ADELPHI UNIVERSITY

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2024/2025

DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

ADELPHI UNIVERSTY INTERNATIONAL PLAN

Garden City, NY
("the Policyholder")

Policy Number: WNY2425NYSHIP25-00

Effective: 8/15/2024 – 8/14/2025

Group Number: ST1881SH

UNDERWRITTEN BY:
Wellfleet New York 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 2024 – 2025 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 NY SHIP Cert (2024). 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.

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

Risk Strategies Education, University Health Plans
PO Box 818078
Cleveland, OH 44181
www.universityhealthplans.com/adelphi
(800) 437-6448

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

PPO Network

Cigna

Cigna
www.mycigna.com

Pharmacy Benefits Manager

For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit **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

International Students

All eligible International Students are required to have health insurance coverage and will be automatically enrolled in this Student Health Insurance Plan and billed the plan costs for the Student Health Insurance Plan. Eligible students do not have the option to waive coverage.

Dependents

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

Dependents are eligible.

How Do I Enroll My Dependents?

To Waive:

- Go to **www.universityhealthplans.com/adelphi.**
- Click the "Enroll" tab and proceed as directed to enroll in and purchase the student health insurance plan.

Refer to the dates in the Effective Date & Costs section for the deadline dates to purchase dependent coverage.

NOTE: Paper copies of the enrollment form are available at Adelphi University.

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	Dependent Enrollment Deadline Date
Annual	8/15/2024	8/14/2025	9/30/2024

Insurance Premiums	
	Annual
Student	$1,440
Spouse	$1,440
Each Child	$1,440
3 or more Children	$4,320

Broker Fees	
	Annual
Student	$103
Spouse	$103
Each Child	$103
3 or more Children	$309

Shorelight Fees	
	Annual
Student	$949
Spouse	$949
Each Child	$949
3 or more Children	$2,847

Travel Assist Fees	
	Annual
Student	$8
Spouse	$8
Each Child	$8
3 or more Children	$24

Total Plan Costs (Premiums + Fees) for International Students and their Dependents	
	Annual
Student	$2,500
Spouse	$2,500
Each Child	$2,500
3 or more Children	$7,500

The plan costs for Dependents are in addition to the plan costs for student.

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	Student Health Center	Participating Provider	Non-Participating Provider
Plan Year Deductible **Individual**	$0	$100	$200
Out-of-Pocket Limit **Individual** **Family**	$2,500 $5,000 In-network Cost-Sharing amounts to which an Out-of-Pocket Limit applies will accumulate toward both the Out-of-Pocket Limits for Student Health Center Providers and for Participating Providers.		$5,000 $10,000
Coinsurance	0% of the Allowed Amount unless otherwise specified	10% of the Allowed Amount	30% of the Allowed Amount
Preventive Care	Covered in full	Covered in full	20% Coinsurance after Deductible
Primary Care Office Visits (or Home Visits) including Specialist Office Visits ***Check below for additional copayments**	0% Coinsurance	$10 Copayment 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible
Emergency Department	N/A	$50 Copayment after Deductible then 10% Coinsurance	$50 Copayment after Deductible then 10% Coinsurance
Urgent Care Center	N/A	$10 Copayment not subject to Deductible	20% Coinsurance after Deductible

Schedule of Benefits

ADELPHI UNIVERSITY – INTERNATIONAL PLAN SCHEDULE OF BENEFITS
Platinum Metal Level
Insert Actuarial Value: 92.66%
Adelphi University – International Plan

COST-SHARING	**Student Health Center Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Medical Deductible • Individual	$0	$100	$200	
Out-of-Pocket Limit • Individual • Family	$2,500 $5,000	$2,500 $5,000	$5,000 $10,000	
Accidental Death and Dismemberment Benefits $10,000 **Annual Maximum.**			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.	
OFFICE VISITS	**Student Health Center Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	Limits
Primary Care Office Visits (or Home Visits)	0% Coinsurance	$10 Copayment 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	0% Coinsurance	$10 Copayment 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	See benefit for description

