



# BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2025/2026

DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

**MANHATTAN UNIVERSITY**

**Bronx, NY**  
("the Policyholder")

**UNDERWRITTEN BY:**

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

**Policy Number: WNY2526NYSHIP23**

**Group Number: ST1263SH**

**Effective: 8/1/2025 – 7/31/2026**

**ADMINISTERED BY:**

Wellfleet Group, LLC



## Welcome Students...

We are pleased to provide you with this summary of the 2025 – 2026 Student Health Insurance Plan (“Plan”), which is fully compliant with the Affordable Care Act. This is only a brief description of the coverage(s) available under Certificate form NYSHIP Cert (2025). The Certificate will contain reductions, limitations, exclusions, and termination provisions. Full details of coverage are contained in the Certificate. If there are any conflicts between this document and the Certificate, the Certificate shall govern in all cases.

“Benefits at a Glance” includes effective dates and costs of coverage, as well as other helpful information. For additional details about the Plan, please consult the Plan Certificate and other materials at [www.wellfleetstudent.com](http://www.wellfleetstudent.com).

This is not an insurance Policy and your receipt of this document does not constitute the insurance or delivery of a policy of insurance. Any provisions of the Policy, as described in this Summary, that may be in conflict with the laws of the state where the school is located will be administered to conform with the requirements of that state’s laws, including those relating to mandated benefits.

The information contained in this Summary is accurate at the time of publication, but may change in accordance with state and federal insurance regulations during the course of the Policy year. The most current version of this document will be posted online. 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**

## Servicing Agent

### (Enrollment, Waivers)

Academic HealthPlans  
PO Box 1605  
Colleyville, TX 76034  
<https://manhattan.myahpcare.com/>

## Plan Administration

### Eligibility, Benefits, Claim Status, & ID Cards

Wellfleet Group, LLC  
PO Box 15369  
Springfield, Massachusetts 01115-5369  
**(877) 657-5030, TTY 711**  
[www.wellfleetstudent.com](http://www.wellfleetstudent.com)  
Monday–Thursday, 8:30 a.m. to 7:00 p.m.  
Eastern Time  
Friday, 9:00 a.m. to 5:00 p.m.  
Eastern Time

### Claims

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



## PPO Network



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



## Pharmacy Benefits Manager

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

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**



## Telehealth Service

Your plan includes access to virtual healthcare advice by phone, video, or app.

- Scheduled mental health services – 7 days a week

Register at [https://www.teladoc.com/wellfleetstudent/](http://www.teladoc.com/wellfleetstudent/)

- In addition, your plan includes virtual physical therapy and other musculoskeletal services from Hinge Health
- Register at [https://hinge.health/wellfleet](http://hinge.health/wellfleet)



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



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# General Information

## Am I Eligible

All registered full-time undergraduate students taking 12 or more credits, all degree-seeking international students, all students residing in the college dormitories, and all Division 1 student athletes of the policyholder are required to have health insurance coverage, either through this Student Health Plan or through another individual or family health plan. Eligible students are automatically enrolled in and charged premium for the Student Health Plan coverage unless proof of comparable coverage is provided by completing the waiver by the applicable waiver deadline date.

## Dependents

Dependents are not eligible.

## How Do I Waive?

### To Waive:

International graduate students are not eligible to waive the insurance and will automatically be enrolled in the student health insurance for the same dates as the Session they attend.

All registered full-time undergraduate students in an on-campus program will need to **confirm enrollment** or **waive** the Manhattan University Student Health Insurance Plan (SHIP) and will be required to make their selection by the deadline.

To Waive or confirm Enrollment, go to:

- <https://www.studentinsurance.com/Client/1263>
- Select Waive.
- New students must Create and Account with Wellfleet. Returning students can Login to their current account.
- Once successfully logged into your account there will be an option to "Waive". Select and proceed as directed.
- Students will need a copy of their current insurance card to enter their insurance information.
- All students will receive a confirmation of their submission via email. Review email to make sure additional information is not needed. Retain the email confirmation for your records.

