THECOOPERUNION

BENEFITS AT A GLANCE

STUDENT HEALTH INSURANCE PLAN | PLAN YEAR 2023/2024

DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

THE COOPER UNION
New York City, NY

("the Policyholder")

Policy Number: WNY2324NYSHIP15

Group Number: ST0566SH

Effective: 8/15/2023 – 8/14/2024

UNDERWRITTEN BY:

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

ADMINISTERED BY:

Wellfleet Group, LLC

WELLFLEET STUDENT

Welcome Students…

We are pleased to provide you with this summary of the 2023 – 2024 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 (2023). 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 at the website listed on the cover. In the case of a discrepancy between two versions of the Summary, the most recent will apply.

Important Contact Information & Resources

Contact Us

Wellfleet Group, LLC

PO Box 15369
Springfield, Massachusetts 01115-5369
(877) 657-5030, TTY 711

Plan Administration

Enrollment, Eligibility, & Waivers
Benefits, Claim Status, & ID Cards

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

Friday, 9:00 a.m. to 5:00 p.m.
Eastern Time

Claims

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

PPO Network

Cigna

Cigna
www.mycigna.com

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

Pharmacy Benefits Manager

For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit **www.wellfleetstudent.com**.

Your plan includes Wellfleet Rx – offering over 40 generics at a $0 copay. Please ask your health care provider to review our formulary to see if these medications are right for you. Click here http://wellfleetrx.com/students/formularies/ for more information.

Member Pharmacy Help

(877) 640-7940

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

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

General Information

Am I Eligible

All registered Domestic and International Undergraduate students enrolled in 6 or more credit hours and all registered Graduate students enrolled in 4.5 or more credit hours are eligible and are automatically enrolled in and charged premium for the Cooper Union Student Health Insurance Plan. Students who have other insurance can opt out of the Cooper Union SHIP by completing an online waiver and providing proof of comparable coverage to insurance company by the waiver deadline date.

Dependents

Insured Students who are enrolled in the Student Health Plan may also enroll their eligible Dependents.

Dependents are eligible.

How Do I Waive/Enroll?

To Waive:

- Go to www.wellfleetstudent.com.
- Search **Cooper Union**
- Click the waiver tab and proceed as directed. You must fill in all of the required information on the waiver form. If any information is missing, your waiver will not be accepted.
- Click submit and review the information being provided is accurate.
- When your online waiver form is successfully submitted you will receive a confirmation e-mail.

The deadline to waive coverage for Annual coverage is 10/15/2023.

To Purchase coverage and Enroll your dependents:

- Go to www.wellfleetstudent.com.
- Select **Cooper Union**
- Click the "Enroll" tab and proceed as directed to enroll in and purchase the student health insurance plan.

The deadline to enroll and purchase coverage for Annual coverage is 10/15/2023.

NOTE: Paper copies of the waiver form and/or enrollment form are available from The Cooper Union.

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/Dependent Enrollment Deadline Dates
Annual	8/15/2023	8/14/2024	10/15/2023

Insurance Premiums

	Annual
Student	$2,655
Spouse	$2,655
Each Child	$2,655
3 or more Children	$7,965

Broker Fees

	Annual
Student*	$140
Spouse*	$140
Each Child*	$140
3 or more Children*	$420

Total Plan Costs (Premiums + Fees) for eligible students and their Dependents

	Annual
Student*	$2,795
Spouse*	$2,795
Each Child*	$2,795
3 or more Children*	$8,385

***The above plan costs include an administrative service fee.**
The plan costs for Dependents are in addition to the plan costs for student.

Plan Benefits

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

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

Key Plan Benefits

BENEFIT	PARTICPATING PROVIDER	NON-PARTICIPATING PROVIDER
Plan Year Deductible **Individual** **Family**	 $50 $100	 $100 $200
Out-of-Pocket Limit **Individual** **Family**	 $$5,000 $10,000	 $$6,850 $13,700
Coinsurance	10% of the Allowed Amount	40% of the Allowed Amount
Preventive Care	Covered in full	30% Coinsurance not subject to Deductible
Primary Care Office Visits (or Home Visits) including Specialist Office Visits ***Check below for additional copayments**	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Department	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Urgent Care Center	10% Coinsurance after Deductible	40% Coinsurance after Deductible

Schedule of Benefits

THE COOPER UNION SCHEDULE OF BENEFITS
Metal Level Platinum
Actuarial Value: 91.95%
The Cooper Union

Policy Number: WNY2324NYSHIP15
Group/Plan Number: ST0566SH
Policyholder Effective Date: August 15, 2023
Policyholder Termination Date: August 14, 2024

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Medical Deductible • Individual • Family	 $50 $100	 $100 $200	
Out-of-Pocket Limit • Individual • Family	 $5,000 $10,000	 $6,850 $13,700	
Accidental Death and Dismemberment Benefits $10,000 **Annual Maximum.**		See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how We calculate the Allowed Amount. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount.	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

