



Benefits at a Glance

Student Health Insurance Plan (2026/2027)



Designed exclusively for the students of:

THE COOPER UNION

New York City, NY

("the policyholder")

Policy Number: WNY2627NYSHIP15

Group Number: ST0566SH

Effective: 08/15/2026 – 08/14/2027

Underwritten by: Wellfleet New York Insurance Company

New York, NY

("the Company")

Administered by: Wellfleet Group, LLC



WELLFLEET
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

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
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.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://www.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 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.

New International Students 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

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.
- **Please Note:** Waivers are required to be completed for each plan year.

The deadline to waive coverage for Annual coverage is 10/15/2026.

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 10/15/2026.

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	8/15/2026	8/14/2027	10/15/2026

Insurance Premiums

Annual	
Student	\$4,620
Spouse	\$4,620
Each Child	\$4,620
3 or more Children	\$13,860

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*	\$4,760
Spouse*	\$4,760
Each Child*	\$4,760
3 or more Children*	\$14,280

*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	PARTICIPATING 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	10% Coinsurance after Deductible

Schedule of Benefits

THE COOPER UNION SCHEDULE OF BENEFITS

Metal Level Platinum
Actuarial Value: 92.44%
The Cooper Union

Policy Number: WNY2627NYSHIP15
Group/Plan Number: ST0566SH
Policyholder Effective Date: August 15, 2026
Policyholder Termination Date: August 14, 2027

COST-SHARING Medical Deductible - Individual - Family Out-of-Pocket Limit - Individual - Family Accidental Death and Dismemberment Benefits \$10,000 Annual Maximum.	Participating Provider Member Responsibility for Cost-Sharing \$50 \$100 \$5,000 \$10,000	Non-Participating Provider Member Responsibility for Cost-Sharing \$100 \$200 \$6,850 \$13,700 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)	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 *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 - 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 Covered in full Covered in full Covered in full Covered in full 10% Coinsurance after Deductible Covered in full Covered in full 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 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 after 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 Use Cost-Sharing for appropriate service (Primary Care Office Visit Specialist Office Visit Diagnostic Radiology Services Laboratory Procedures and Diagnostic Testing)	See benefit for description

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)	10% Coinsurance after Deductible	10% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services (Ground and Air Ambulance)	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	10% 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
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 10% Coinsurance after Deductible 10% 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	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 - Scalp Cooling Systems 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
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 The visits limit does not apply to Habilitation Services for a Mental Health or Substance Use Disorder.
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

○ Outpatient Donor Breast Milk	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	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
Preauthorization Required			
Therapeutic Radiology Services			See benefit for description
• Performed in a Specialist Office	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Performed in a Freestanding Radiology Facility	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
Preauthorization Required			
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 The visits 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	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
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 BENEFITS, 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 10% Coinsurance after Deductible	See the Prescription Drug Cost-Sharing See the Prescription Drug Cost-Sharing 40% Coinsurance after Deductible	See benefit for description See Prescription Drug benefit

Durable Medical Equipment and Braces Preauthorization Required	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
External Hearing Aids Prescription Hearing Aids	10% Coinsurance after Deductible	40% Coinsurance after Deductible	Single purchase once every 3 years
Cochlear Implants Preauthorization Required	10% Coinsurance after Deductible	40% Coinsurance after Deductible	One per ear per time Covered
Hospice Care - Inpatient - Outpatient	10% Coinsurance after Deductible 10% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible	Unlimited visits Unlimited visits for family bereavement counseling
Medical Supplies	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Prosthetic Devices - External - Internal Preauthorization Required	10% Coinsurance after Deductible 10% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible	One (1) prosthetic device, per limb, per lifetime, with coverage for repairs and replacements Unlimited See benefit for description
Shoe Inserts	10% Coinsurance after Deductible	40% Coinsurance after Deductible	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	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 or 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.	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)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

Preauthorization Required. However, Preauthorization is not required for emergency admissions or for participating Facilities licensed, certified or otherwise authorized by OASAS.			
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) - Office Visits - All Other Outpatient Services - Opioid Treatment Programs	10% Coinsurance after Deductible 10% Coinsurance after Deductible Covered in full	40% Coinsurance after Deductible 40% Coinsurance after Deductible 30% Coinsurance not subject to 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 *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
Retail Pharmacy			
30-day supply Tier 1	\$10 Copayment 0% Coinsurance not subject to Deductible	\$10 Copayment after Deductible then 0% Coinsurance	See benefit for description

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 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.	Cost-Sharing for epinephrine devices shall not exceed \$100 per Plan Year.	Cost-Sharing for epinephrine devices shall not exceed \$100 per Plan Year.	
Up to a 90-day supply for Maintenance Drugs			See benefit for description
Tier 1	\$30 Copayment 0% Coinsurance not subject to Deductible	\$30 Copayment after Deductible then 0% Coinsurance	
Tier 2	\$75 Copayment 0% Coinsurance not subject to Deductible	\$75 Copayment after Deductible then 0% Coinsurance	
Tier 3	\$75 Copayment 0% Coinsurance not subject to Deductible	\$75 Copayment after Deductible then 0% Coinsurance	
	Cost-Sharing for epinephrine devices shall not exceed \$100 per Plan Year.	Cost-Sharing for epinephrine devices shall not exceed \$100 per Plan Year.	

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 Tier 1 Tier 2 Tier 3 If You purchase a Prescription Drug from a Non-Participating Pharmacy, You must pay for the Prescription Drug at the time it is dispensed and then file a claim for reimbursement with Us. We will not reimburse You for the difference between what You pay the Non-Participating Pharmacy and Our price for the Prescription Drug. In most cases, You will pay more if You purchase Prescription Drugs from a Non-Participating Pharmacy.	\$10 Copayment 0% Coinsurance not subject to Deductible \$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
Adult Vision Care for Members age 19 and over - Exams - Lenses and Frames - Contact Lenses	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	One (1); exam per Plan Year One (1) prescribed lenses and frames per Plan Year \$1,000 Annual Limit

Adult Dental Care for Members age 19 and over Preventive Dental Care Routine Dental Care Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics)	0% Coinsurance not subject to Deductible	0% Coinsurance not subject to 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 \$1,000 Annual Limit
	20% Coinsurance not subject to Deductible	20% Coinsurance not subject to Deductible	
	20% Coinsurance not subject to Deductible	20% Coinsurance not subject to Deductible	
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

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 Out 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>.



Your Wellfleet Student health plan gives you access to purchase voluntary Dental and/or Vision plans through our partnership with Ameritas. For more information and to enroll, visit <https://myplan.ameritas.com/id/b5e92262>. Please enter the zip code of your resident address during your college placement. Note: voluntary dental plans are not available in MA, and voluntary vision plans are not available in MD.