

Benefits at a Glance

Student Health Insurance Plan (2026/2027)



Designed exclusively for the students of:

MANHATTAN UNIVERSITY

Bronx, NY

("the policyholder")

Policy Number: WNY2627NYSHIP23

Group Number: ST1263SH

Effective: 08/01/2026 – 07/31/2027

Underwritten by: Wellfleet New York Insurance Company

New York, NY

("the Company")

Administered by: Wellfleet Group, LLC



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STUDENT



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Welcome Students...

We are pleased to provide you with this summary of the 2026 – 2027 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 (2026). 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

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
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



Pharmacy Benefits Manager

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

- In addition, your plan includes virtual physical therapy and other musculoskeletal services from Hinge Health
- Register at <https://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.

International Students taking one or more credits are required to have student health insurance coverage through this Student Health Plan. They will automatically be enrolled and they do not have the option to waive coverage.

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 **waive** the Manhattan University Student Health Insurance Plan (SHIP) by the deadline.

To Waive, go to:

manhattan.myahpcare.com

The deadline to waive coverage for Annual coverage is 08/23/2026.

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	08/01/2026	07/31/2027	08/23/2026
Spring/Summer	01/01/2027	07/31/2027	01/15/2027

Insurance Premiums

	Annual	Spring/Summer
Student*	\$2,422	\$1,407

Broker Fees

	Annual	Spring/ Summer
Student*	\$142	\$82

School Administrative Fees

	Annual	Spring/Summer
Student*	\$0	\$0

Total Plan Costs (Premiums + Fees)

	Annual	Spring/Summer
Student*	\$2,564	\$1,489

*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
Plan Year Deductible Individual	\$250	\$500
Out-of-Pocket Limit Individual	\$7,900	\$15,800
Coinsurance	30% 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	\$25 Copayment per visit then 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible
Emergency Department	30% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care Center	30% Coinsurance after Deductible	30% Coinsurance after Deductible

Schedule of Benefits

MANHATTAN UNIVERSITY SCHEDULE OF BENEFITS

Gold Metal Level

Actuarial Value: 82.74%

Manhattan University

Policy Number: WNY2627NYSHIP23

Group/Plan Number: ST1263SH

Policyholder Effective Date: August 1, 2026

Policyholder Termination Date: July 31, 2027

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Medical Deductible Individual	\$250	\$500	
Out-of-Pocket Limit Individual	\$7,900	\$15,800	
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 *Cost-Sharing for Covered Services with a primary diagnosis of Mental Health or Substance Use Disorder may be lower than the Cost-Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).	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
PREVENTIVE CARE *Cost-Sharing for Covered Services with a primary diagnosis of Mental Health or Substance Use Disorder may be lower than the Cost-Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
- Well Child Visits and Immunizations* - Adult Annual Physical Examinations* - Adult Immunizations* - Routine Gynecological Services/Well Woman Exams* - Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer - Sterilization Procedures for Women* - Vasectomy - Bone Density Testing* - Prostate Cancer Screening	Covered in full Covered in full Covered in full Covered in full Covered in full Covered in full 30% Coinsurance after Deductible Covered in full Covered in full	30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible 40% Coinsurance after Deductible 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible	See benefit for description

- Colon Cancer Screening - All other preventive services required by USPSTF and HRSA. *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Covered in full Covered in Full Use Cost-Sharing for appropriate service (Primary Care Office Visit Specialist Office Visit Diagnostic Radiology Services Laboratory Procedures and Diagnostic Testing)	30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible Use Cost-Sharing for appropriate service (Primary Care Office Visit Specialist Office Visit Diagnostic Radiology Services Laboratory Procedures and Diagnostic Testing)	
EMERGENCY CARE *Cost-Sharing for Covered Services with a primary diagnosis of Mental Health or Substance Use Disorder may be lower than the Cost-Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
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
PROFESSIONAL SERVICES and OUTPATIENT CARE *Cost-Sharing for Covered Services with a primary diagnosis of Mental Health or Substance Use Disorder may be lower than the Cost-Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).	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	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	40% Coinsurance after Deductible 40% 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	\$25 Copayment 0% Coinsurance not subject to Deductible \$25 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	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 - Performed in a Specialist Office - Performed as Outpatient Hospital Services - Performed as Inpatient Hospital Services	30% Coinsurance after Deductible 30% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing	40% Coinsurance after 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	30% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

- Performed in a Specialist Office - Performed as Outpatient Hospital Services - Scalp Cooling Systems Preauthorization Required	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	
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 - Performed in a PCP Office - Performed in a Specialist Office - Performed as Outpatient Hospital Services	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after 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	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after 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)	30% Coinsurance after Deductible	40% Coinsurance after Deductible	60 visits per condition, per Plan Year combined therapies The visits limit does not apply to Habilitation Services for a Mental Health or Substance Use Disorder.
Home Health Care Preauthorization Required	30% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited visits per Plan Year
Infertility Services Preauthorization Required	Use Cost-Sharing for appropriate service (Office Visit Diagnostic Radiology Services Surgery Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit Diagnostic Radiology Services Surgery Laboratory & Diagnostic Procedures)	See benefit for description
Infusion Therapy - Performed in a PCP Office - Performed in Specialist Office - Performed as Outpatient Hospital Services - Home Infusion Therapy Preauthorization Required	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Inpatient Medical Visits	30% 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	30% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

