BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2024/2025

DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

SCHOOL OF VISUAL ARTS

New York, NY

("the Policyholder")

Policy Number: WNY2425NYSHIP05

Group Number: ST0654SH

Effective: 8/25/2024 – 8/24/2025

UNDERWRITTEN BY:

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

ADMINISTERED BY:

Wellfleet Group, LLC

WELLFLEET STUDENT

Welcome Students…

We are pleased to provide you with this summary of the 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
Phone: (833) 251-1138
Fax: (617) 472-6419

www.universityhealthplans.com
or email us at info@univhealthplans.com

Benefits, Claim Status, & ID Cards

Wellfleet Group, LLC
PO Box 15369
Springfield, Massachusetts 01115-5369
(877) 657-5030, TTY 711
www.wellfleetstudent.com
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.

What's Inside (Click on section title below to go to section in "Benefits at a Glance.")

General Information

Am I Eligible

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

Dependents

Dependents are not eligible.

How Do I Waive?

If you have other health insurance coverage that is comparable to the SVA Student Health Plan and, therefore, you do not wish to be enrolled in the Plan, you must complete the online waiver form and provide proof of comparable health insurance coverage at **www.sva.edu/uhp** by the applicable waiver deadline date. If you do not complete a waiver form by the applicable waiver deadline date, 10/2/2024 for Annual / Fall, you will be enrolled in the Plan and will be responsible for the Plan Cost.

If you have other comparable health insurance coverage but miss the Annual / Fall waiver deadline date, you may complete and submit an online waiver appeal form as proof of your comparable health insurance coverage by the Fall waiver appeal deadline, 12/16/2024. 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, 2/3/2025. 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, 4/30/2025. Waiver submissions may be audited by SVA, University Health Plans, and/or their contractors or representatives. You may be required to provide, upon request, any coverage documents and/or other records demonstrating that you meet the Policyholder's requirements for waiving coverage under the Plan. By submitting the waiver form, you agree that your current health insurance plan may be contacted for confirmation that your coverage is in force for the applicable Plan Year and that it meets the Policyholder's waiver requirements.

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

Effective Dates & Costs

All time periods begin at 12:00 A.M. local time and end at 11:59 P.M. local time at the Policyholder's address.

Coverage Period	Coverage Start Date	Coverage End Date	Waiver Deadline
Annual	08/25/2024	08/24/2025	10/02/2024
Fall	08/25/2024	02/23/2025	10/02/2024
Spring (for new students to the School in the Spring Semester only)	01/01/2025	08/24/2025	02/03/2025

Insurance Premiums

	Annual	Fall	Spring
Student	$3,098	$1,553	$2,003

Broker Fees

	Annual	Fall	Spring
Student	$64	$32	$41

School Administrative Fees

	Annual	Fall	Spring
Student	$8	$0	$1

Total Plan Costs (Premiums + Fees)

	Annual	Fall	Spring
Student	$3,170	$1,585	$2,045

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	PARTICPATING PROVIDER	NON-PARTICIPATING PROVIDER
Plan Year Deductible Individual	$500	$500
Out-of-Pocket Limit Individual	$6,350	None
Coinsurance	20% of the Allowed Amount	40% of the Allowed Amount
Preventive Care	Covered in full	30% Coinsurance not subject to Deductible
Primary Care Office Visits (or Home Visits) including Specialist Office Visits *Check below for additional copayments	$10 Copayment then 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible
Emergency Department	$250 Copayment after Deductible then 20% Coinsurance	$250 Copayment after Deductible then 20% Coinsurance
Urgent Care Center	0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible

Schedule of Benefits

SCHOOL OF VISUAL ARTS SCHEDULE OF BENEFITS
Gold Metal Level
Actuarial Value: 87.07%
School of Visual Arts

Policy Number: WNY2425NYSHIP05
Group/Plan Number: ST0654SH
Policyholder Effective Date: August 25, 2024
Policyholder Termination Date: August 24, 2025

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Medical Deductible • Individual	$500	$500	
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 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	**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	30% Coinsurance not subject to Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	See benefit for description

PREVENTIVE CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
• 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	
• Prostate Cancer Screening	Covered in full	30% Coinsurance not subject to Deductible	
• Colon Cancer Screening	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	$250 Copayment after Deductible then 20% Coinsurance Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	$250 Copayment after Deductible then 20% 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	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**
Advanced Imaging 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 20% Coinsurance after Deductible 20% Coinsurance after Deductible	 30% Coinsurance not subject to Deductible 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	 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit 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 not subject to Deductible 20% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing	 30% Coinsurance not subject to Deductible 40% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing	See benefits for description
Chemotherapy and Immunotherapy • 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 20% Coinsurance after Deductible	 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible 40% Coinsurance after Deductible	See benefit for description
Chiropractic Services	$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to 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 not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible 20% Coinsurance after Deductible	 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible 40% Coinsurance after Deductible	See benefit for description