PREVENTIVE CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
• Well Child Visits and Immunizations*	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description
• Adult Annual Physical Examinations*	Covered in full	30% Coinsurance not subject to Deductible	
• Adult Immunizations*	Covered in full	30% Coinsurance not subject to Deductible	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	30% Coinsurance not subject to Deductible	
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	30% Coinsurance not subject to Deductible	
• Sterilization Procedures for Women*	Covered in full	30% Coinsurance not subject to Deductible	
• Vasectomy	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
• Bone Density Testing*	Covered in full	30% Coinsurance not subject to Deductible	
• Screening for Prostate Cancer	Covered in full	30% Coinsurance not subject to Deductible	
• Screening for Colon Cancer	Covered in full	30% Coinsurance not subject to Deductible	
• All other preventive services required by USPSTF and HRSA.	Covered in full	30% Coinsurance not subject to Deductible	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost-Sharing for appropriate service (Primary Care Office Visit Specialist Office Visit Diagnostic Radiology Services Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit Specialist Office Visit Diagnostic Radiology Services Laboratory Procedures and Diagnostic Testing)	

EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	10% Coinsurance after Deductible	10% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services	10% Coinsurance after Deductible	10% Coinsurance after Deductible	See benefit for description
Emergency Department	10% Coinsurance after Deductible Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	10% Coinsurance after Deductible Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	See benefit for description
Urgent Care Center	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Acupuncture	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Advanced Imaging Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services **Preauthorization Required**	 10% Coinsurance after Deductible $50 Copayment after Deductible then 10% Coinsurance 10% Coinsurance after Deductible	 40% Coinsurance after Deductible $50 Copayment after Deductible then 40% Coinsurance 40% Coinsurance after Deductible	See benefit for description
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	 10% Coinsurance after Deductible 10% 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 • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Preauthorization Required**	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Chiropractic Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Clinical Trials	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Dialysis • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Center • Performed as Outpatient Hospital Services • Performed at Home	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description

Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	60 visits per condition, per Plan Year combined therapies
Home Health Care **Preauthorization Required**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited visits
Infertility Services **Preauthorization Required**	Use Cost-Sharing for appropriate service (Office Visit Diagnostic Radiology Services Surgery Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit Diagnostic Radiology Services Surgery Laboratory & Diagnostic Procedures)	See benefit for description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy **Preauthorization Required**	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Inpatient Medical Visits	10% 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 • Performed in a Specialist Office • Performed in a Freestanding Laboratory Facility • Performed as Outpatient Hospital Services	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description

Maternity and Newborn Care			See benefit for description
• Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	30% Coinsurance not subject to Deductible	
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early
• Inpatient Hospital Services and Birthing Center	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Physician and Midwife Services for Delivery	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	Covered in full	30% Coinsurance not subject to Deductible	Covered for duration of breast feeding
• Postnatal Care	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
Outpatient Hospital Surgery Facility Charge	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Preadmission Testing	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities			See benefit for description
• Performed in a PCP Office	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Performed in Specialist Office	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Performed in Outpatient Facilities	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
Diagnostic Radiology Services			See benefit for description
• Performed in a PCP Office	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Performed in a Specialist Office	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Performed in a Freestanding Radiology Facility	$50 Copayment after Deductible then 10% Coinsurance	$50 Copayment after Deductible then 40% Coinsurance	
• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
Preauthorization Required			

Therapeutic Radiology Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services **Preauthorization Required**	 10% Coinsurance after Deductible $50 Copayment after Deductible then 10% Coinsurance 10% Coinsurance after Deductible	 40% Coinsurance after Deductible $50 Copayment after Deductible then 40% Coinsurance 40% Coinsurance after Deductible	See benefit for description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	60 visits per condition, per Plan Year combined therapies
Second Opinions on the Diagnosis of Cancer, Surgery and Other	10% Coinsurance after Deductible	40% Coinsurance after Deductible Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.	See benefit for description
Surgical Services (including Oral Surgery Reconstructive Breast Surgery Other Reconstructive and Corrective Surgery; and Transplants • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery **Preauthorization Required**	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description

ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Diabetic Equipment, Supplies and Self-Management Education			See benefit for description
• Diabetic Equipment, Supplies and Insulin (up to a 90-day supply)	See the Prescription Drug Cost-Sharing but not more than $100 for a 30-day supply of insulin	See the Prescription Drug Cost-Sharing but not more than $100 for a 30-day supply of insulin	See Prescription Drug benefit
• Diabetic Education	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
Durable Medical Equipment and Braces **Preauthorization Required**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
External Hearing Aids	10% Coinsurance after Deductible	40% Coinsurance after Deductible	Single purchase once every 3 years
Cochlear Implants **Preauthorization Required**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	One per ear per time Covered
Hospice Care			Unlimited visits
• Inpatient	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Outpatient	10% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited visits for family bereavement counseling
Medical Supplies	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Prosthetic Devices			One (1) prosthetic device, per limb, per lifetime, with coverage for repairs and replacements
• External	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Internal **Preauthorization Required**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited See benefit for description

