com](http://www.wellfleetstudent.com)

### 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 Hour Nurseline

Students who enroll and maintain medical coverage in this insurance plan have access to the 24 Hour Nurseline. This 24-Hour Nurseline 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
- a call to a physician
- or a visit to the emergency room.

Calls are answered 24 hours a day, 365 days a year 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. The 24 Hour Nurseline toll free number will be on the ID card.  
(800) 634-7629.



## 24/7 Behavioral Telehealth and Nurseline Access

CareConnect is an integrated behavioral health program offering students easy access to licensed behavioral healthclinicians 24/7/365 via telephone (888) 857-5462

Connect to a registered nurse within seconds, helping students manage their health on their terms through easy access.