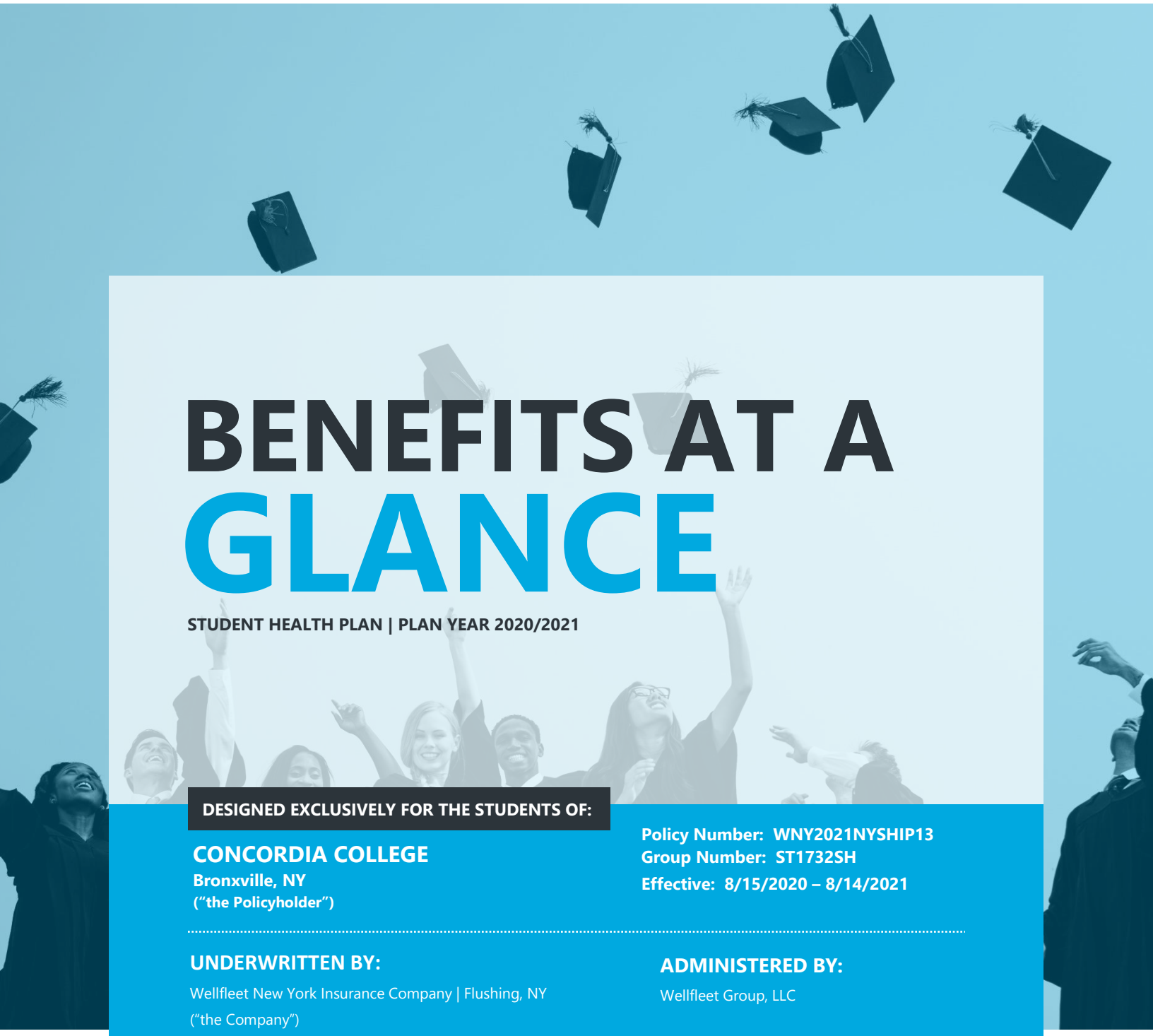
CONCORDIA COLLEGE
New York Since 1881



BENEFITS AT A GLANCE

STUDENT HEALTH PLAN | PLAN YEAR 2020/2021

DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

CONCORDIA COLLEGE

Bronxville, NY
("the Policyholder")

Policy Number: WNY2021NYSHIP13
Group Number: ST1732SH
Effective: 8/15/2020 – 8/14/2021

UNDERWRITTEN BY:

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

ADMINISTERED BY:

Wellfleet Group, LLC

WELLFLEET STUDENT

Table of Contents (Click on section title below to go to section in "Benefits at a Glance.")

