School of Visual Arts

("the Policyholder")

2020-2021
Student Health Plan

("the Plan")

Designed Exclusively for the Students of:

School of Visual Arts

New York, NY

2020 - 2021

Underwritten by:
Wellfleet New York Insurance Company
Flushing, NY
("the Company")

Policy Number: WNY2021NYSHIP05

Group Number: ST0654SH

Effective: 8/25/2020 – 8/24/2021

ADMINISTERED BY:

Wellfleet Group, LLC

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Welcome Students…

We are pleased to provide you with this summary of the 2020 – 2021 Student Health Plan ("Plan"), which is fully compliant with the Affordable Care Act. "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**. If you have questions about enrollment into the Plan, please call University Health Plans at (800) 437-6448. For questions about medical benefits or claims, please call Wellfleet Student at (877) 657-5030, TTY 711.

Where to Find Help

For Questions About:	Please Contact:
Servicing Agent **Enrollment** **Waiver**	**University Health Plans, a division of Risk Strategies** 15 Pacella Park Drive, Suite 130 Randolph, MA 02368 Phone: (800) 437-6448 Fax: (617) 472-6419 www.universityhealthplans.com or email us at info@univhealthplans.com
Insurance Benefits **Claims Processing** **ID Cards** **ID Card Requests**	**Wellfleet Group, LLC** **PO Box 15369** **Springfield, Massachusetts 01115-5369** **(877) 657-5030, TTY 711** **www.wellfleetstudent.com**
Preferred PPO Provider Listings **Cigna Claims:**	**University Health Plans** www.universityhealthplans.com or www.cigna.com **Send Cigna claims to:** **CIGNA** **PO Box 188061** **Chattanooga, TN 37422 – 8061** **Electronic Payor ID: 62308**
Prescription Drug Provider	**For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit www.wellfleetstudent.com**

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 (below) 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.

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** by the applicable waiver deadline date. If You do not complete a waiver form by the applicable waiver deadline date, 11/1/20 for Annual / Fall, You will be enrolled in the Plan and will be responsible for the Health 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, 12/23/20. 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, 2/6/21. 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, 4/30/21. 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.

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	8/25/2020	8/24/2021	11/1/2020
Fall	8/25/2020	2/23/2021	11/1/2020
Spring (for new students to the School in the Spring Semester only	1/1/2021	8/24/2021	2/6/2021

Insurance Premiums			
	Annual	**Fall**	**Spring**
Student	$2,687	$1,347	$1,737

Broker Fees			
	Annual	**Fall**	**Spring**
Student*	$64	$32	$32

School Administrative Fees			
	Annual	**Fall**	**Spring**
Student*	$9	$1	$6

Total Plan Costs (Premiums + Fees) for Students			
	Annual	**Fall**	**Spring**
Student*	$2,760	$1,380	$1,775

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

Preferred Provider Organization (PPO) Network

…providing access to quality health care at discounted costs!

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

School of Visual Arts Schedule of Benefits

This is only a brief description of coverage available under Certificate form NY SHIP CERT (2020). The Certificate will contain full details of coverage, coinsurance, limitations, exclusions, and termination provisions. If there are any conflicts between this document and the Certificate, the Certificate governs in all cases.

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

SCHOOL OF VISUAL ARTS SCHEDULE OF BENEFITS
Platinum Metal Level
School of Visual Arts

Policy Number: WNY2021NYSHIP05
Group/Plan Number: ST0654SH
Policyholder Effective Date: August 25, 2020
Policyholder Termination Date: August 24, 2021

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Medical Deductible • Individual	$100	$100	
Out-of-Pocket Limit • Individual	$6,350	None	
Accidental Death and Dismemberment Benefits $10,000 **Annual Maximum.**		See the Cost-Sharing Expenses and Allowed Amount section of the 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	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$10 Copayment 0% Coinsurance not subject to Deductible	$10 Copayment 30% Coinsurance not subject to Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	$10 Copayment 0% Coinsurance not subject to Deductible	$10 Copayment 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
• Well Child Visits and Immunizations*	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description
• Adult Annual Physical Examinations*	Covered in full	30% Coinsurance not subject to Deductible	
• Adult Immunizations*	Covered in full	30% Coinsurance not subject to Deductible	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	30% Coinsurance not subject to Deductible	
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	30% Coinsurance not subject to Deductible	
• Sterilization Procedures for Women*	Covered in full	30% Coinsurance not subject to Deductible	
• Vasectomy	Covered in full	30% Coinsurance not subject to Deductible	
• Bone Density Testing*	Covered in full	30% Coinsurance not subject to Deductible	
• Screening for Prostate Cancer	Covered in full	30% Coinsurance not subject to Deductible	
• All other preventive services required by USPSTF and HRSA.	Covered in full	30% Coinsurance not subject to Deductible	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	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)	

EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
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	10% Coinsurance after Deductible Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	10% Coinsurance after Deductible	See benefit for description
Urgent Care Center	0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Acupuncture	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Advanced Imaging Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services **Preauthorization Required**	 $10 Copayment 10% Coinsurance after Deductible $10 Copayment 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 $10 Copayment 30% Coinsurance after Deductible $10 Copayment 30% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office	 $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible	 $10 Copayment 30% Coinsurance not subject to Deductible $10 Copayment 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
Autologous Blood Banking	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefits for description
Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	 $10 Copayment 0% Coinsurance after Deductible 10% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing	 $10 Copayment 30% Coinsurance after Deductible 40% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing	See benefits for description
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Preauthorization Required**	 $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible 10% Coinsurance after Deductible	 $10 Copayment 30% Coinsurance not subject to Deductible $10 Copayment 30% Coinsurance not subject to Deductible 40% Coinsurance after Deductible	See benefit for description
Chiropractic Services **Preauthorization Required**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Clinical Trials	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	 $10 Copayment 0% Coinsurance after Deductible $10 Copayment 0% Coinsurance after Deductible 10% Coinsurance after Deductible	 $10 Copayment 30% Coinsurance after Deductible $10 Copayment 30% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description

Dialysis • Performed in a PCP Office	$10 Copayment 0% Coinsurance after Deductible	$10 Copayment 30% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	$10 Copayment 0% Coinsurance after Deductible	$10 Copayment 30% Coinsurance after Deductible	
• Performed in a Freestanding Center	$10 Copayment 0% Coinsurance after Deductible	$10 Copayment 30% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Performed at Home	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Preauthorization Required**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	60 visits per condition, per Plan Year combined therapies
Home Health Care **Preauthorization Required**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40 visits per Plan Year
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)	See benefit for description

Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy **Preauthorization Required**	 $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 $10 Copayment 30% Coinsurance not subject to Deductible $10 Copayment 30% Coinsurance not subject to Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description Home infusion counts toward home health care visit limits
Inpatient Medical Visits	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Interruption of Pregnancy • Medically Necessary Abortions • Elective Abortions	 Covered in full 10% Coinsurance after Deductible	 30% Coinsurance not subject to Deductible 40% Coinsurance after Deductible	 Unlimited One (1) procedure per Plan Year
Laboratory Procedures • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Laboratory Facility • Performed as Outpatient Hospital	 $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible 10% Coinsurance after Deductible	 $10 Copayment 30% Coinsurance not subject to Deductible $10 Copayment 30% Coinsurance not subject to Deductible $10 Copayment 30% Coinsurance not subject to Deductible 40% Coinsurance after Deductible	See benefit for description

Maternity and Newborn Care			See benefit for description
• Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	30% Coinsurance not subject to Deductible	
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	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)	
• Inpatient Hospital Services and Birthing Center	10% Coinsurance after Deductible	40% 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	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	Covered in full	30% Coinsurance not subject to Deductible	Covered for duration of breast feeding
• Postnatal Care	0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	
Outpatient Hospital Surgery Facility Charge	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Preadmission Testing	10% Coinsurance after Deductible	40% 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 not subject to Deductible	30% Coinsurance not subject to Deductible	
• Performed in Specialist Office	0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	
• Performed in Outpatient Facilities	0% Coinsurance not subject to Deductible	30% Coinsurance not subject to 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**	 $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible 10% Coinsurance after Deductible	 $10 Copayment 30% Coinsurance not subject to Deductible $10 Copayment 30% Coinsurance not subject to Deductible $10 Copayment 30% Coinsurance not subject to Deductible 40% 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**	 $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible 10% Coinsurance after Deductible	 $10 Copayment 30% Coinsurance not subject to Deductible $10 Copayment 30% Coinsurance not subject to Deductible 40% Coinsurance after Deductible	See benefit for description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Preauthorization Required**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	60 visits per condition, per Plan Year combined therapies
Second Opinions on the Diagnosis of Cancer, Surgery and Other	0% Coinsurance after Deductible	30% 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 • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery **Preauthorization Required**	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit description
Assistive Communication Devices for Autism Spectrum Disorder	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin (up to a 90 day supply) • Diabetic Education	See the Prescription Drug Cost-Sharing $10 Copayment 0% Coinsurance not subject to Deductible	See the Prescription Drug Cost-Sharing $10 Copayment 30% Coinsurance not subject to Deductible	See benefit for description See Prescription Drug benefit
Durable Medical Equipment and Braces **Preauthorization Required**	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 **Preauthorization Required**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	One per ear per time Covered
Hospice Care • Inpatient • Outpatient	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible	210 days per Plan Year Five (5) visits for family bereavement counseling
Medical Supplies	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Prosthetic Devices • External • Internal **Preauthorization Required**	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible	 One (1) prosthetic device, per limb, per lifetime Unlimited See benefit for description
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
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.**	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) **Preauthorization Required**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	200 days per Plan Year See benefit for description
Inpatient Habilitation Services (Physical Speech and Occupational Therapy) **Preauthorization Required**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	60 days per Plan Year See benefit for description
Inpatient Rehabilitation Services (Physical Speech and Occupational Therapy) **Preauthorization Required**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	60 days per Plan Year See benefit for description
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health 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.**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) • Office Visits • All Other Outpatient Services **Except for Office Visits, Preauthorization Required**	 $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance after Deductible	 $10 Copayment 30% Coinsurance not subject to Deductible $10 Copayment 30% 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.**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) • Office Visits • All Other Outpatient Services **Except for Office Visits, Preauthorization Required. However, Preauthorization is not required for Participating OASAS-certified Facilities.**	 $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance after Deductible	 $10 Copayment 30% Coinsurance not subject to Deductible $10 Copayment 30% Coinsurance after Deductible	Up to 20 visits per Plan Year may be used for family counseling See benefit for description

