Schedules of Basic Plan (pp. 5-24) and Comprehensive Plan (pp. 25-43) Benefits

One Schedule for BASIC Plan and one Schedule for COMPREHENSIVE Plan
Availability of services at SHC locations varies, please verify location when making appointments.

For a more complete description of plan benefits, general terms and conditions, Preauthorization and Referral requirements, etc., please review the 2020-2021 Student Health Insurance Certificate at www.wellfleetstudent.com/nyu.

NEW YORK UNIVERSITY
BASIC PLAN
Metal Level: Gold

COST-SHARING	Student Health Center Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In- Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	
Deductible	None	None	None	None	
Out-of-Pocket Limit: Individual **Family**	$7,350 $14,700	$7,350 $14,700	$7,350 $14,700	$14,700 $29,400 See section IV 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 Out- of-Pocket Limit. You must pay the amount by which the Non-Participating Provider's charge exceeds Our Allowed Amount.	
Benefits Subject to Annual and Lifetime Limits					
Emergency Medical Evacuation					$250,000 Annual Limit
Repatriation of Remains					$250,000 Annual Limit
Accidental Death and Dismemberment					$10,000 Annual and Lifetime Maximum

OFFICE VISITS	**Student Health Center Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	Covered in full	N/A	$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	See Benefit For Description
Specialist Office Visits (or Home Visits)	$20 Copayment per Visit	N/A	$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	See Benefit For Description
PREVENTIVE CARE	**Student Health Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost- Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*					See Benefit For Description
Students	Covered in full	N/A	Covered in full	50% Coinsurance	
Dependents	N/A	N/A	Covered in full	50% Coinsurance	
• Adult Annual Physical Examinations*					
Students	Covered in full	N/A	Covered in full	50% Coinsurance	
Dependents	N/A	N/A	Covered in full	50% Coinsurance	
• Adult Immunizations*					
Students	Covered in full	N/A	Covered in full	50% Coinsurance	
Dependents	N/A	N/A	Covered in full	50% Coinsurance	
• Routine Gynecological Services/Well Woman Exams*					
Students	Covered in full	Covered in full	Covered in full	50% Coinsurance	
Dependents	N/A	Covered in full	Covered in full	50% Coinsurance	

PREVENTIVE CARE	Student Health Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost- Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
• Mammography Screening and Diagnostic Imaging for the Detection of Breast Cancer					
Students	N/A	N/A	Covered in full	50% Coinsurance	
Dependents	N/A	N/A	Covered in full	50% Coinsurance	
• Sterilization Procedures for Women*					
Students	N/A	N/A	Covered in full	50% Coinsurance	
Dependents	N/A	N/A	Covered in full	50% Coinsurance	
• Vasectomy					
Students	N/A	N/A	Covered in full	50% Coinsurance	
Dependents	N/A	N/A	Covered in full	50% Coinsurance	
• Bone Density Testing*					
Students	N/A	N/A	Covered in full	50% Coinsurance	
Dependents	N/A	N/A	Covered in full	50% Coinsurance	
• Screening for Prostate Cancer					
Students	Covered in full	N/A	Covered in full	50% Coinsurance	
Dependents	N/A	N/A	Covered in full	50% Coinsurance	

PREVENTIVE CARE	**Student Health Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost- Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
• All other preventive services required by USPSTF and HRSA. Students Dependents • *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	 Covered in full N/A Use Cost Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	 N/A N/A Use Cost Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing	 Covered in full Covered in full Use Cost Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	 50% Coinsurance 50% Coinsurance Use Cost Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	
EMERGENCY CARE	**Student Health Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	N/A	N/A	Covered in full	Covered in full	See Benefit For Description
Non-Emergency Ambulance Services	N/A	N/A	Covered in full	Covered in full	See Benefit For Description
Emergency Department	N/A	N/A	$250 Copayment per Visit then 20% Coinsurance Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	$250 Copayment per Visit then 20% Coinsurance	See Benefit For Description
Urgent Care Center	N/A	N/A	$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	See Benefit For Description