Welcome Students…

We are pleased to provide you with this summary of the 2020 – 2021 Student Health Plan ("Plan"), which is fully compliant with the Affordable Care Act. "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**. If you have questions about Enrollment into the Plan, please call Gallagher Student Health & Special Risk at (888) 272-3505. For questions about medical benefits or claims, please call Wellfleet Student at (877) 657-5030, TTY 711.

Where to Find Help

For Questions About:	Please Contact:
Servicing Agent	**Gallagher Student Health & Special Risk** www.gallagherstudent.com/Concordiany (888) 272-1764
Enrollment **Insurance Benefits** **Claims Processing** **ID Cards** **Preferred Provider Listings**	**Wellfleet Group, LLC** **PO Box 15369** **Springfield, Massachusetts 01115-5369** **(877) 657-5030, TTY 711** **www.wellfleetstudent.com**
Preferred PPO Provider Listings	**Wellfleet Student** **www.wellfleetstudent.com** or **www.magnacare.com** **https://www.multiplan.com/webcenter/portal/ProviderSearch?SiteId=84524**
Prescription Drug Provider	**For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit www.wellfleetstudent.com**

Am I Eligible?

All full-time students taking 12 or more credit hours are automatically enrolled and billed for the Student Health Insurance Plan unless proof of comparable cover is received by the published deadline. All part-time students taking 6-11 credit hours are eligible to enroll in the Student Health Insurance Plan on the same basis as full-time students.

How Do I Waive?

To document proof of comparable coverage an Online Waiver Form must be completed and submitted by the deadline.

- Go to http://www.gallagherstudent.com/concordiany
- On the left toolbar, click on 'Student Waive/Enroll'.
- Log in (if you haven't already).
- Select the Blue "I want to Waive/Enroll" button. If waiving the insurance, please have your current health insurance ID card ready as you will need this information in order to complete the waiver form.

Immediately upon submitting the Concordia College Annual Waiver Enrollment Form, you will receive a confirmation number indicating that the form has been successfully submitted. Print this reference number for your records. If you do not receive a reference number, you will need to correct any errors and resubmit the form. The online method is the only accepted process for waiving coverage. Concordia College reserves the right to audit and subsequently reject a waiver request. If it is determined that a student waived coverage with a health insurance plan that was not comparable coverage, the student will be automatically enrolled in the Student Health Insurance Plan, effective the date that the determination was made and there will be no pro-rata of premium.

Deadline to waive coverage for Annual coverage is 9/15/2020.

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	Enrollment/Waiver Deadline
Annual	8/15/2020	8/14/2021	9/15/2020
Spring/Summer (New Students Only)	1/1/2021	8/14/2021	2/4/2021

Insurance Premiums

	Annual	Spring/Summer (New Students Only)
Student	$2,001	$1,162

Broker Fees

	Annual	Spring/Summer (New Students Only)
Student	$161	$93

School Fees		
	Annual	**Spring/Summer (New Students Only)**
Student	$100	$50

Total Plan Costs (Premiums + Fees) for Full-time and Part-time students		
	Annual	**Spring/Summer (New Students Only)**
Student	$2,262	$1,305

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

Preferred Provider Organization (PPO) Network

…providing access to quality health care at discounted costs!

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

Concordia College Schedule of Benefits

This is only a brief description of coverage available under Certificate form NY SHIP CERT (2020). The Certificate will contain full details of coverage, coinsurance, limitations, exclusions, and termination provisions. If there are any conflicts between this document and the Certificate, the Certificate governs in all cases.

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

CONCORDIA COLLEGE SCHEDULE OF BENEFITS
Platinum
Concordia College

Policy Number: WNY2021NYSHIP13
Group/Plan Number: ST1732SH
Policyholder Effective Date: August 15, 2020
Policyholder Termination Date: August 14,2021

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Medical Deductible			
• Individual	$100	$100	
Out-of-Pocket Limit			
• Individual	$6,850	$6,850	

Accidental Death and Dismemberment Benefits $10,000 **Annual Maximum.**		See the Cost-Sharing Expenses and Allowed Amount section of the Certificate for a description of how We calculate the Allowed Amount. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount.	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	30% Coinsurance after Deductible	See benefit for description
• Adult Annual Physical Examinations*	Covered in full	30% Coinsurance after Deductible	
• 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	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
• Bone Density Testing*	Covered in full	30% Coinsurance after Deductible	

