Benefits at a Glance

Student Health Insurance Plan (2026/2027)

Designed exclusively for the students of:

ALBANY MEDICAL COLLEGE
Albany, NY
("the policyholder")

Policy Number: WNY2627NYSHIP26

Group Number: ST2412SH
Effective: 7/01/2026 - 6/30/2027

Underwritten by: Wellfleet Insurance Company
Fort Wayne, IN
("the Company")
Administered by: Wellfleet Group, LLC

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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

Haylor, Freyer & Coon Inc.
P.O. Box 4743, 300 South State Street
Syracuse, New York 13221
866-535-0456

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 OAP
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

Albany Medical College requires all fulltime students to have health coverage, through either a family health insurance plan, a private insurer, or the quality plan offered by the College. Students who enroll will be billed an annual premium for the Student Health Insurance Plan unless they submit an online waiver and provide proof of alternate coverage that is equal or better health coverage from another US-based company

Dependents

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

How Do I Waive/Enroll?

To Waive:

- Go to Albany Medical College dedicated page: https://haylor.com/college/albany-medical-college/
- Click Full-Time Student Waive/Enroll
- You must fill in all of the required information on the waiver form. If any information is missing, your waiver will not be accepted.
- 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.

To Purchase coverage and Enroll your dependents:

How do I enroll my spouse or child in the health coverage? You can enroll your dependents through the Waive/Enroll portal at https://www.haylor.com/albany-medical-college. Premium for dependents will be posted to your student bill

The deadline to enroll and purchase coverage for Annual coverage is 08/01/2026

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 Date/ Dependent Enrollment Deadline Date
Annual	07/01/2026	06/30/2027	08/01/2026
Fall	07/01/2026	12/31/2026	08/01/2026
Spring	01/01/2027	06/30/2027	01/22/2027
Summer	05/01/2027	06/30/2027	05/14/2027

Plan Costs for Students and their Dependents

	Annual	Spring/Summer
Student*	$6,240	$3,120
Spouse*	$6,240	$3,120
Each Child*	$6,240	$3,120
3 or more Children*	$18,720	$9,360

***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**	$300	$4,000
Out-of-Pocket Limit **Individual** **Family**	$1,450 $2,900	$25,000 No Maximum

Coinsurance	20% of the Allowed Amount	50% of the Allowed Amount
Preventive Care	Covered in full	30% Coinsurance after Deductible
Primary Care Office Visits (or Home Visits)	$15 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible
Specialist Office Visits	$15 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible
Emergency Department	$100 Copayment not subject to Deductible Copayment waived if admitted to Hospital	$100 Copayment not subject to Deductible Copayment waived if admitted to Hospital
Urgent Care Center	$15 Copayment not subject to Deductible	$15 Copayment not subject to Deductible

Schedule of Benefits

THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:

1. THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;
2. ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND
3. DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY AN IN-NETWORK OR OUT-OF-NETWORK PROVIDER.
4. UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE WILL ALWAYS APPLY.
5. UNLESS SPECIFIED BELOW, ANY APPLICABLE COPAYMENTS ARE APPLIED AFTER DEDUCTIBLE IS MET.
6. UNLESS OTHERWISE SPECIFIED BELOW, ANY DAY OR VISIT LIMITS WILL BE APPLIED TO IN-NETWORK AND OUT-OF-NETWORK COMBINED.

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Medical Deductible • Individual	$300	$4,000	
Out-of-Pocket Limit • Individual • Family	$1,450 $2,900	$25,000 None	

Accidental Death and Dismemberment Benefits $10,000 **Annual Maximum.**		See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how We calculate the Allowed Amount. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount.	
OFFICE VISITS *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)	$15 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	$15 Copayment 0% Coinsurance not subject to Deductible	30% 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*	Covered in full Covered in full	30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description

• Adult Immunizations*	Covered in full	30% Coinsurance after Deductible	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	30% Coinsurance after Deductible	
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	30% Coinsurance after Deductible	
• Sterilization Procedures for Women*	Covered in full	30% Coinsurance after Deductible	
• Vasectomy	Covered in full	30% Coinsurance after Deductible	
• Bone Density Testing*	Covered in full	30% Coinsurance after Deductible	
• Prostate Cancer Screening	Covered in full	30% Coinsurance after Deductible	
• Colon Cancer Screening	Covered in full	30% Coinsurance after Deductible	
• All other preventive services required by USPSTF and HRSA.	Covered in full	30% Coinsurance after 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 *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)	$100 Copayment per trip not subject to Deductible	$100 Copayment per trip not subject to Deductible	See benefit for description
Non-Emergency Ambulance Services (Ground and Air Ambulance)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Emergency Department Copayment waived if admitted to Hospital	$100 Copayment 0% Coinsurance not subject to Deductible Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	$100 Copayment 0% Coinsurance not subject to 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	$15 Copayment 0% Coinsurance not subject to Deductible	$15 Copayment 0% Coinsurance not subject to 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**	 0% Coinsurance not subject to Deductible 0% Coinsurance not subject to Deductible 0% Coinsurance not subject to Deductible	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description

Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office	 $15 Copayment 0% Coinsurance not subject to Deductible $15 Copayment 0% Coinsurance not subject to Deductible	 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)	20% Coinsurance after Deductible	50% 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	 $15 Copayment 0% Coinsurance not subject to Deductible $15 Copayment 0% Coinsurance not subject to Deductible Included as part of inpatient Hospital service Cost-Sharing	 30% Coinsurance after Deductible 30% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing	See benefit 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**	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	See benefit for description

Chiropractic Services **Preauthorization Required**	$15 Copayment 0% Coinsurance not subject to Deductible	30% 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	0% Coinsurance not subject to Deductible 0% Coinsurance not subject to Deductible 0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% 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	$15 Copayment 0% Coinsurance not subject to Deductible $15 Copayment 0% Coinsurance not subject to Deductible $15 Copayment 0% Coinsurance not subject to Deductible $15 Copayment 0% Coinsurance not subject to Deductible $15 Copayment 0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	60 visits per condition, per Plan Year combined therapies. The visit limit does not apply to Habilitation Services for a Mental Health or Substance Use Disorder.

Home Health Care **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	40 visits per Plan Year The visit limit does not apply to Habilitation Services for a Mental Health or Substance Use Disorder.
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**	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	See benefit for description Home infusion counts toward home health care visit limits
Inpatient Medical Visits	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Interruption of Pregnancy • Abortion Services	 Covered in full	 30% Coinsurance after 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	 0% Coinsurance not subject to Deductible 0% Coinsurance not subject to Deductible 0% Coinsurance not subject to Deductible 0% Coinsurance not subject to Deductible	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description

Maternity and Newborn Care • Prenatal Care ○ Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	30% Coinsurance after Deductible	See benefit for description
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	
• Inpatient Hospital Services and Birthing Center	20% Coinsurance after Deductible	50% Coinsurance after Deductible	One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early
• Physician and Midwife Services for Delivery	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	Covered in full	30% Coinsurance after Deductible	Covered for duration of breast feeding
• Postnatal Care ○ Postnatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	30% Coinsurance after Deductible	
○ Postnatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	30% Coinsurance after Deductible	
○ Outpatient Donor Breast Milk	Covered in full	30% Coinsurance after Deductible	

Outpatient Hospital Surgery Facility Charge	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Preadmission Testing	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities			See benefit for description
• Performed in a PCP Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Performed in Specialist Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Performed in Outpatient Facilities	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Diagnostic Radiology Services			See benefit for description
• Performed in a PCP Office	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
• Performed in a Specialist Office	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
• Performed in a Freestanding Radiology Facility	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services **Preauthorization Required**	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
Therapeutic Radiology Services			See benefit for description
• Performed in a Specialist Office	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
• Performed in a Freestanding Radiology Facility	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	

• Performed as Outpatient Hospital Services **Preauthorization Required**	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Unlimited visits
Second Opinions on the Diagnosis of Cancer, Surgery and Other	$15 Copayment not subject to Deductible	30% 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			See benefit for description
• Inpatient Hospital Surgery	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Outpatient Hospital Surgery	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Surgery Performed at an Ambulatory Surgical Center	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Office Surgery **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
Telemedicine Program Behavioral Health	Covered in full		See benefit for description

Conditions Physical Therapy	Covered in full		
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 **Preauthorization Required**	See the Prescription Drug Cost-Sharing Covered in full 20% Coinsurance after Deductible	See the Prescription Drug Cost-Sharing See the Prescription Drug Cost-Sharing 50% Coinsurance after Deductible	See benefit for description See Prescription Drug benefit
Durable Medical Equipment and Braces **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
External Hearing Aids • Prescription Hearing Aids	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Single purchase once every 3 years
Cochlear Implants **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	One per ear per time Covered