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Student Health Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Advanced Imaging Services					See Benefit For Description
• Performed in a Specialist Office	N/A	N/A	20% Coinsurance	50% Coinsurance	
• Performed in a Freestanding Radiology Facility	N/A	N/A	20% Coinsurance	50% Coinsurance	
• Performed as Outpatient Hospital Services	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
Preauthorization Required					
Allergy Testing & Treatment					See Benefit For Description
• Performed in a PCP Office	20% Coinsurance	N/A	20% Coinsurance	50% Coinsurance	
• Performed in a Specialist Office	N/A	N/A	20% Coinsurance	50% Coinsurance	
Ambulatory Surgical Center Facility Fee	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	50% Coinsurance	See Benefit For Description
Preauthorization Required					
Anesthesia Services (all settings)	N/A	N/A	20% Coinsurance	50% Coinsurance	See Benefit For Description
Preauthorization Required					
Autologous Blood Banking	N/A	N/A	20% Coinsurance	50% Coinsurance	See Benefits For Description

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Student Health Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Cardiac & Pulmonary Rehabilitation					See Benefits For Description
• Performed in a Specialist Office	N/A	N/A	$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
• Performed as Outpatient Hospital Services	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
• Performed as Inpatient Hospital Services	N/A	N/A	Included As Part of Inpatient Hospital Service Cost- Sharing	Included As Part of Inpatient Hospital Service Cost-Sharing	
Chemotherapy					See Benefit For Description
• Performed in a PCP Office	N/A	N/A	20% Coinsurance	50% Coinsurance	
• Performed in a Specialist Office	N/A	N/A	20% Coinsurance	50% Coinsurance	
• Performed as Outpatient Hospital Services **Preauthorization Required**	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
Chiropractic Services **Preauthorization Required**	N/A	N/A	$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	See Benefit For Description
Clinical Trials	Use Cost- Sharing for appropriate service	N/A	Use Cost- Sharing for appropriate service	Use Cost- Sharing for appropriate service	See Benefit For Description

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Student Health Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Diagnostic Testing					See Benefit For Description
• Performed in a PCP Office	20% Coinsurance	N/A	20% Coinsurance	50% Coinsurance	
• Performed in a Specialist Office	20% Coinsurance	N/A	20% Coinsurance	50% Coinsurance	
• Performed as Outpatient Hospital Services	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
Dialysis					See Benefit For Description
• Performed in a PCP Office	N/A	N/A	20% Coinsurance	50% Coinsurance	
• Performed in a Specialist Office	N/A	N/A	20% Coinsurance	50% Coinsurance	
• Performed in a Freestanding Center	N/A	N/A	20% Coinsurance	50% Coinsurance	
• Performed as Outpatient Hospital Services	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
• Performed at Home	N/A	N/A	20% Coinsurance	50% Coinsurance	
Habilitation Services (Physical Therapy, Occupational Therapy)	$20 Copayment per Visit	N/A	$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	60 visits per condition per Plan Year (combined therapies)
(Speech or Hearing Therapy)	N/A	N/A	$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
Home Health Care **Preauthorization Required**	N/A	N/A	20% Coinsurance	20% Coinsurance	40 Visits per Plan Year

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Student Health Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Infertility Services	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	N/A	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					See Benefit For Description
• Performed in a PCP Office	$20 Copayment per Visit then 20% Coinsurance	N/A	$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
• Performed in Specialist Office	$20 Copayment per Visit then 20% Coinsurance	N/A	$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
• Performed as Outpatient Hospital Services	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	50% Coinsurance	Home infusion counts toward home health care visit limits
• Home Infusion Therapy	N/A	N/A	20% Coinsurance	50% Coinsurance	
Inpatient Medical Visits	N/A	N/A	20% Coinsurance	50% Coinsurance	See Benefit For Description
Interruption of Pregnancy					Unlimited
• Medically Necessary Abortions	N/A	N/A	Covered in full	50% Coinsurance	
• Elective Abortions	N/A	N/A	20% Coinsurance	50% Coinsurance	One (1) procedure per Plan Year

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Student Health Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Laboratory Procedures					See Benefit For Description
• Performed in a PCP Office	20% Coinsurance	N/A	20% Coinsurance	50% Coinsurance	
• Performed in a Specialist Office	N/A	N/A	20% Coinsurance	50% Coinsurance	
• Performed in a Freestanding Laboratory Facility	N/A	N/A	20% Coinsurance	50% Coinsurance	
• Performed as Outpatient Hospital Services	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
Maternity & Newborn Care					See Benefit For Description
• Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	N/A	Covered in full	Covered in full	50% Coinsurance	
• 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)	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	N/A	Covered in full	20% Coinsurance	50% Coinsurance	One (1) home care visit is Covered at no Cost- Sharing if mother is discharged from Hospital early