Performed in a Specialist Office	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
Performed in a Freestanding Laboratory Facility	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
Performed as Outpatient Hospital Services	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
Maternity and Newborn Care Prenatal Care - Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA - Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA - Inpatient Hospital Services and Birthing Center - Physician and Midwife Services for Delivery - Breastfeeding Support, Counseling and Supplies, Including Breast Pumps Postnatal Care - Postnatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA - Postnatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing) 30% Coinsurance after Deductible 30% Coinsurance after Deductible Covered in full Covered in full \$25 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing) 40% Coinsurance after Deductible 40% Coinsurance after Deductible 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible	See benefit for description One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding

○ Outpatient Donor Breast Milk	\$25 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	
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
Prescription Drugs Administered in Office or Outpatient Facilities			See benefit for description
• Performed in a PCP Office	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Performed in Specialist Office	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Performed in Outpatient Facilities	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
Diagnostic Radiology Services			See benefit for description
• Performed in a PCP Office	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Performed in a Specialist Office	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Performed in a Freestanding Radiology Facility	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
Preauthorization Required			
Therapeutic Radiology Services			See benefit for description
• Performed in a Specialist Office	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Performed in a Freestanding Radiology Facility	30% Coinsurance after Deductible	40% Coinsurance after Deductible	

Performed as Outpatient Hospital Services Preauthorization Required	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	30% Coinsurance after Deductible	40% Coinsurance after Deductible	60 visits per condition, per Plan Year combined therapies The visit limit does not apply to Rehabilitation Services for a Mental Health or Substance Use Disorder.
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 Preauthorization Required	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after 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 *Cost-Sharing for Covered Services with a primary diagnosis of a Mental Health or Substance Use Disorder may be lower than the Cost-Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Diabetic Equipment, Supplies and Self-Management Education - Diabetic Equipment and Supplies (up to a 90 day supply) - Diabetic Insulin (30 day supply) - Diabetic Education	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 Preauthorization Required	30% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
External Hearing Aids Prescription Hearing Aids	30% Coinsurance after Deductible	40% Coinsurance after Deductible	Single purchase once every 3 years
Cochlear Implants Preauthorization Required	30% Coinsurance after Deductible	40% Coinsurance after Deductible	One per ear per time Covered
Hospice Care - Inpatient - Outpatient	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 The visit limit does not apply to Hospice Care for a Mental Health or Substance Use Disorder.

Medical Supplies	30% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Prosthetic Devices • External • Internal Preauthorization Required	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 *Cost-Sharing for Covered Services with a primary diagnosis of a Mental Health or Substance Use Disorder may be lower than the Cost-Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).	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) 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.	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) Preauthorization Required	30% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited days See benefit for description

Inpatient Habilitation Services (Physical Speech and Occupational Therapy) Preauthorization Required	30% Coinsurance after Deductible	40% Coinsurance after Deductible	60 days per Plan Year for all therapies combined See benefit for description The days per Plan Year do not apply to Inpatient Habilitation Services for a Mental Health or Substance Use Disorder.
Inpatient Rehabilitation Services (Physical Speech and Occupational Therapy) Preauthorization Required	30% Coinsurance after Deductible	40% Coinsurance after Deductible	60 days per Plan Year for all therapies combined See benefit for description The days per Plan Year do not apply to Inpatient Rehabilitation Services for a Mental Health or Substance Use Disorder.
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 or Residential Facility Preauthorization Required. However, Preauthorization is not required for emergency admissions or for admissions at participating Hospitals or crisis residence Facilities licensed or operated by OMH	30% 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	\$25 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	See benefit for description

All Other Outpatient Services Preauthorization Required for surgical services.	0% Coinsurance after Deductible	30% Coinsurance after Deductible	
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) Preauthorization Required. However, Preauthorization is not required for emergency admissions or for participating Facilities licensed, certified or otherwise authorized by OASAS.	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) - Office Visits - All Other Outpatient Services - Opioid Treatment Programs	\$25 Copayment 0% Coinsurance not subject to Deductible 0% Coinsurance after Deductible Covered in full	30% Coinsurance not subject to Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	Unlimited days per Plan Year may be used for family counseling See benefit for description
PRESCRIPTION DRUGS *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	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits

*Cost-Sharing for Covered Services with a primary diagnosis of a Mental Health or Substance Use Disorder may be lower than the Cost-Sharing listed below in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).			
Retail Pharmacy			
30-day supply			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	
Preauthorization is not required for Covered antiretroviral Prescription Drugs for the treatment or prevention of HIV or AIDS and Prescription Drugs used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.			
If You purchase a Prescription Drug from a Non-Participating Pharmacy, You must pay for the Prescription Drug at the time it is dispensed and then file a claim for reimbursement with Us. We will not reimburse You for the difference between what You pay the Non-Participating Pharmacy and Our price for the Prescription Drug. In most cases, You will pay more if You purchase Prescription Drugs from a Non-Participating Pharmacy.			

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.	Cost-Sharing for epinephrine devices shall not exceed \$100 per Plan Year.	Cost-Sharing for epinephrine devices shall not exceed \$100 per Plan Year.	
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.			
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 - Preventive Dental Care - Routine Dental Care - Major Dental (Endodontics, Periodontics, Oral Surgery and Prosthodontics) - Orthodontics	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
Pediatric Vision Care for Members through the end of the month in which the Member turns 19 years of age - Exams - Lenses and Frames - Contact Lenses	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

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

Contact Us at the number on Your ID card for information on Your financial responsibility when You receive Covered Services with a primary diagnosis of a Mental Health or Substance Use Disorder.

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.

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>.

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

You 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.



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>.