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	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy			
30-day supply Tier 1 Tier 2 Tier 3 If You have an Emergency Condition, Preauthorization is not required for a five (5) day emergency supply of 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.	$10 Copayment 0% Coinsurance not subject to Deductible $30 Copayment 0% Coinsurance not subject to Deductible $50 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible	See benefit for description
Up to a 90-day supply for Maintenance Drugs Tier 1 Tier 2 Tier 3	$30 Copayment 0% Coinsurance not subject to Deductible $60 Copayment 0% Coinsurance not subject to Deductible $90 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible	See benefit for description

Mail Order Pharmacy			
Up to a 90-day supply Tier 1 Tier 2 Tier 3	 $25 Copayment 0% Coinsurance not subject to Deductible $50 Copayment 0% Coinsurance not subject to Deductible $75 Copayment 0% Coinsurance not subject to Deductible	 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible	See benefit for description
Enteral Formulas Tier 1 Tier 2 Tier 3	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Exercise Facility Reimbursement	Up to $200 per six (6) month period	Up to $200 per six (6) month period	See Benefit description
PEDIATRIC DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive Dental Care • Routine Dental Care • Major Dental (Endodontics, Periodontics, Oral Surgery and Prosthodontics) • Orthodontics **Orthodontics and Major Dental Require Preauthorization**	 $35 Copayment 0% Coinsurance not subject to Deductible 0% Coinsurance not subject to Deductible 0% Coinsurance not subject to Deductible 50% Coinsurance not subject to Deductible	 $35 Copayment 0% Coinsurance not subject to Deductible 0% Coinsurance not subject to Deductible 0% Coinsurance not subject to Deductible 50% Coinsurance not subject to Deductible	 One (1) dental exam and cleaning per six (6)-month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at six (6) month intervals

Pediatric Vision Care • Exams • Lenses and Frames • Contact Lenses	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	One (1) exam per Plan Year One (1) prescribed lenses and frames per Plan Year
Non-emergency Care While Traveling Outside of the United States	30% coinsurance of - Actual Cost after Deductible		Unlimited
Emergency Medical Evacuation	0% coinsurance of - Actual Cost not subject to Deductible		Unlimited Combined with Repatriation Benefit.
Repatriation of Remains	0% coinsurance of - Actual Cost not subject to Deductible		Unlimited Combined with Medical Evacuation Benefit.
Accidental Death and Dismemberment Benefits	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.

Preauthorization

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.

Exclusions and Limitations

No coverage is available under the 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 the 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 the 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 the 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 the 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 the Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of the 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 the 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 the 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 Vision Care section of the 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.

Definitions

Defined terms will appear capitalized throughout the Certificate.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of the Certificate for a description of how the Allowed Amount is calculated. If Your Non-Participating Provider charges more than the Allowed Amount, You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

Ambulatory Surgical Center: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Certificate: The Certificate issued by Wellfleet New York Insurance Company, including the Schedule of Benefits and any attached riders.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of the Certificate.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Durable Medical Equipment ("DME"): Equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Exclusions: Health care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; a comprehensive care center for eating disorders pursuant to Article 27-J of the New York Public Health Law; and a Facility defined in New York Mental Hygiene Law Sections 1.03(10) and (33), certified by the New York State Office of Alcoholism and Substance Abuse Services, or certified under Article 28 of the New York Public Health Law (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by The Joint Commission to provide a substance use disorder treatment program.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under the Certificate.