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Student Health Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Maternity & Newborn Care (continued)					Maternity & Newborn Care (continued)
• Physician and Midwife Services for Delivery	N/A	Covered in full	20% Coinsurance	50% Coinsurance	
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	N/A	N/A	Covered in full	50% Coinsurance	Covered for duration of breast feeding
• Postnatal Care **Preauthorization Required for Inpatient Services; Breast Pump**	N/A	Covered in full	20% Coinsurance	50% Coinsurance	
Outpatient Hospital Surgery Facility Charge **Preauthorization Required**	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	50% Coinsurance	See Benefit For Description
Preadmission Testing	N/A	N/A	20% Coinsurance	50% Coinsurance	See Benefit For Description
Prescription Drugs Administrated in Office or Outpatient Facilities					See Benefit For Description
• Performed in a PCP Office	20% Coinsurance	N/A	20% Coinsurance	50% Coinsurance	
• Performed in Specialist Office	20% Coinsurance	N/A	20% Coinsurance	50% Coinsurance	
• Performed in Outpatient Facilities	N/A	N/A	20% Coinsurance	50% Coinsurance	

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Student Health Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Diagnostic Radiology Services					See Benefit For Description
• Performed in a PCP Office	20% Coinsurance	N/A	20% Coinsurance	50% Coinsurance	
• Performed in a Specialist Office	N/A	N/A	20% Coinsurance	50% Coinsurance	
• Performed in a Freestanding Radiology Facility	N/A	N/A	20% Coinsurance	50% Coinsurance	
• Performed as Outpatient Hospital Services	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
Preauthorization Required					
Therapeutic Radiology Services					See Benefit For Description
• Performed in a Specialist Office	N/A	N/A	20% Coinsurance	50% Coinsurance	
• Performed in a Freestanding Radiology Facility	N/A	N/A	20% Coinsurance	50% Coinsurance	
• Performed as Outpatient Hospital Services	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
Preauthorization Required					
Rehabilitation Services:					60 visits per condition per Plan Year (combined therapies)
(Physical Therapy, Occupational Therapy)	$20 Copayment per Visit	N/A	$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
(Speech or Hearing Therapy)	N/A	N/A	$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	

PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Student Health Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$20 Copayment per Visit 20% Coinsurance	N/A	$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance 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	N/A	N/A	20% Coinsurance	50% Coinsurance	
• Outpatient Hospital Surgery	N/A	N/A	20% Coinsurance	50% Coinsurance	
• Surgery Performed at an Ambulatory Surgical Center	N/A	N/A	20% Coinsurance	50% Coinsurance	
• Office Surgery	20% Coinsurance	N/A	20% Coinsurance	50% Coinsurance	
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Student Health Center Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	$20 Copayment per Visit then 20% Coinsurance	N/A	$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	See Benefit For Description
Assistive Communication Devices for Autism Spectrum Disorder	$20 Copayment per Visit then 20% Coinsurance	N/A	$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	See Benefit For Description

ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Student Health Center Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Diabetic Equipment, Supplies and Self-Management Education					See Benefit For Description
• Diabetic Equipment, Supplies and Insulin (30-Day Supply)	$20 Copayment per prescription	N/A	$20 Copayment per prescription	30% Coinsurance	See Prescription Drug Benefit
• Diabetic Education	20% Coinsurance	N/A	20% Coinsurance	50% Coinsurance	
Durable Medical Equipment & Braces	20% Coinsurance	N/A	20% Coinsurance	20% Coinsurance	See Benefit For Description
External Hearing Aids	N/A	N/A	20% Coinsurance	20% Coinsurance	Single Purchase Once Every three (3) Years
Cochlear Implants **Preauthorization Required**	N/A	N/A	20% Coinsurance	50% Coinsurance	One (1) Per Ear Per Time Covered
Hospice Care					210 days per Plan Year
• Inpatient **Preauthorization Required**	N/A	N/A	Covered in full	Covered in full	
• Outpatient	N/A	N/A	Covered in full	Covered in full	Five (5) Visits for Family Bereavement Counseling
Medical Supplies	20% Coinsurance	N/A	20% Coinsurance	50% Coinsurance	See Benefit For Description
Prosthetic Devices					
• External	20% Coinsurance	N/A	20% Coinsurance	20% Coinsurance	One (1) prosthetic device, per limb, per lifetime
• Internal	N/A	N/A	20% Coinsurance	20% Coinsurance	Unlimited; See Benefit For Description