**The deadline to waive coverage for Annual coverage is 08/31/2025.**

**NOTE:** Paper copies of the waiver form are available from Manhattan University.

## Effective Dates & Costs

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

Coverage Period	Coverage Start Date	Coverage End Date	Waiver Deadline
Annual	08/01/2025	07/31/2026	08/31/2025
Fall Semester	08/01/2025	12/31/2025	08/31/2025
Spring (students new to the University for the spring term)	01/01/2026	07/31/2026	02/01/2026

### Insurance Premiums

	Annual	Fall Semester	Spring (students new to the University for the spring term)
Student*	\$2,261	\$948	\$1,313

### Broker Fees

	Annual	Fall Semester	Spring (students new to the University for the spring term)
Student*	\$119	\$50	\$69

### School Administrative Fees

	Annual	Fall Semester	Spring (students new to the University for the spring term)
Student*	\$12	\$5	\$7

### Total Plan Costs (Premiums + Fees)

	Annual	Fall Semester	Spring (students new to the University for the spring term)
Student*	\$2,392	\$1,003	\$1,389

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

## Plan Benefits

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

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

## Key Plan Benefits

BENEFIT	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
<b>Plan Year Deductible Individual</b>	\$250	\$500
<b>Out-of-Pocket Limit Individual</b>	\$7,900	\$15,800
<b>Coinsurance</b>	30% of the Allowed Amount	40% of the Allowed Amount
<b>Preventive Care</b>	Covered in full	30% Coinsurance not subject to Deductible
<b>Primary Care Office Visits (or Home Visits) including Specialist Office Visits *Check below for additional copayments</b>	\$25 Copayment per visit then 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible
<b>Emergency Department Copayment waived if admitted to Hospital</b>	30% Coinsurance after Deductible	30% Coinsurance after Deductible
<b>Urgent Care Center</b>	30% Coinsurance after Deductible	30% Coinsurance after Deductible

## Schedule of Benefits

### MANHATTAN UNIVERSITY SCHEDULE OF BENEFITS

**Gold Metal Level**

**Actuarial Value: 82.29%**

**Manhattan University**

**Policy Number:** WNY2526NYSHIP23

**Group/Plan Number:** ST1263SH

**Policyholder Effective Date:** August 1, 2025

**Policyholder Termination Date:** July 31, 2026

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
<b>Medical Deductible</b> <ul style="list-style-type: none"> <li>• Individual</li> </ul>	\$250	\$500	
<b>Out-of-Pocket Limit</b> <ul style="list-style-type: none"> <li>• Individual</li> </ul>	\$7,900	\$15,800	
<b>Accidental Death and Dismemberment Benefits</b> <b>\$10,000 Annual Maximum.</b>		See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how We calculate the Allowed Amount. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount.	
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)	\$25 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	See benefit for description

Specialist Office Visits (or Home Visits)	\$25 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	See benefit for description
<b>PREVENTIVE CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
• 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	30% Coinsurance after Deductible	40% Coinsurance after 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)	
<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Emergency Ambulance Transportation (Pre-Hospital Emergency Medical Services and Emergency Transportation including Air Ambulance)	30% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services (Ground and Air Ambulance)	30% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Emergency Department Copayment waived if admitted to Hospital	30% Coinsurance after Deductible  Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	30% Coinsurance after Deductible  Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	See benefit for description
Urgent Care Center	30% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
<b>PROFESSIONAL SERVICES and OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Advanced Imaging Services <ul style="list-style-type: none"> <li>• Performed in a Specialist Office</li> <li>• Performed in a Freestanding Radiology Facility</li> <li>• Performed as Outpatient Hospital Services</li> </ul> <b>Preadmission Required</b>	\$25 Copayment 0% Coinsurance not subject to Deductible  30% Coinsurance after Deductible  30% Coinsurance after Deductible	30% Coinsurance not subject to Deductible  40% Coinsurance after Deductible  40% Coinsurance after Deductible	See benefit for description

Allergy Testing and Treatment			See benefit for description
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> </ul>	<p>\$25 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$25 Copayment 0% Coinsurance not subject to Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p>	
Ambulatory Surgical Center Facility Fee	30% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)	30% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Cardiac and Pulmonary Rehabilitation			See benefits for description
<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> <li>Performed as Inpatient Hospital Services</li> </ul>	<p>\$25 Copayment 0% Coinsurance not subject to Deductible</p> <p>30% Coinsurance after Deductible</p> <p>Included as part of inpatient Hospital service Cost-Sharing</p>	<p>30% Coinsurance not subject to Deductible</p> <p>40% Coinsurance after Deductible</p> <p>Included as part of inpatient Hospital service Cost-Sharing</p>	
Chemotherapy and Immunotherapy			See benefit for description
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$25 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$25 Copayment 0% Coinsurance not subject to Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p> <p>40% Coinsurance after Deductible</p>	
<b>Preadmission Required</b>			
Chiropractic Services	\$25 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 <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	\$25 Copayment 0% Coinsurance not subject to Deductible \$25 Copayment 0% Coinsurance not subject to Deductible 30% Coinsurance after Deductible	30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible 40% Coinsurance after Deductible	See benefit for description
Dialysis <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Center</li> <li>Performed as Outpatient Hospital Services</li> <li>Performed at Home</li> </ul>	\$25 Copayment 0% Coinsurance not subject to Deductible \$25 Copayment 0% Coinsurance not subject to Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <p>The visits limit does not apply to Habilitation Services for a Mental Health or Substance Use Disorder.</p>	30% Coinsurance after Deductible	40% Coinsurance after Deductible	60 visits per condition, per Plan Year combined therapies
Home Health Care <b>Preatuthorization Required</b>	30% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited visits per Plan Year