Home Health Agency: An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to Article 40 of the New York Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);

- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a Hospital that usually doesn't require an overnight stay.

In-Network Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the Covered Service that You are required to pay to a Participating Provider. The amount can vary by the type of Covered Service.

In-Network Copayment: A fixed amount You pay directly to a Participating Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

In-Network Deductible: The amount You owe before We begin to pay for Covered Services received from a Participating Provider. The In-Network Deductible applies before any Copayments or Coinsurance are applied. The In-Network Deductible may not apply to all Covered Services. You may also have an In-Network Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

In-Network Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Participating Providers. This limit never includes Your Premium or services We do not Cover.

Medically Necessary: See the How Your Coverage Works section of the Certificate for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Student for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission. "Member" also means the Member's designee.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide services to You. You will pay more to see a Non-Participating Provider.

Out-of-Network Coinsurance: Your share of the costs of a Covered Service calculated as a percent of the Allowed Amount for the service You are required to pay to a Non-Participating Provider. The amount can vary by the type of Covered Service.

Out-of-Network Copayment: A fixed amount You pay directly to a Non-Participating Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Out-of-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Non-Participating Providers. The Out-of-Network Deductible applies before any Copayments or Coinsurance are applied. The Out-of-Network Deductible may not apply to all Covered Services. You may also have an Out-of-Network Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Out-of-Network Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Non-Participating Providers. This limit never includes any Premium, Balance Billing charges or services We do not Cover. You are also responsible for all differences, if any, between the Allowed Amount and the Non-Participating Provider's charge for out-of-network services regardless of whether the Out-of-Pocket Limit has been met.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website at **www.wellfleetstudent.com** or upon Your request to Us. The list will be revised from time to time by Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: The 12-month period beginning on the effective date of the Policy or any anniversary date thereafter, during which the Certificate is in effect.

Policy: The Policy issued by Wellfleet New York Insurance Company to the Policyholder.

Policyholder: The institution of higher education that has entered in to an agreement with Us.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of the Certificate.

Premium: The amount that must be paid for Your health insurance coverage.

Prescription Drugs: A medication, product or device that has been approved by the Food and Drug Administration ("FDA") and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.

Primary Care Physician ("PCP"): A participating nurse practitioner or Physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, Health Care Professional or Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are Covered under the Certificate that is licensed, registered, certified or accredited as required by state law.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a participating Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form. Except as provided in the Access to Care and Transitional Care section of the Certificate or as otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider. A Referral is not required but is needed in order for You to pay the lower Cost-Sharing for certain services listed in the Schedule of Benefits section of the Certificate.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Schedule of Benefits: The section of the Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service area consists of: Albany; Allegany; Bronx; Broome; Cattaraugus; Cayuga; Chautauqua;

Chemung; Chenango; Clinton; Columbia; Cortland; Delaware; Dutchess; Erie; Essex; Franklin; Fulton; Genesee; Greene; Hamilton; Herkimer; Jefferson; Kings; Lewis; Livingston; Madison; Monroe; Montgomery; Nassau; New York; Niagara; Oneida; Onondaga; Ontario; Orange; Orleans; Oswego; Otsego; Putnam; Queens; Rensselaer; Richmond; Rockland; St. Lawrence; Saratoga; Schenectady; Schoharie; Schuyler; Seneca; Steuben; Suffolk; Sullivan; Tioga; Tompkins; Ulster; Warren; Washington; Wayne; Westchester; Wyoming; Yates County.

Skilled Nursing Facility: An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by The Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Us to meet the standards of any of these authorities.

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Student: The person to whom the Certificate is issued.

Student Health Services: Any organization, facility, or clinic, operated, maintained, or supported by the school which provides health care services to a Student and has received accreditation by either the Accreditation Association of Ambulatory Health Care (AAAHC) or The Joint Commission for the ambulatory health care provided within their student health services.

UCR (Usual, Customary and Reasonable): The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

Urgent Care Center: A licensed Facility (other than a Hospital) that provides Urgent Care.

Us, We, Our: Wellfleet New York Insurance Company and anyone to whom We legally delegate performance, on Our behalf, under the Certificate.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

You, Your: The Member.

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.

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

CareConnect

Integrated Behavioral Health from Wellfleet Student

With CareConnect from Wellfleet Student, students have 24/7 access to professional assistance to help manage personal concerns, emotional issues, transition and adjustment concerns, academic stress, career development, and the demands of daily and family obligations.

Members in need of assistance simply call the behavioral health hotline on their ID card, **(888) 857-5462**, or via the Wellfleet Student mobile app for immediate access to a masters-level mental health professional. Students are run through a clinical assessment to determine if CareConnect counseling, health center referral, or other treatment is necessary. To access mobile features, students simply download their school's app in their device's app store.