PREVENTIVE CARE	**Student Health Center Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	Limits
• Well Child Visits and Immunizations*	Covered in full	Covered in full	20% Coinsurance after Deductible	See benefit for description
• Adult Annual Physical Examinations*	Covered in full	Covered in full	20% Coinsurance after Deductible	
• Adult Immunizations*	Covered in full	Covered in full	20% Coinsurance after Deductible	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Covered in full	20% Coinsurance after Deductible	
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	N/A	Covered in full	20% Coinsurance after Deductible	
• Sterilization Procedures for Women*	N/A	Covered in full	20% Coinsurance after Deductible	
• Vasectomy	N/A	Covered in full	20% Coinsurance after Deductible	
• Bone Density Testing*	N/A	Covered in full	20% Coinsurance after Deductible	
• Prostate Cancer Screening	Covered in full	Covered in full	20% Coinsurance after Deductible	

• Colon Cancer Screening • All other preventive services required by USPSTF and HRSA. *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Covered in full Covered in Full Use Cost-Sharing for appropriate service (Primary Care Office Visit Specialist Office Visit Diagnostic Radiology Services Laboratory Procedures and Diagnostic Testing)	Covered in full Covered in Full Use Cost-Sharing for appropriate service (Primary Care Office Visit Specialist Office Visit Diagnostic Radiology Services Laboratory Procedures and Diagnostic Testing)	20% Coinsurance after Deductible 20% Coinsurance after Deductible Use Cost-Sharing for appropriate service (Primary Care Office Visit Specialist Office Visit Diagnostic Radiology Services Laboratory Procedures and Diagnostic Testing)	
EMERGENCY CARE	**Student Health Center Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	N/A	10% Coinsurance after Deductible	10% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Emergency Department	N/A Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	$50 Copayment after Deductible then 10% Coinsurance Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	$50 Copayment after Deductible then 10% Coinsurance Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	See benefit for description
Urgent Care Center	N/A	$10 Copayment not subject to Deductible	20% Coinsurance after Deductible	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE	**Student Health Center Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	Limits
Advanced Imaging Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services **Preauthorization Required**	N/A N/A N/A	$10 Copayment 0% Coinsurance not subject to Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	20% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office	0% Coinsurance 0% Coinsurance	$10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services	N/A N/A	$10 Copayment 0% Coinsurance not subject to Deductible 10% Coinsurance after Deductible	20% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefits for description

• Performed as Inpatient Hospital Services	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Chemotherapy and Immunotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Preauthorization Required**	 N/A N/A N/A	 $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible 10% Coinsurance after Deductible	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Chiropractic Services	0% Coinsurance	$10 Copayment 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Clinical Trials	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 0% Coinsurance 0% Coinsurance N/A	 $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible 10% Coinsurance after Deductible	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Dialysis • Performed in a PCP Office • Performed in a Specialist Office	 N/A N/A	 $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible	 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description

• Performed in a Freestanding Center • Performed as Outpatient Hospital Services • Performed at Home	N/A N/A N/A	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) The visits limit does not apply to Habilitation Services for a Mental Health or Substance Use Disorder.	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	60 visits per condition, per Plan Year combined therapies
Home Health Care **Preauthorization Required**	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Unlimited visits
Infertility Services **Preauthorization Required**	Use Cost-Sharing for appropriate service (Office Visit Diagnostic Radiology Services Surgery Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit Diagnostic Radiology Services Surgery Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit Diagnostic Radiology Services Surgery Laboratory & Diagnostic Procedures)	See benefit for description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services	 N/A N/A N/A	 $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible 10% Coinsurance after Deductible	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description

• Home Infusion Therapy **Preauthorization Required**	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Inpatient Medical Visits	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Interruption of Pregnancy • Abortion Services	N/A	Covered in full	30% Coinsurance after Deductible	See benefit for description
Laboratory Procedures • Performed in a PCP Office	0% Coinsurance	$10 Copayment 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	0% Coinsurance	$10 Copayment 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	
• Performed in a Freestanding Laboratory Facility	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Maternity and Newborn Care • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	N/A	Covered in full	20% Coinsurance after Deductible	See benefit for description
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit,	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit,	

by USPSTF and HRSA	Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	Radiology Services, Laboratory Procedures and Diagnostic Testing)	Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	
• Inpatient Hospital Services and Birthing Center	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early
• Physician and Midwife Services for Delivery	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	N/A	Covered in full	20% Coinsurance after Deductible	Covered for duration of breast feeding
• Postnatal Care	N/A	$10 Copayment 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	
Outpatient Hospital Surgery Facility Charge	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Preadmission Testing	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities				See benefit for description
• Performed in a PCP Office	0% Coinsurance	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	
• Performed in Specialist Office	0% Coinsurance	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	
• Performed in Outpatient Facilities	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	

Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services **Preauthorization Required**	 N/A N/A N/A N/A	 $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Therapeutic Radiology Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services **Preauthorization Required**	 N/A N/A N/A	 $10 Copayment 0% Coinsurance not subject to Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 20% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) The visits limit does not apply to Rehabilitation Services for a Mental Health or Substance Use Disorder.	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	60 visits per condition, per Plan Year combined therapies

Second Opinions on the Diagnosis of Cancer, Surgery and Other	N/A	$10 Copayment 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.	See benefit for description
Surgical Services (including Oral Surgery Reconstructive Breast Surgery Other Reconstructive and Corrective Surgery; and Transplants				See benefit for description
• Inpatient Hospital Surgery	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
• Outpatient Hospital Surgery	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
• Surgery Performed at an Ambulatory Surgical Center	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
• Office Surgery **Preauthorization Required**	0% Coinsurance	$10 Copayment 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	
Telemedicine Program Behavioral Health Conditions	$0 Copayment then 0% Coinsurance not subject to Deductible			See benefit for description
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Student Health Center Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Diabetic Equipment, Supplies and Self-Management Education				See benefit for description
• Diabetic Equipment, Supplies and Insulin	N/A	See the Prescription Drug Cost-Sharing but not more than $100	See the Prescription Drug Cost-Sharing but not more than	See Prescription Drug benefit

(up to a 90- day supply) • Diabetic Education	 0% Coinsurance	for a 30-day supply of insulin $10 Copayment 0% Coinsurance not subject to Deductible	$100 for a 30-day supply of insulin 20% Coinsurance after Deductible	
Durable Medical Equipment and Braces **Preauthorization Required**	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
External Hearing Aids • Prescription Hearing Aids	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Single purchase once every 3 years
Cochlear Implants **Preauthorization Required**	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	One per ear per time Covered
Hospice Care • Inpatient • Outpatient	 N/A N/A	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 30% Coinsurance after Deductible 30% Coinsurance after Deductible	 Unlimited visits Unlimited visits for family bereavement counseling
Medical Supplies	0% Coinsurance	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Prosthetic Devices • External • Internal **Preauthorization Required**	 N/A N/A	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 30% Coinsurance after Deductible 30% Coinsurance after Deductible	 One (1) prosthetic device, per limb, per lifetime, with coverage for repairs and replacements Unlimited See benefit for description

INPATIENT SERVICES and FACILITIES	**Student Health Center Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Autologous Blood Banking	N/A	10% Coinsurance after Deductible	30% 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) **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.**	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Observation Stay	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) **Preauthorization Required**	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	200 days per Plan Year See benefit for description
Inpatient Habilitation Services (Physical Speech and Occupational Therapy) **Preauthorization Required**	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Unlimited days See benefit for description
Inpatient Rehabilitation Services (Physical Speech and Occupational Therapy) **Preauthorization Required**	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Unlimited days

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Student Health Center Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment) **Preauthorization Required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH-licensed Facilities for Members under 18.**	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)				See benefit for description
• Office Visits	0% Coinsurance	$10 Copayment 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	
• All Other Outpatient Services **Preauthorization Required for surgical services.**	N/A	0% Coinsurance after Deductible	30% Coinsurance after Deductible	
ABA Treatment for Autism Spectrum Disorder	N/A	$10 Copayment 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	See benefit description
Assistive Communication Devices for Autism Spectrum Disorder	N/A	$10 Copayment 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	See benefit for description

Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment) **Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions or for Participating OASAS-certified Facilities.**	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)				Unlimited days per Plan Year may be used for family counseling See benefit for description
• Office Visits	0% Coinsurance	$10 Copayment 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	
• All Other Outpatient Services	N/A	0% Coinsurance after Deductible	30% Coinsurance after Deductible	
• Opioid Treatment Programs	N/A	Covered in full	30% Coinsurance after Deductible	
PRESCRIPTION DRUGS *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 and obtained at a participating pharmacy	**Student Health Center Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**