INPATIENT SERVICES and FACILITIES	**Student Health Center Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac & 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.**	N/A	N/A	20% Coinsurance	50% Coinsurance	See Benefit For Description
Observation Stay	N/A	N/A	20% Coinsurance	50% Coinsurance	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) **Preauthorization Required**	N/A	N/A	20% Coinsurance	50% Coinsurance	200 days per Plan Year
Inpatient Habilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	N/A	N/A	20% Coinsurance	50% Coinsurance	
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	N/A	N/A	20% Coinsurance	50% Coinsurance	

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Student Health Center Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network 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.**	N/A	Covered in full	20% Coinsurance	50% Coinsurance	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) **Except for Office Visits, Preauthorization Required.**	Use Cost-Sharing for appropriate service (For neuropsych testing only, Covered in full.)	$5 Copayment per Visit (Copayment waived for neuropsych testing only.)	20% Coinsurance (For neuropsych testing only, Covered in full.)	50% Coinsurance (For neuropsych testing only, Covered in full.)	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**	N/A	N/A	20% Coinsurance	50% Coinsurance	See Benefit For Description

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Student Health Center Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) **Except for Office Visits, Preauthorization Required. However, Preauthorization is not required for Participating OASAS-certified Facilities.**	N/A	N/A	Covered in full	Covered in full	Up to 20 visits a Plan Year may be Used For Family Counseling
PRESCRIPTION DRUGS	**Student Health Center Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
You may request a copy of the Wellfleet Rx/KPP Formulary. The Formulary is also available on the Wellfleet Rx website at www.WellfleetRx.com. You may inquire if a specific drug is Covered under the Certificate by contacting Wellfleet Student at the number on Your ID card, (877) 373-1170.					
*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					
Retail Pharmacy					
Supply Limits. Except for contraceptive drugs, devices, or products, We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for one (1) Cost-Sharing amount for up to a 30-day supply. You may have the entire supply (of up to 12 months) of the contraceptive drug, device, or product dispensed at the same time. Contraceptive drugs, devices, or products are not subject to Cost-Sharing when provided by a Participating Pharmacy. Please refer to Certificate of coverage for details.					
30 Day Supply (except contraceptive drugs or devices)*					See Benefit For Description
Tier 1 (Including Enteral Formulas)	$15 Copayment per prescription	N/A	$15 Copayment per prescription	30% Coinsurance	
Tier 2 (Including Enteral Formulas)	$40 Copayment per prescription	N/A	$40 Copayment per prescription	30% Coinsurance	
Tier 3 (Including Enteral Formulas)	$60 Copayment per prescription	N/A	$60 Copayment per prescription	30% Coinsurance	

PRESCRIPTION DRUGS	**Student Health Center Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
*Contraceptive Drugs or Devices: Up to a 90 Day Supply					
Tier 1	Covered in full	N/A	Covered in full	30% Coinsurance	
Tier 2	Covered in full	N/A	Covered in full	30% Coinsurance	
Tier 3	Covered in full	N/A	Covered in full	30% Coinsurance	
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.					
WELLNESS BENEFITS	**Student Health Center Responsibility for Cost- Sharing**	**Preferred Provider Responsibility for Cost- Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	
Gym Reimbursement	N/A	N/A	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	Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for Covered Dependents

DENTAL and ROUTINE VISION CARE	**Student Health Center Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	
Pediatric Dental Care (Members through the end of the month in which the Member turns 19 years of age)					One (1) dental exam and cleaning per six (6)- month period
• Preventive Dental Care	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	40% Coinsurance	Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at six (6) - month intervals
• Routine Dental Care	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	40% Coinsurance	
• Major Dental (Endodontics, Periodontics. Oral Surgery and Prosthodontics)	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	40% Coinsurance	
• Orthodontia **Orthodontics and Major Dental Require Preauthorization; Referral**	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	40% Coinsurance	