• Screening for Prostate Cancer • 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 Use Cost-Sharing for appropriate service (Primary Care Office Visit Specialist Office Visit Diagnostic Radiology Services Laboratory Procedures and Diagnostic Testing)	30% Coinsurance after Deductible Use Cost-Sharing for appropriate service (Primary Care Office Visit Specialist Office Visit Diagnostic Radiology Services Laboratory Procedures and Diagnostic Testing)	
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	10% Coinsurance after Deductible	10% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services	10% Coinsurance after Deductible	10% Coinsurance after Deductible	See benefit for description
Emergency Department Coinsurance waived if Hospital admission	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	See benefit for description
Urgent Care Center	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
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	 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	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Autologous Blood Banking	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefits 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 10% Coinsurance after Deductible	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefits for description
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Preauthorization Required**	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Chiropractic Services **Preauthorization Required**	10% Coinsurance after 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	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after 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	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after 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) **Preauthorization Required**	10% Coinsurance after Deductible	30% Coinsurance after Deductible	60 visits per condition, per Plan Year combined therapies
Home Health Care **Preauthorization Required**	10% Coinsurance after Deductible	30% Coinsurance after Deductible	40 visits per Plan Year
Infertility Services **Preauthorization Required**	Use Cost-Sharing for appropriate service (Office Visit Diagnostic Radiology Services Surgery Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit Diagnostic Radiology Services Surgery Laboratory & Diagnostic Procedures)	See benefit for description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy **Preauthorization Required**	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description Home infusion counts toward home health care visit limits
Inpatient Medical Visits	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description

Interruption of Pregnancy • Medically Necessary Abortions • Elective Abortions	Covered in full 10% Coinsurance after Deductible	30% Coinsurance after Deductible 30% Coinsurance after Deductible	Unlimited One (1) procedure per Plan Year
Laboratory Procedures • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Laboratory Facility • Performed as Outpatient Hospital Services **Preauthorization Required**	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after 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 provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA • Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA • Inpatient Hospital Services and Birthing Center • Physician and Midwife Services for Delivery • Breastfeeding Support, Counseling and Supplies, Including Breast Pumps • Postnatal Care	Covered in full Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing) 10% Coinsurance after Deductible 10% Coinsurance after Deductible Covered in full 10% Coinsurance after Deductible	30% Coinsurance after Deductible Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing) 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding

Outpatient Hospital Surgery Facility Charge	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Preadmission Testing	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities			See benefit for description
• Performed in a PCP Office	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	
• Performed in Specialist Office	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	
• Performed in Outpatient Facilities	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Diagnostic Radiology Services			See benefit for description
• Performed in a PCP Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
• Performed in a Specialist Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
• Performed in a Freestanding Radiology Facility	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Preauthorization Required			
Therapeutic Radiology Services			See benefit for description
• Performed in a Specialist Office	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
• Performed in a Freestanding Radiology Facility	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Preauthorization Required			

Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Preauthorization Required**	10% Coinsurance after Deductible	30% Coinsurance after Deductible	60 visits per condition, per Plan Year combined therapies Speech and physical therapy are only Covered following a Hospital stay or surgery
Second Opinions on the Diagnosis of Cancer, Surgery and Other	10% Coinsurance after 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 • 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	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit description
Assistive Communication Devices for Autism Spectrum Disorder	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description

maintenencec Equipment, Supplies and Self-Management Education Diabetic Equipment, Supplies and Insulin (up to a 90- day supply) Diabetic Education	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description See Prescription Drug benefit
Durable Medical Equipment and Braces **Preauthorization Required**	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
External Hearing Aids	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Single purchase once every 3 years
Cochlear Implants **Preauthorization Required**	10% Coinsurance after Deductible	30% Coinsurance after Deductible	One per ear per time Covered
Hospice Care • Inpatient • Outpatient	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 30% Coinsurance after Deductible 30% Coinsurance after Deductible	210 days per Plan Year Five (5) visits for family bereavement counseling
Medical Supplies	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Prosthetic Devices • External • Internal **Preauthorization Required**	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 30% Coinsurance after Deductible 30% Coinsurance after Deductible	One (1) prosthetic device, per limb, per lifetime Unlimited See benefit for description

INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
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	30% Coinsurance after Deductible	See benefit for description
Observation Stay	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) **Preauthorization Required**	10% Coinsurance after Deductible	30% Coinsurance after Deductible	200 days per Plan Year See benefit for description
Inpatient Habilitation Services (Physical Speech and Occupational Therapy) **Preauthorization Required**	10% Coinsurance after Deductible	30% Coinsurance after Deductible	60 days per Plan Year for all therapies combined See benefit for description
Inpatient Rehabilitation Services (Physical Speech and Occupational Therapy) **Preauthorization Required**	10% Coinsurance after Deductible	30% Coinsurance after Deductible	60 days per Plan Year or all therapies combined

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment) **Preauthorization Required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH-licensed Facilities for Members under 18.**	10% Coinsurance after Deductible	30% 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 **Except for Office Visits, Preauthorization Required**	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 30% Coinsurance after 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 OASAS-certified Facilities.**	10% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description

Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) • Office Visits • All Other Outpatient Services **Except for Office Visits, Preauthorization Required. However, Preauthorization is not required for Participating OASAS-certified Facilities.**	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 30% Coinsurance after Deductible 30% Coinsurance after Deductible	Up to 20 visits per Plan Year may be used for family counseling See benefit for description
PRESCRIPTION DRUGS *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and obtained at a participating pharmacy	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy			
30-day supply Tier 1 Tier 2 Tier 3 If You have an Emergency Condition, Preauthorization is not required for a five (5) day emergency supply of a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.	 $25 Copayment not subject to Deductible $30 Copayment not subject to Deductible $60 Copayment not subject to Deductible	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description

Up to a 90-day supply for Maintenance Drugs Tier 1 Tier 2 Tier 3	 $50 Copayment not subject to Deductible $60 Copayment not subject to Deductible $120 Copayment not subject to Deductible	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Enteral Formulas Tier 1 Tier 2 Tier 3	 $25 Copayment not subject to Deductible $30 Copayment not subject to Deductible $60 Copayment not subject to Deductible	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Up to $200 per six (6) month period	Up to $200 per six (6) month period	See Benefit description
PEDIATRIC DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive Dental Care • Routine Dental Care • Major Dental (Endodontics, Periodontics, Oral Surgery and Prosthodontics) • Orthodontics	 0% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One (1) dental exam and cleaning per six (6)-month period Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals
Pediatric Vision Care • Exams • Lenses and Frames • Contact Lenses	 0% Coinsurance after Deductible 0% Coinsurance after Deductible 10% Coinsurance after Deductible	 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	 One (1) exam per Plan Year One (1) prescribed lenses and frames per Plan Year

Accidental Injury Dental Treatment for Members over age 19	10% Coinsurance after Deductible	30% Coinsurance after Deductible	
Non-emergency Care While Traveling Outside of the United States	0% coinsurance After Deductible	$ 10,000 Annual Limits	
Emergency Medical Evacuation	0% coinsurance not subject to Deductible	$ 50,000 Annual Limits	
Repatriation of Remains	0% coinsurance not subject to Deductible	$ 25,000 Annual Limits	
Accidental Death and Dismemberment Benefits	N/A	N/A	$10,000 Annual Maximum

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

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

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

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

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

Preauthorization

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.

Exclusions and Limitations

No coverage is available under the 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 any 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 the 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 the 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 the 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 the 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 the Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of the 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 the Certificate.

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

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

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

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

O. Services Provided by a Family Member.
We do not Cover services performed by a member of Your immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your 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; Pediatric Vision Care section of the Certificate.

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

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

Value Added Services

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

VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:

www.wellfleetstudent.com

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

Wellfleet Student provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Wellfleet Student at (877) 657-5030, TTY 711. **If you are traveling and need assistance in North America, call the Assistance Center toll-free at: (877) 305-1966 *or* if you are in a foreign country, call collect at: (715) 295-9311**. When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

24 HOUR NURSELINE

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

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

Appropriate care may include self-care at home, a call to a physician, or a visit to the emergency room.

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

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

(800) 634-7629

CareConnect

Integrated Behavioral Health from Wellfleet Student

With CareConnect from Wellfleet Student, students have 24/7 access to professional assistance to help manage personal concerns, emotional issues, transition and adjustment concerns, academic stress, career development, and the demands of daily and family obligations.

Members in need of assistance simply call the behavioral health hotline on their ID card, **(888) 857-5462**, or via the Wellfleet Student mobile app for immediate access to a masters-level mental health professional. Students are run through a clinical assessment to determine if CareConnect counseling, health center referral, or other treatment is necessary. To access mobile features, students simply download their school's app in their device's app store.