Infertility Services <b>Preatuthorization Required</b>	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 <ul style="list-style-type: none"><li>• Performed in a PCP Office</li><li>• Performed in Specialist Office</li><li>• Performed as Outpatient Hospital Services</li><li>• Home Infusion Therapy</li></ul> <b>Preatuthorization Required</b>	<p>\$25 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$25 Copayment 0% Coinsurance not subject to Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p>	See benefit for description
Inpatient Medical Visits	30% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Interruption of Pregnancy <ul style="list-style-type: none"><li>• Abortion Services</li></ul>	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description
Laboratory Procedures <ul style="list-style-type: none"><li>• Performed in a PCP Office</li><li>• Performed in a Specialist Office</li><li>• Performed in a Freestanding Laboratory Facility</li><li>• Performed as Outpatient Hospital Services</li></ul>	<p>\$25 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$25 Copayment 0% Coinsurance not subject to Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p>	See benefit for description

Maternity and Newborn Care			See benefit for description
<ul style="list-style-type: none"> <li>Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> <li>Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> <li>Inpatient Hospital Services and Birthing Center</li> <li>Physician and Midwife Services for Delivery</li> <li>Breastfeeding Support, Counseling and Supplies, Including Breast Pumps</li> <li>Postnatal Care <ul style="list-style-type: none"> <li>Postnatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> <li>Postnatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> </ul> </li> </ul>	<p>Covered in full</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>Covered in full</p> <p>Covered in full</p> <p>\$25 Copayment 0% Coinsurance not subject to Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p>	<p>One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early</p> <p>Covered for duration of breast feeding</p>
Outpatient Hospital Surgery Facility Charge	30% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Preadmission Testing	30% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

<p>Prescription Drugs Administered in Office or Outpatient Facilities</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in Specialist Office</li> <li>Performed in Outpatient Facilities</li> </ul>	<p>\$25 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$25 Copayment 0% Coinsurance not subject to Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p> <p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Diagnostic Radiology Services</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Radiology Facility</li> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Preauthorization Required</b></p>	<p>\$25 Copayment 0% Coinsurance not subject to Deductible</p> <p>\$25 Copayment 0% Coinsurance not subject to Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>30% Coinsurance not subject to Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Therapeutic Radiology Services</p> <ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Radiology Facility</li> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Preauthorization Required</b></p>	<p>\$25 Copayment 0% Coinsurance not subject to Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>30% Coinsurance not subject to Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p>

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.	30% 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	\$25 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 <b>Preauthorization Required</b>	30% Coinsurance after Deductible  30% Coinsurance after Deductible  30% Coinsurance after Deductible  \$25 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  Physical Therapy	\$0 Copayment then 0% Coinsurance not subject to Deductible  \$0 Copayment then 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 <ul style="list-style-type: none"> <li>• Diabetic Equipment and (up to a 90 day supply)</li> <li>• Diabetic Insulin (30 day supply)</li> <li>• Diabetic Education</li> </ul>	See the Prescription Drug Cost-Sharing Covered in full \$25 Copayment 0% Coinsurance not subject to Deductible	See the Prescription Drug Cost-Sharing See the Prescription Drug Cost-Sharing 30% Coinsurance not subject to Deductible	See benefit for description See Prescription Drug benefit
Durable Medical Equipment and Braces  <b>Preauthorization Required</b>	30% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
External Hearing Aids <ul style="list-style-type: none"> <li>• Prescription Hearing Aids</li> </ul>	30% Coinsurance after Deductible	40% Coinsurance after Deductible	Single purchase once every 3 years
Cochlear Implants  <b>Preauthorization Required</b>	30% Coinsurance after Deductible	40% Coinsurance after Deductible	One per ear per time Covered
Hospice Care <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Outpatient</li> </ul>	30% Coinsurance after Deductible  30% Coinsurance after Deductible	40% Coinsurance after Deductible  40% Coinsurance after Deductible	210 days per Plan Year  Unlimited visits for family bereavement counseling
Medical Supplies	30% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Prosthetic Devices <ul style="list-style-type: none"> <li>• External</li> <li>• Internal</li> </ul> <b>Preauthorization Required</b>	30% Coinsurance after Deductible  30% Coinsurance after Deductible	40% Coinsurance after Deductible  40% Coinsurance after Deductible	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements  Unlimited See benefit for description