Pediatric Vision Care (Members through the end of the month in which the Member turns 19 years of age):					
Exams	Covered in full	N/A	$30 Copayment per Visit then 20% Coinsurance	40% Coinsurance	One (1) exam per Plan Year
Lenses and Frames	$30 Copayment then 20% Coinsurance	N/A	$50 Copayment then 20% Coinsurance	40% Coinsurance	One (1) prescribed lenses and frames per Plan Year
Contact Lenses **Contact Lenses Require Preauthorization**	$30 Copayment then 20% Coinsurance	N/A	$50 Copayment then 20% Coinsurance	40% Coinsurance	
Adult Vision Care (Members over age 18)					One (1) exam per Plan Yea
Exams	$20 Copayment per Visit	N/A	Not Covered	Not Covered	
Benefits Subject to Limits					
Emergency Medical Evacuation	N/A				$250,000 Annual Limit
Repatriation of Remains	N/A				$250,000 Annual Limit
Accidental Death and Dismemberment	N/A				$10,000 Annual and Lifetime Maximum

For a more complete description of plan benefits, general terms and conditions, Preauthorization and Referral requirements, etc., please review the 2020-2021 Student Health Insurance Certificate at www.wellfleetstudent.com/nyu.

NEW YORK UNIVERSITY
COMPREHENSIVE PLAN
Metal Level: Platinum

COST-SHARING	**Student Health Center Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In- Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	
Deductible	None	None	None	None	
Out-of-Pocket Limit: Individual Family	$5,000 $10,000	$5,000 $10,000	$5,000 $10,000	$10,000 $20,000 See section IV of this Policy 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 Out- of-Pocket Limit. The Member must pay the amount by which the Non-Participating Provider's charge exceeds Our Allowed Amount.	
Benefits Subject to Annual and Lifetime Limits					
Emergency Medical Evacuation					$1,000,000 Annual Limit
Repatriation of Remains					$1,000,000 Annual Limit
Accidental Death and Dismemberment					$10,000 Annual and Lifetime Maximum

OFFICE VISITS	**Student Health Center Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	Covered in full	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	See Benefit For Description
Specialist Office Visits (or Home Visits)	$20 Copayment per Visit	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	See Benefit For Description
PREVENTIVE CARE	**Student Health Responsibility for Cost-Sharing**	**Preferred Provider Responsibility For Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*					See Benefit For Description
Students	Covered in full	N/A	Covered in full	40% Coinsurance	
Dependents	N/A	N/A	Covered in full	40% Coinsurance	
• Adult Annual Physical Examinations*					
Students	Covered in full	N/A	Covered in full	40% Coinsurance	
Dependents	N/A	N/A	Covered in full	40% Coinsurance	
• Adult Immunizations*					
Students	Covered in full	N/A	Covered in full	40% Coinsurance	
Dependents	N/A	N/A	Covered in full	40% Coinsurance	
• Routine Gynecological Services/Well Woman Exams*					
Students	Covered in full	Covered in full	Covered in full	40% Coinsurance	
Dependents	N/A	Covered in full	Covered in full	40% Coinsurance	

PREVENTIVE CARE	Student Health Responsibility for Cost-Sharing	Preferred Provider Responsibility For Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
• Mammography Screening and Diagnostic Imaging for the Detection of Breast Cancer					
Students	N/A	N/A	Covered in full	40% Coinsurance	
Dependents	N/A	N/A	Covered in full	40% Coinsurance	
• Sterilization Procedures for Women*					
Students	N/A	N/A	Covered in full	40% Coinsurance	
Dependents	N/A	N/A	Covered in full	40% Coinsurance	
• Vasectomy					
Students	N/A	N/A	Covered in full	40% Coinsurance	
Dependents	N/A	N/A	Covered in full	40% Coinsurance	
• Bone Density Testing*					
Students	N/A	N/A	Covered in full	40% Coinsurance	
Dependents	N/A	N/A	Covered in full	40% Coinsurance	
• Screening for Prostate Cancer					
Students	Covered in full	N/A	Covered in full	40% Coinsurance	
Dependents	N/A	N/A	Covered in full	40% Coinsurance	