Shoe Inserts	10% Coinsurance after Deductible	40% Coinsurance after Deductible	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	10% 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.**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Observation Stay	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) **Preauthorization Required**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited days See benefit for description
Inpatient Habilitation Services (Physical Speech and Occupational Therapy) **Preauthorization Required**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited days See benefit for description
Inpatient Rehabilitation Services (Physical Speech and Occupational Therapy) **Preauthorization Required**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited days 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 (including Residential Treatment) **Preauthorization Required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH-licensed Facilities for Members under 18.**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) • Office Visits • All Other Outpatient Services **Preauthorization Required for surgical services**.	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
ABA Treatment for Autism Spectrum Disorder	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit description
Assistive Communication Devices for Autism Spectrum Disorder	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment) **Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions or for Participating OASAS-certified Facilities.**	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)			Unlimited days per Plan Year may be used for family counseling
• Office Visits	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
• All Other Outpatient Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
• Opioid Treatment Programs	Covered in full	30% Coinsurance not subject to Deductible	
PRESCRIPTION DRUGS *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and obtained at a participating pharmacy	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy			
30-day supply			See benefit for description
Tier 1	$10 Copayment 0% Coinsurance not subject to Deductible	$10 Copayment after Deductible then 0% Coinsurance	
Tier 2	$25 Copayment 0% Coinsurance not subject to Deductible	$25 Copayment after Deductible then 0% Coinsurance	
Tier 3	$25 Copayment 0% Coinsurance not subject to Deductible	$25 Copayment after Deductible then 0% Coinsurance	
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.			

Up to a 90-day supply for Maintenance Drugs Tier 1 Tier 2 Tier 3	 $30 Copayment 0% Coinsurance not subject to Deductible $75 Copayment 0% Coinsurance not subject to Deductible $75 Copayment 0% Coinsurance not subject to Deductible	 $30 Copayment after Deductible then 0% Coinsurance $75 Copayment after Deductible then 0% Coinsurance $75 Copayment after Deductible then 0% Coinsurance	See benefit for description
Enteral Formulas Tier 1 Tier 2 Tier 3	 $10 Copayment 0% Coinsurance not subject to Deductible $25 Copayment 0% Coinsurance not subject to Deductible $25 Copayment 0% Coinsurance not subject to Deductible	 $10 Copayment after Deductible then 0% Coinsurance $25 Copayment after Deductible then 0% Coinsurance $25 Copayment after Deductible then 0% Coinsurance	See benefit for description
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Exercise Facility Reimbursement	Up to $200 per six (6) month period up to an additional $100 per six (6) month period for Covered Dependents	Up to $200 per six (6) month period up to an additional $100 per six (6) month period for Covered Dependents	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	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 40% Coinsurance after Deductible 40% 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 **Contact Lenses Require Preauthorization**	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	One (1) exam per Plan Year One (1) prescribed lenses and frames per Plan Year
Non-emergency Care While Traveling Outside of the United States	40% coinsurance of - Actual Cost after Deductible		$1,000 Annual Limit
Emergency Medical Evacuation	0% coinsurance of – Actual Cost not subject to Deductible		$50,000 Annual Limits Combined with Repatriation Benefit.
Repatriation of Remains	0% coinsurance of - Actual Cost not subject to Deductible		$50,000 Annual Limits Combined with Medical Evacuation Benefit.
Accidental Death and Dismemberment Benefits	N/A	N/A	$10,000 Annual Maximum

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

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

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

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

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

Exclusions and Limitations

No coverage is available under this Certificate for the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VALUE ADDED SERVICES

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

VISION DISCOUNT PROGRAM

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

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

Wellfleet Student provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Wellfleet Student at (877) 657-5030, TTY 711.

If you are traveling and need assistance in North America, call the Assistance Center toll-free at: (877) 305-1966 or if you are in a foreign country, call collect at: (715) 295-9311.

When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

How to Access Services

If you require medical assistance or you need assistance with a non-medical situation, such as lost luggage, lost documents or other travel issues, follow these steps:

- Inside the U.S. and Canada: Dial toll-free **(877) 305-1966.**
- Outside the U.S. and Canada:
  - **a)** Request an international operator.
  - **b)** Request the operator to place a collect call to the U.S. at **+1 (715) 295-9311**.

Please provide the following information when you call:

- Policy number or school name
- Nature of your call and/or emergency
- Current location
- Contact phone number and email address
- Secondary point of contact
- Date of birth

24 Hour Nurseline

Students who enroll and maintain medical coverage in this insurance plan have access to the 24 Hour Nurseline. This 24-Hour Nurseline program provides:

- Phone-based, reliable health information in response to health concerns and questions; and
- Assistance in decisions on the appropriate level of care for an injury or sickness.

Appropriate care may include:

- self-care at home
- a call to a physician
- or a visit to the emergency room.

Calls are answered 24 hours a day, 365 days a year by experienced registered nurses who have been specifically trained to handle telephone health inquiries.

This program is not a substitute for doctor visits or emergency response systems. The Nurseline does not answer health plan benefit questions. Health benefit questions should be referred to the Plan Administrator. The 24 Hour Nurseline toll free number will be on the ID card.
(800) 634-7629.

24/7 Behavioral Telehealth and Nurseline Access

CareConnect is an integrated behavioral health program offering students easy access to licensed behavioral healthclinicians 24/7/365 via telephone (888) 857-5462

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