INPATIENT SERVICES and FACILITIES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Autologous Blood Banking	30% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefits for description
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)  <b>Preauthorization Required. However, Preauthorization is not required for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.</b>	30% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Observation Stay	30% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)  <b>Preauthorization Required</b>	30% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited days  See benefit for description
Inpatient Habilitation Services (Physical Speech and Occupational Therapy)  <b>Preauthorization Required</b>	30% Coinsurance after Deductible	40% Coinsurance after Deductible	60 days per Plan Year for all therapies combined  See benefit for description
Inpatient Rehabilitation Services (Physical Speech and Occupational Therapy)  <b>Preauthorization Required</b>	30% Coinsurance after Deductible	40% Coinsurance after Deductible	60 days per Plan Year for all therapies combined  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 Care for a continuous confinement when in a Hospital Residential Facility  <b>Preauthorization Required.</b>	30% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

<b>However, Preauthorization is not required for emergency admissions or for admissions at participating Hospitals or crisis residence Facilities licensed or operated by OMH</b>			
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) <ul style="list-style-type: none"> <li>Office Visits</li> <li>All Other Outpatient Services</li> </ul> <b>Preauthorization Required for surgical services.</b>	\$25 Copayment 0% Coinsurance not subject to Deductible  0% Coinsurance after Deductible	30% Coinsurance not subject to Deductible  30% Coinsurance after Deductible	See benefit for description
ABA Treatment for Autism Spectrum Disorder	\$25 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	See benefit description
Assistive Communication Devices for Autism Spectrum Disorder	\$25 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)  <b>Preauthorization Required. However, Preauthorization is not required for emergency admissions or for participating Facilities licensed, certified or otherwise authorized by OASAS.</b>	30% 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) <ul style="list-style-type: none"> <li>Office Visits</li> </ul>	\$25 Copayment 0% Coinsurance not subject to Deductible	Unlimited days per Plan Year may be used for family counseling  30% Coinsurance not subject to Deductible	See benefit for description

<ul style="list-style-type: none"> <li>• All Other Outpatient Services</li> <li>• Opioid Treatment Programs</li> </ul>	0% Coinsurance after Deductible  Covered in full	30% Coinsurance after Deductible  30% Coinsurance after Deductible	
<b>PRESCRIPTION DRUGS</b>  *Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and obtained at a participating pharmacy	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Retail Pharmacy</b>			
30-day supply  Tier 1  Tier 2  Tier 3  Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.  If You purchase a Prescription Drug from a Non-Participating Pharmacy, You must pay for the Prescription Drug at the time it is dispensed and then file a claim for reimbursement with Us. We will not reimburse You for the difference between what You pay the Non-Participating Pharmacy and Our price for the Prescription Drug.	\$20 Copayment 0% Coinsurance not subject to Deductible  \$50 Copayment 0% Coinsurance not subject to Deductible  \$100 Copayment 0% Coinsurance not subject to Deductible	\$20 Copayment 0% Coinsurance not subject to Deductible  \$50 Copayment 0% Coinsurance not subject to Deductible  \$100 Copayment 0% Coinsurance not subject to Deductible	See benefit for description