PREVENTIVE CARE	Student Health Responsibility for Cost-Sharing	Preferred Provider Responsibility For Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
• All other preventive services required by USPSTF and HRSA.					
Students	Covered in full	N/A	Covered in full	40% Coinsurance	
Dependents	N/A	N/A	Covered in full	40% Coinsurance	
• *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 & Diagnostic Testing)	Use Cost Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Use Cost Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Use Cost Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	
EMERGENCY CARE	**Student Health Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	N/A	N/A	Covered in full	Covered in full	See Benefit For Description
Non-Emergency Ambulance Services	N/A	N/A	Covered in full	Covered in full	See Benefit For Description
Emergency Department	N/A	N/A	$100 Copayment per Visit then 10% Coinsurance Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	$100 Copayment per Visit then 10% Coinsurance	See Benefit For Description
Urgent Care Center	N/A	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	See Benefit For Description

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Student Health Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Advanced Imaging Services					See Benefit For Description
• Performed in a Specialist Office	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed in a Freestanding Radiology Facility	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed as Outpatient Hospital Services **Preauthorization Required**	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
Allergy Testing & Treatment					See Benefit For Description
• Performed in a PCP Office	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	
• Performed in a Specialist Office	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	
Ambulatory Surgical Center Facility Fee **Preauthorization Required**	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	See Benefit For Description
Anesthesia Services (all settings) **Preauthorization Required**	N/A	N/A	10% Coinsurance	40% Coinsurance	See Benefit For Description
Autologous Blood Banking	N/A	N/A	10% Coinsurance	40% Coinsurance	See Benefit For Description

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Student Health Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Cardiac & Pulmonary Rehabilitation					See Benefit For Description
• Performed in a Specialist Office	N/A	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
• Performed as Outpatient Hospital Services	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
• Performed as Inpatient Hospital Services	N/A	N/A	Included As Part of Inpatient Hospital Service Cost-Sharing	Included As Part of Inpatient Hospital Service Cost-Sharing	
Chemotherapy					See Benefit For Description
• Performed in a PCP Office	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed in a Specialist Office	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed as Outpatient Hospital Services **Preauthorization Required**	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
Chiropractic Services **Preauthorization Required**	N/A	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	See Benefit For Description
Clinical Trials	Use Cost-Sharing for appropriate service	N/A	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See Benefit For Description

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Student Health Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Diagnostic Testing					See Benefit For Description
• Performed in a PCP Office	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	
• Performed in a Specialist Office	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	
• Performed as Outpatient Hospital Services	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
Dialysis					See Benefit For Description
• Performed in a PCP Office	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed in a Specialist Office	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed in a Freestanding Center	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed as Outpatient Hospital Services	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
• Performed at Home	N/A	N/A	10% Coinsurance	40% Coinsurance	
Habilitation Services (Physical Therapy, Occupational Therapy)	$20 Copayment per Visit	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	60 visits per condition per Plan Year (combined therapies)
(Speech or Hearing Therapy)	N/A	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	

PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Student Health Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
Home Health Care **Preauthorization Required**	N/A	N/A	10% Coinsurance	10% Coinsurance	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	N/A	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					See Benefit For
• Performed in a PCP Office	$20 Copayment per Visit then 10% Coinsurance	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	Description
• Performed in Specialist Office	$20 Copayment per Visit then 10% Coinsurance	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
• Performed as Outpatient Hospital Services	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	Home infusion counts toward home health care visit limits
• Home Infusion Therapy	N/A	N/A	10% Coinsurance	40% Coinsurance	
Inpatient Medical Visits	N/A	N/A	10% Coinsurance	40% Coinsurance	See Benefit For Description
Interruption of Pregnancy					
• Medically Necessary Abortions	N/A	N/A	Covered in full	40% Coinsurance	Unlimited
• Elective Abortions	N/A	N/A	10% Coinsurance	40% Coinsurance	One (1) procedure per Plan Year

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Student Health Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Laboratory Procedures					See Benefit For Description
• Performed in a PCP Office	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	
• Performed in a Specialist Office	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed in a Freestanding Laboratory Facility	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed as Outpatient Hospital Services	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
Maternity & Newborn Care					See Benefit For Description
• Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	N/A	Covered in full	Covered in full	40% Coinsurance	One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
• 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)	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	N/A	Covered in full	10% Coinsurance	40% Coinsurance	