Dialysis • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Center • Performed as Outpatient Hospital Services • Performed at Home	 $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment after Deductible then 0% Coinsurance 20% Coinsurance after Deductible 20% Coinsurance after Deductible	 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible 30% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
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	20% Coinsurance after Deductible	40% Coinsurance after Deductible	60 visits per condition, per Plan Year combined therapies
Home Health Care **Preauthorization Required**	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
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	 $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible 20% Coinsurance after Deductible	 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible 40% Coinsurance after Deductible	See benefit for description

• Home Infusion Therapy **Preauthorization Required**	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Inpatient Medical Visits	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Interruption of Pregnancy • Abortion Services	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description
Laboratory Procedures • Performed in a PCP Office	$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	See benefit for description
• Performed in a Specialist Office	$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	
• Performed in a Freestanding Laboratory Facility	0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	
• Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Maternity and Newborn Care • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description
• 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	20% Coinsurance after Deductible	40% Coinsurance after Deductible	One (1) home care visit is covered at no Cost-Sharing if

• Physician and Midwife Services for Delivery	20% Coinsurance after Deductible	40% Coinsurance after Deductible	mother is discharged from Hospital early
• 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	$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	
Outpatient Hospital Surgery Facility Charge	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Preadmission Testing	20% 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	$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	
• Performed in Specialist Office	$10 Copayment 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			See benefit for description
• Performed in a PCP Office	$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	
• Performed in a Specialist Office	$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	
• Performed in a Freestanding Radiology Facility	$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	
• Performed as Outpatient Hospital Services **Preauthorization Required**	20% Coinsurance after Deductible	40% Coinsurance after Deductible	

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 20% Coinsurance after Deductible	 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible 40% 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.	20% 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	$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to 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**	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible $10 Copayment 0% Coinsurance not subject to Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 30% Coinsurance not subject to Deductible	See benefit for description

Telemedicine Program Behavioral Health Conditions	$0 Copayment 0% Coinsurance not subject to 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**
Diabetic Equipment, Supplies and Self-Management Education			See benefit for description
• Diabetic Equipment, Supplies and Insulin (up to a 90 day supply)	See the Prescription Drug Cost-Sharing but not more than $100 for a 30-day supply of insulin	See the Prescription Drug Cost-Sharing but not more than $100 for a 30-day supply of insulin	See Prescription Drug benefit
• Diabetic Education	$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	
Durable Medical Equipment and Braces **Preauthorization Required**	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
External Hearing Aids			Single purchase once every 3 years
• Prescription Hearing Aids	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Cochlear Implants **Preauthorization Required**	20% Coinsurance after Deductible	40% Coinsurance after Deductible	One per ear per time Covered
Hospice Care			210 days per Plan Year
• Inpatient	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited visits for family bereavement counseling
• Outpatient	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Medical Supplies	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Prosthetic Devices			
• External	20% Coinsurance after Deductible	40% Coinsurance after Deductible	One (1) prosthetic device, per limb, per lifetime, with coverage for repairs and replacements

• Internal **Preauthorization Required**	20% Coinsurance after Deductible	40% Coinsurance after Deductible	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**
Autologous Blood Banking	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefits for description
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care) **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.**	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Observation Stay	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) **Preauthorization Required**	20% 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**	20% 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**	20% 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.**	20% 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 **Preauthorization Required for surgical services.**	 $10 Copayment 0% Coinsurance not subject to Deductible 0% Coinsurance not subject to Deductible	 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible	See benefit for description
ABA Treatment for Autism Spectrum Disorder	$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	See benefit description
Assistive Communication Devices for Autism Spectrum Disorder	$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	See benefit for description
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.**	20% 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)			Unlimited days per Plan Year may be used for family counseling See benefit for description
• Office Visits	$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	
• All Other Outpatient Services	0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	
• Opioid Treatment Programs	Covered in full	30% Coinsurance not subject to 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	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy			
30-day supply Tier 1	$10 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	See benefit for description
Tier 2	$30 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to 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.	$50 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	

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.			
Up to a 90-day supply for Maintenance Drugs 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.	 $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 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.	 $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
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 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	$35 Copayment 0% Coinsurance not subject to Deductible	$35 Copayment 0% Coinsurance not subject to Deductible	
• Routine Dental Care	0% Coinsurance not subject to Deductible	0% Coinsurance not subject to Deductible	Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at six (6) month intervals
• Major Dental (Endodontics, Periodontics, Oral Surgery and Prosthodontics)	0% Coinsurance not subject to Deductible	0% Coinsurance not subject to Deductible	
• Orthodontics	50% Coinsurance not subject to Deductible	50% Coinsurance not subject to 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	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Lenses and Frames	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Contact Lenses	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Accidental Injury Dental Treatment	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
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
Repatriation of Remains	0% coinsurance of - Actual Cost not subject to Deductible		Unlimited
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.

Exclusions and Limitations

No coverage is available under this Certificate for the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

N. Services Not Listed.
We do not Cover services that are not listed in this Certificate as being Covered.

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

P. Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Q. Services With No Charge.
We do not Cover services for which no charge is normally made.

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

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

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

VALUE ADDED SERVICES

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

VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:
www.wellfleetstudent.com

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 healthclinicians 24/7/365 via telephone (888) 857-5462

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