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			See benefit for description
Tier 1	\$60 Copayment 0% Coinsurance not subject to Deductible	\$60 Copayment 0% Coinsurance not subject to Deductible	
Tier 2	\$150 Copayment 0% Coinsurance not subject to Deductible	\$150 Copayment 0% Coinsurance not subject to Deductible	
Tier 3	\$300 Copayment 0% Coinsurance not subject to Deductible	\$300 Copayment 0% 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.			
Enteral Formulas			See benefit for description
Tier 1	\$20 Copayment 0% Coinsurance not subject to Deductible	\$20 Copayment 0% Coinsurance not subject to Deductible	
Tier 2	\$50 Copayment 0% Coinsurance not subject to Deductible	\$50 Copayment 0% Coinsurance not subject to Deductible	
Tier 3	\$100 Copayment 0% Coinsurance not subject to Deductible	\$100 Copayment 0% 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.			
<b>WELLNESS BENEFITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Exercise Facility Reimbursement</b>	Up to \$200 per six (6) month period	Up to \$200 per six (6) month period	See Benefit description
<b>PEDIATRIC DENTAL and VISION CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Pediatric Dental Care for Members through the end of the month in which the Member turns 19 years of age</b> <ul style="list-style-type: none"> <li>Preventive Dental Care</li> <li>Routine Dental Care</li> <li>Major Dental (Endodontics, Periodontics, Oral Surgery and Prosthodontics)</li> <li>Orthodontics</li> </ul>	0% Coinsurance not subject to Deductible  50% Coinsurance after Deductible  50% Coinsurance after Deductible  50% Coinsurance after Deductible	0% Coinsurance not subject to Deductible  50% Coinsurance after Deductible  50% Coinsurance after Deductible  50% Coinsurance after Deductible	Two (2) dental exams and cleanings per Plan Year  Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at six (6) month intervals
<b>Pediatric Vision Care for Members through the end of the month in which the Member turns 19 years of age</b> <ul style="list-style-type: none"> <li>Exams</li> <li>Lenses and Frames</li> <li>Contact Lenses</li> </ul>	30% Coinsurance after Deductible  30% Coinsurance after Deductible  30% Coinsurance after Deductible	40% Coinsurance after Deductible  40% Coinsurance after Deductible  40% Coinsurance after Deductible	One (1) exam per Plan Year  One (1) prescribed lenses and frames per Plan Year

<b>Accidental Injury Dental Treatment</b>	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
<b>Non-emergency Care While Traveling Outside of the United States</b>	40% coinsurance of - Actual Cost after Deductible		\$ 10,000 Annual Limits
<b>Accidental Death and Dismemberment Benefits</b>	N/A	N/A	\$10,000 Annual Maximum

#### **ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**

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

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

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

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

#### **Exclusions and Limitations**

No coverage is available under this Certificate for the following:

##### **A. Aviation.**

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

##### **B. Convalescent and Custodial Care.**

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

##### **C. Conversion Therapy.**

We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support and understanding of an

individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

**D. Cosmetic Services.**

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

**E. Dental Services.**

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

**F. Experimental or Investigational Treatment.**

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

**G. Felony Participation.**

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

**H. Foot Care.**

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

**I. Government Facility.**

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

**J. Medically Necessary.**

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

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

We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When You are enrolled in Medicare, We will reduce Our benefits by the amount Medicare pays

for Covered Services. Benefits for Covered Services will not be reduced if We are required by federal law to pay first or if You are not enrolled in premium-free Medicare.

**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.

## 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

## 24/7 Nurseline

Students who enroll and maintain medical coverage in this insurance plan have **free** access to the 24/7 Nurseline by calling (800) 634-7629. This 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

- an office or telehealth visit with a healthcare provider
- Or a visit to an urgent care center or emergency room.

Calls are answered 24/7/365 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.

## Contracted Providers for Telemedicine/Telehealth

### The right care when you need it most

Your Wellfleet health plan gives you access to virtual healthcare by phone, video, or app.

**Teladoc** gives you access to board-certified physicians for **Mental Health (at no additional cost to you)** 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.teladochealth.com/benefits/wellfleetstudent> or call (800)-Teladoc (835-2362).

**Hinge Health** gives you access to licensed physical therapists and health coaches for personalized musculoskeletal services including **virtual physical therapy** to help alleviate pain concerns.

Whether you are at school, home, or traveling, Hinge Health can assist in providing exercise therapy wherever and whenever you need treatment at **no additional cost to you**.

Register your account today and start your exercise therapy at <https://hinge.health/wellfleet>.



## 24/7 Telehealth Counseling for Mental Health

CareConnect is an integrated behavioral health program offering students easy access to licensed mental health clinicians 24/7/365 via telephone (888) 857-5462 and website access to expert mental health and emotional wellbeing resources.

The CareConnect hotline is available at **no additional cost to you**, and you also have free access to courses, articles, and short videos that support mental health and wellbeing by visiting <https://careconnect.mysupportportal.com/welcome>.