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Student Health Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Maternity & Newborn Care (continued)					Maternity & Newborn Care (continued)
• Physician and Midwife Services for Delivery	N/A	Covered in full	10% Coinsurance	40% Coinsurance	
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	N/A	N/A	Covered in full	40% Coinsurance	Covered for duration of breast feeding
• Postnatal Care **Preauthorization Required for Inpatient Services; Breast Pump**	N/A	Covered in full	10% Coinsurance	40% Coinsurance	
Outpatient Hospital Surgery Facility Charge **Preauthorization Required**	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	See Benefit For Description
Preadmission Testing	N/A	N/A	10% Coinsurance	40% Coinsurance	See Benefit For Description
Prescription Drugs Administrated in Office or Outpatient Facilities					See Benefit For Description
• Performed in a PCP Office	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	
• Performed in Specialist Office	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	
• Performed in Outpatient Facilities	N/A	N/A	10% Coinsurance	40% Coinsurance	

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Student Health Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Diagnostic Radiology Services					See Benefit For Description
• Performed in a PCP Office	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	
• Performed in a Specialist Office	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed in a Freestanding Radiology Facility	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed as Outpatient Hospital Services **Preauthorization Required**	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
Therapeutic Radiology Services					See Benefit For Description
• Performed in a Specialist Office	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed in a Freestanding Radiology Facility	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed as Outpatient Hospital Services **Preauthorization Required**	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
Rehabilitation Services: (Physical Therapy, Occupational Therapy)	$20 Copayment per Visit	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	60 visits per condition per Plan Year (combined therapies)
(Speech or Hearing Therapy)	N/A	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	

PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Student Health Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$20 Copayment per Visit then 10% Coinsurance	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance 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	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Outpatient Hospital Surgery	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Surgery Performed at an Ambulatory Surgical Center	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Office Surgery	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Student Health Center Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	$20 Copayment per Visit then 10% Coinsurance	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	See Benefit For Description
Assistive Communication Devices for Autism Spectrum Disorder	$20 Copayment per Visit then 10% Coinsurance	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	See Benefit For Description

ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Student Health Center Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Diabetic Equipment, Supplies and Self-Management Education					See Benefit For Description
• Diabetic Equipment, Supplies and Insulin (30-Day Supply)	$20 Copayment per prescription	N/A	$20 Copayment per prescription	30% Coinsurance	See Prescription Drug Benefit
• Diabetic Education	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	
Durable Medical Equipment & Braces	10% Coinsurance	N/A	10% Coinsurance	10% Coinsurance	See Benefit For Description
External Hearing Aids	N/A	N/A	10% Coinsurance	10% Coinsurance	Single Purchase Once Every three (3) Years
Cochlear Implants **Preauthorization Required**	N/A	N/A	10% Coinsurance	40% Coinsurance	One (1) Per Ear Per Time Covered
Hospice Care					
• Inpatient **Preauthorization Required**	N/A	N/A	Covered in full	Covered in full	210 days per Plan Year
Outpatient	N/A	N/A	Covered in full	Covered in full	Five (5) Visits for Family Bereave-ment Counseling
Medical Supplies	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	See Benefit For Description

ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Student Health Center Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
Prosthetic Devices • External	10% Coinsurance	N/A	10% Coinsurance	10% Coinsurance	One (1) prosthetic device, per limb, per lifetime
• Internal	N/A	N/A	10% Coinsurance	10% Coinsurance	Unlimited; See Benefit For Description
INPATIENT SERVICES and FACILITIES	**Student Health Center Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & 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.**	N/A	N/A	10% Coinsurance	40% Coinsurance	See Benefit For Description
Observation Stay	N/A	N/A	10% Coinsurance	40% Coinsurance	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) **Preauthorization Required**	N/A	N/A	10% Coinsurance	40% Coinsurance	200 days per Plan Year

INPATIENT SERVICES and FACILITIES	**Student Health Center Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
Inpatient Habilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	N/A	N/A	10% Coinsurance	40% Coinsurance	
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	N/A	N/A	10% Coinsurance	40% Coinsurance	
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Student Health Center Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network 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.**	N/A	Covered in full	10% Coinsurance	40% Coinsurance	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) **Except for Office Visits, Preauthorization Required.**	Use Cost-Sharing for appropriate service (For neuropsych testing only, Covered in full.)	$5 Copayment per Visit (Copayment waived for neuropsych testing only.)	10% Coinsurance (For neuropsych testing only, Covered in full.)	40% Coinsurance (For neuropsych testing only, Covered in full)	See Benefit For Description

