Ithaca College
2019-2020 Student Health Plan
Group No: ST0775SH
Policy No: AIIC1920NYSHIP11

Who Is Eligible To Enroll?

Ithaca College requires all matriculated undergraduate and graduate students to have coverage and are automatically enrolled in the Student Health Insurance Plan. Student Accounts will initially charge for the plan unless proof of comparable coverage can be furnished. All International students will be automatically enrolled in the plan.

Important Dates and Deadlines:

Open Enrollment Periods for all Dependents and Hard Waiver Students:
Fall Semester Deadline: 8/10/2019
Spring Semester Deadline: 1/19/20

Online Waiver/Enrollment Instructions

Why should I submit the online enrollment form?
Submitting the online enrollment form confirms that you do want to be enrolled in the student health insurance plan and expedites the processing of your enrollment in the plan. Students who are enrolled in the plan for the 2018-2019 policy year should submit the online enrollment form for the 2019-2020 policy year as early as possible to avoid a disruption in coverage.

To submit a waiver or enrollment form:

1. Visit www.universityhealthplans.com
2. Click "Ithaca College" on the homepage.
3. On the left of the next page, you will see blue boxes that say "Waiver Form" and "Enrollment Form". Students who wish to enroll dependents in the plan may do so when submitting their online enrollment form.
4. Carefully follow all instructions and click "Apply" to submit your form. If you are submitting a waiver form, you will need to enter your current health insurance information.
5. When your waiver or enrollment form has been successfully submitted, you will see a waiver confirmation number and receive a confirmation email to your Ithaca College email address shortly thereafter. ***If you do not receive the confirmation email, your form may not have been submitted and you should contact University Health Plans at 1-800-437-6448 for assistance.***

Cost and Periods of Coverage*

	Annual 8/10/19 to 8/9/20	Fall 8/10/19 to 12/31/19	Spring 1/1/20 to 8/9/20	Summer 6/1/20 to 8/9/20
Student Only	$2,112	$831	$1,281	$404
Spouse	$2,112	$831	$1,281	$404
Each Child	$2,112	$831	$1,281	$404

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

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

- Vision discount program through Davis Vision
- Medical Travel Assistance Through Travel Guard
- 24-hour nurse line and behavioral health hotline CareConnect

Exclusions and Limitations

Where Can I Obtain More Information About The Plan?

Waive Off/Enroll In the insurance plan:	www.universityhealthplans.com
Insurance Benefits Claim Processing ID Cards	www.wellfleetstudent.com
Find Network Provider:	Cigna www.cigna.com
Find Prescription Drug Provider:	Cigna Pharmacy Network www.cigna.com

HEALTH INSURANCE BENEFIT SUMMARY*

BENEFIT	IN-NETWORK	NON-NETWORK
Deductible	$150	$150
Out-of-Pocket Expense Limit	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
Coinsurance Amount	20%	40%
Preventive Care	0% (No Cost Sharing)	30% Not subject to deductible
Hospital Room & Board (Inpatient)**	20%	40%
In Office Physician Visit/Consultant or Specialist	20% After $10 Copayment	40% After $10 Copay
Mental Health and Substance Abuse	20%	40%
Emergency Services Expense	20% After $50 copay After deductible	20% After $50 copay After deductible
Urgent Care Center	20% After $10 Copay	20% After $10 Copay
Diagnostic X-ray & Laboratory	20% After $10 copay after deductible	40% After $10 copay After deductible
Outpatient Prescription Drugs 30 day supply Not subject to deductible	0% after Copay Tier 1 $15 copay Tier 2 $30 copay Tier 3 $50 Copay	0% after Copay Tier 1 $15 copay Tier 2 $30 copay Tier 3 $50 Copay

*This is only a brief description of the coverage(s) available under Certificate form NY SHIP Cert (2019). The Certificate will contain reductions, limitations, exclusions and termination provisions. Full details of coverage are contained in the Certificate. If there are any conflicts between this document and the Certificate, the Certificate shall govern in all cases.

**All inpatient confinements require pre-certification. The phone number can be found on the back of the Insured's ID card. The call should be made prior to Hospital Confinement. In the case of an emergency, the call should take place as soon as reasonably possible

Underwritten By:
Wellfleet New York Insurance Company

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

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 any 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 a member of Your immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your 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; Pediatric and Routine Vision Care sections 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.