Retail Pharmacy				
30-day supply Tier 1	N/A	$10 Copayment 0% Coinsurance not subject to Deductible	$10 Copayment 0% Coinsurance after Deductible	See benefit for description
Tier 2	N/A	$20 Copayment 0% Coinsurance not subject to Deductible	$20 Copayment 0% Coinsurance after Deductible	
Tier 3 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. If You purchase a Prescription Drug from a Non-Participating Pharmacy, You must pay for the Prescription Drug at the time it is dispensed and then file a claim for reimbursement with Us. We will not reimburse You for the difference between what You pay the Non-Participating Pharmacy and Our price for the Prescription Drug. In most cases, You will pay more if You purchase Prescription Drugs from a Non-Participating Pharmacy.	N/A	$40 Copayment 0% Coinsurance not subject to Deductible	$40 Copayment 0% Coinsurance after Deductible	

Enteral Formulas Tier 1 Tier 2 Tier 3 If You purchase a Prescription Drug from a Non-Participating Pharmacy, You must pay for the Prescription Drug at the time it is dispensed and then file a claim for reimbursement with Us. We will not reimburse You for the difference between what You pay the Non-Participating Pharmacy and Our price for the Prescription Drug. In most cases, You will pay more if You purchase Prescription Drugs from a Non-Participating Pharmacy.	 N/A N/A N/A	 $10 Copayment 0% Coinsurance not subject to Deductible $20 Copayment 0% Coinsurance not subject to Deductible $40 Copayment 0% Coinsurance not subject to Deductible	 $10 Copayment 0% Coinsurance after Deductible $20 Copayment 0% Coinsurance after Deductible $40 Copayment 0% Coinsurance after Deductible	See benefit for description
WELLNESS BENEFITS	**Student Health Center Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	N/A	Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for Covered Dependents	Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for Covered Dependents	See Benefit description

PEDIATRIC DENTAL and VISION CARE	Student Health Center Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care for Members through the end of the month in which the Member turns 19 years of age				Two (2) dental exams and cleanings per Plan Year
• Preventive Dental Care	N/A	Covered in Full	Covered in Full	Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals
• Routine Dental Care	N/A	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Major Dental (Endodontics, Periodontics, Oral Surgery and Prosthodontics)	N/A	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Orthodontics	N/A	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
Pediatric Vision Care for Members through the end of the month in which the Member turns 19 years of age				One (1) exam per Plan Year One (1) prescribed lenses and frames per Plan Year
• Exams	N/A	0% Coinsurance after Deductible	0% Coinsurance after Deductible	
• Lenses and Frames	N/A	0% Coinsurance after Deductible	0% Coinsurance after Deductible	
• Contact Lenses	N/A	0% Coinsurance after Deductible	0% Coinsurance after Deductible	
Adult Dental Care for Members over age 18				
• **Preventive Dental Care**	N/A	0% Coinsurance not subject to Deductible	0% Coinsurance not subject to Deductible	Two (2) dental exams and cleanings per Plan Year

• **Routine Dental Care** • **Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics)** • **Orthodontics**	N/A N/A N/A	0% Coinsurance not subject to Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	0% Coinsurance not subject to Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals
Accidental Injury Dental Treatment	N/A	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Non-emergency Care While Traveling Outside of the United States	30% coinsurance of - Actual Cost after Deductible			$ 10,000 Annual Limits
Emergency Medical Evacuation	0% coinsurance of Actual Cost not subject to Deductible			$ 50,000 Annual Limits
Repatriation of Remains	0% coinsurance of Actual Cost not subject to Deductible			$ 25,000 Annual Limits
Accidental Death and Dismemberment Benefits	N/A	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 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

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

Teladoc

By phone or internet, **Teladoc** gives you 24/7 access to board-certified physicians for Behavioral Health 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.teladoc.com/wellfleetstudent or call (800)-Teladoc (835-2362).

CareConnect
Integrated Behavioral Health from Wellfleet Student

24/7 Behavioral Telehealth and Nurseline Access

CareConnect is an integrated behavioral health program offering students easy access to licensed behavioral health clinicians 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.