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Student Health Center Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
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**	N/A	N/A	10% Coinsurance	40% Coinsurance	See Benefit For Description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) **Except for Office Visits, Preauthorization Required. However, Preauthorization is not required for Participating OASAS-certified Facilities.**	N/A	N/A	Covered in full	Covered in full	Up to 20 visits a Plan Year may be Used For Family Counseling
PRESCRIPTION DRUGS	**Student Health Center Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
You may request a copy of the Wellfleet Rx/KPP Formulary. The Formulary is also available on the Wellfleet Rx website at www.WellfleetRx.com. You may inquire if a specific drug is Covered under the Certificate by contacting Wellfleet Student at the number on Your ID card, (877) 373-1170.					
*****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					
Retail Pharmacy					
Supply Limits. Except for contraceptive drugs, devices, or products, We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for one (1) Cost-Sharing amount for up to a 30-day supply. You may have the entire supply (of up to 12 months) of the contraceptive drug, device, or product dispensed at the same time. Contraceptive drugs, devices, or products are not subject to Cost-Sharing when provided by a Participating Pharmacy. Please refer to Certificate of coverage for details.					

PRESCRIPTION DRUGS	Student Health Center Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
30 Day Supply (except contraceptive drugs or devices)*					See Benefit For Description
Tier 1 (Including Enteral Formulas)	$15 Copayment per prescription	N/A	$15 Copayment per prescription	30% Coinsurance	
Tier 2 (Including Enteral Formulas)	$40 Copayment per prescription	N/A	$40 Copayment per prescription	30% Coinsurance	
Tier 3 (Including Enteral Formulas)	$60 Copayment per prescription	N/A	$60 Copayment per prescription	30% Coinsurance	
*Contraceptive Drugs or Devices: Up to a 90 Day Supply					
Tier 1	Covered in full	N/A	Covered in full	30% Coinsurance	
Tier 2	Covered in full	N/A	Covered in full	30% Coinsurance	
Tier 3	Covered in full	N/A	Covered in full	30% Coinsurance	
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.					

WELLNESS BENEFITS	**Student Health Center Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
Gym Reimbursement	N/A	N/A	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	Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for Covered Dependents
DENTAL and ROUTINE VISION CARE	**Student Health Center Responsibility for Cost-Sharing**	**Preferred Provider Responsibility for Cost-Sharing**	**In-Network Responsibility for Cost-Sharing**	**Out-of-Network Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care (Members through the end of the month in which the Member turns 19 years of age)					One (1) dental exam and cleaning per six (6)-month period
• Preventive Dental Care	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	40% Coinsurance	Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at six (6) month intervals
• Routine Dental Care	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	40% Coinsurance	
• Major Dental (Endodontics, Periodontics. Oral Surgery and Prosthodontics)	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	40% Coinsurance	
• Orthodontia **Orthodontics and Major Dental Require Preauthorization; Referral**	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	40% Coinsurance	

DENTAL and ROUTINE VISION CARE	Student Health Center Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Pediatric Vision Care (Members through the end of the month in which the Member turns 19 years of age):					
Exams	Covered in full	N/A	$30 Copayment per Visit then 20% Coinsurance	40% Coinsurance	One (1) exam per Plan Year
Lenses and Frames	$30 Copayment then 20% Coinsurance	N/A	$50 Copayment then 20% Coinsurance	40% Coinsurance	One (1) prescribed lenses and frames per Plan Year
Contact Lenses **Contact Lenses Require Preauthorization**	$30 Copayment then 20% Coinsurance	N/A	$50 Copayment then 20% Coinsurance	40% Coinsurance	
Adult Vision Care (Members over age 18)					One (1) exam per Plan Yea
Exams	$20 Copayment per Visit	N/A	Not Covered	Not Covered	
Benefits Subject to Limits					
Emergency Medical Evacuation	N/A				$1,000,000 Annual Limit
Repatriation of Remains	N/A				$1,000,000 Annual Limit
Accidental Death and Dismemberment	N/A				$10,000 Annual and Lifetime Maximum

Accidental Death and Dismemberment

(Applicable to both the Basic and Comprehensive Plans)

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 90 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.