Hospice Care • Inpatient • Outpatient	20% Coinsurance after Deductible 20% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible	210 days per Plan Year
Medical Supplies	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Prosthetic Devices • External • Internal **Preauthorization Required**	20% Coinsurance after Deductible 20% Coinsurance after Deductible	50% Coinsurance after Deductible 50% 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	Covered in full	30% 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**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description

neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.			
Observation Stay	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	200 days per Plan Year See benefit for description The days per Plan Year do not apply to Skilled Nursing Facility for a Mental Health or Substance Use Disorder.
Inpatient Habilitation Services (Physical Speech and Occupational Therapy) **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Unlimited days See benefit for description
Inpatient Rehabilitation Services (Physical Speech and Occupational Therapy) **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	60 days per Plan Year See benefit for description The days per Plan Year do not apply to Skilled Nursing Facility 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.**	20% Coinsurance after Deductible	50% 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.**	 $15 Copayment not subject to Deductible 20% Coinsurance after Deductible	 30% Coinsurance after Deductible 50% Coinsurance after Deductible	See benefit for description
ABA Treatment for Autism Spectrum Disorder	$15 Copayment not subject to Deductible	30% Coinsurance after Deductible	See benefit description
Assistive Communication Devices for Autism Spectrum Disorder	$15 Copayment not subject to Deductible	30% 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 Facilities licensed, certified or otherwise authorized by OASAS.**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) • Office Visits	 $15 Copayment not subject to Deductible	 30% Coinsurance after Deductible	Unlimited days Up to 20 visits per Plan Year may be used for family counseling See benefit for description The days per Plan Year do not apply to Skilled Nursing Facility for a Mental Health or Substance Use Disorder.

• All Other Outpatient Services • Opioid Treatment Programs	20% Coinsurance after Deductible Covered in full	50% Coinsurance after Deductible 30% Coinsurance after Deductible	
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 Tier 2 Tier 3 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	 $10 Copayment not subject to Deductible $25 Copayment not subject to Deductible $40 Copayment not subject to Deductible Cost-Sharing for epinephrine devices shall not exceed $100 per Plan Year.	 Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

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 not subject to Deductible $75 Copayment not subject to Deductible $120 Copayment not subject to Deductible Cost-Sharing for epinephrine devices shall not exceed $100 per Plan Year.	 Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Mail Order Pharmacy			
Up to a 90-day supply Tier 1 Tier 2 Tier 3	 $25 Copayment not subject to Deductible $62.50 Copayment not subject to Deductible $100 Copayment not subject to Deductible Cost-Sharing for epinephrine devices shall not exceed $100 per Plan Year.	 Non-Participating Provider services are not covered and You pay the full cost	See benefit for description The mail order pharmacy Cost-Sharing will apply to Prescription Drugs obtained at a retail Participating Pharmacy that agrees to the same reimbursement amount as the mail order pharmacy.
Enteral Formulas Tier 1 Tier 2 Tier 3	 $10 Copayment not subject to Deductible $25 Copayment not subject to Deductible $40 Copayment not subject to Deductible	 Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

	Cost-Sharing for epinephrine devices shall not exceed $100 per Plan Year.		
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	Covered in Full Covered in Full 50% Coinsurance not subject to Deductible 50% Coinsurance not subject to Deductible	Covered in Full Covered in Full 50% Coinsurance not subject to Deductible 50% 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
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	Covered in full Covered in full Covered in full	Covered in full Covered in full Covered in full	One (1) exam per Plan Year One (1) prescribed lenses and frames per Plan Year

Accidental Injury Dental Treatment	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
Sickness Dental Expense Benefit	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
Non-emergency Care While Traveling Outside of the United States	50% coinsurance after Deductible		$10,000 Annual or Lifetime Limits
Emergency Medical Evacuation	0% coinsurance not subject to Deductible		$50,000 Annual or Lifetime Limits
Repatriation of Remains	0% coinsurance not subject to Deductible		$25,000 Annual or Lifetime Limits
Accidental Death and Dismemberment Benefits	N/A	N/A	$10,000 Lifetime Maximum

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. Coverage Outside of the United States, Canada or Mexico.
We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

F. 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.

G. 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.

H. 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).

I. 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.

J. 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.

K. 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.

L. 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.

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

N. 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.

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

P. 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.

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

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

S. 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.

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

U. 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)**. 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 Insurance Company and the services are not part of the Plan Underwritten by Wellfleet 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.

SilverCloud® by Amwell®

SilverCloud® by Amwell® is a 24/7 service that provides self-guided, online behavioral healthcare, helping students develop skills for managing their emotions and habits. It also serves as an easily accessible alternative to on- and off-campus behavioral health resources. SilverCloud® helps with personalized behavioral health support for anxiety, depression, stress, and sleep issues. This service is available at no cost to you. Visit https://wellfleetstudent.com/silvercloud-landing-page-for-students/ for more information on how to get started.

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/b5e9233b 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.