Farmingdale State College
2019-2020 Student Health Plan
Group No: ST0840SH
Policy No: AIIC1920NYSHIP42

Dear Students:
We are pleased to provide you with this summary of the Student Health Plan for Farmingdale State College. This plan is fully compliant with the Affordable Care Act.

Who Is Eligible To Enroll?
All registered students residing in campus housing and registered commuter students taking at least 1 credit are eligible to enroll in this insurance plan. Dependents of the student are also eligible to enroll.
Students must attend classes for at least 30 consecutive days to remain eligible for coverage.

How Do I Enroll?
Registered students residing in campus housing are automatically enrolled in this insurance plan and the premium is added to the student's tuition and fees, unless the student waives coverage.
Full-time and part-time commuter students may enroll by completing a form request to the College. The premium will be added to student's tuition and fees.
Students may enroll eligible dependents on a voluntary basis by completing an enrollment form on the CHP website.

How Do I Waive Coverage?
Resident students may waive coverage by completing a waiver form and returning it to Health and Wellness by the waiver deadline date.

Waiver/Enrollment Period Deadline Dates	
Annual	September 13, 2019
Spring	February 15, 2020

Plan Costs and Periods of Coverage	Annual 8/16/19 to 8/15/20	Spring 1/18/20 to 8/15/20
Insurance Premiums		
Student	$2,736	$1,577
Spouse	$2,736	$1,577
Each Child	$2,736	$1,577
3 or More Children	$7,725	$4,731
Broker Fees		
Student*	$104	$60
Spouse*	$104	$60
Each Child*	$104	$60
3 or More Children*	$312	$180
Travel Assistance		
Student*	$12	$7
Spouse*	$12	$7
Each Child*	$12	$7
3 or More Children*	$36	$21
School Administration Fees		
Student*	$45	$26
Spouse*	$45	$26
Each Child*	$45	$26
3 or More Children*	$135	$78
Total Plan Costs (Premium + Fees)		
Student*	$2,897	$1,670
Spouse*	$2,897	$1,670
Each Child*	$2,897	$1,670
3 or More Children*	$8,691	$5,010

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

HEALTH INSURANCE BENEFIT SUMMARY* UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE WILL ALWAYS APPLY		
BENEFIT	**Participating Provider Member Responsibility**	**Non-Participating Member Responsibility**
Medical Deductible	$150 Individual	$600 Individual
Out-of- Pocket Maximum	$5,000 Individual $12,700 Family	$20,000 Individual $20,000 Family
Coinsurance, unless otherwise noted in Certificate	20% coinsurance after deductible	40% coinsurance after deductible
Preventive Care	Covered in Full	30% coinsurance after deductible
Inpatient Hospital for Continuous Confinement	$500 copay 20% coinsurance after deductible	$500 copay 40% coinsurance after deductible
Surgery Services	20% coinsurance after deductible	40% coinsurance after deductible
Primary Care Office or Specialist Visits	$25 copay 20% coinsurance after deductible	$25 copay 40% coinsurance after deductible
Emergency Department Copayment waived if Hospital admission	$150 copay 20% coinsurance after deductible	$150 copay 20% coinsurance after deductible
Urgent Care Center	$100 copay 20% coinsurance after deductible	$100 copay 20% coinsurance after deductible
Diagnostic Testing** or Infusion Therapy** or Chemotherapy**	$25 copay 20% coinsurance after deductible	$25 copay 40% coinsurance after deductible
Advanced Imaging Services in Freestanding Radiology Facility	$100 copay 20% coinsurance after deductible	$100 copay 40% coinsurance after deductible
Laboratory Procedures***	$25 copay 20% coinsurance after deductible	$25 copay 40% coinsurance after deductible
Dialysis**** or Diagnostic or Therapeutic Radiology Services*****	$25 copay 20% coinsurance after deductible	$25 copay 40% coinsurance after deductible
Cardiac and Pulmonary Rehabilitation******	$25 copay 20% coinsurance after deductible	$25 copay 40% coinsurance after deductible
Mental Health or Substance Use Disorder Services	20% coinsurance after deductible	40% coinsurance after deductible
Prescription Drugs Retail Pharmacy (copay per 30 day supply)	Tier 1: $25 copay Tier 2: $50 copay Tier 3: $75 copay 20% coinsurance after deductible	Tier 1: $25 copay Tier 2: $50 copay Tier 3: $75 copay 20% coinsurance after deductible

*This is only a brief description of the coverage(s) available under Certificate form NY SHIP CERT (2019). The Certificate will contain the reductions, limitations, exclusions and termination provisions. Full details of coverage are contained in the Certificate. If there are any conflicts between this document and the Certificate, the Certificate shall govern in all cases.

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.

Underwritten By:
Wellfleet New York Insurance Company

Plan Administrator:
Wellfleet Group, LLC
2077 Roosevelt Ave.
Springfield, MA 01104
wellfleetstudent.com
(877) 657-5030

Servicing Agent:
Student Healthcare Solutions
5001 Genesee Street
Buffalo, NY 14225
(800) 444-5530

**copay applies when performed in PCP or specialist office
***copay applies when performed in PCP or specialist office or freestanding laboratory facility
****copay applies when performed in PCP or specialist office or a freestanding center
*****Diagnostic Radiology copay applies when performed in PCP or specialist office or freestanding radiology facility. *****Therapeutic Radiology copay applies to specialist office or freestanding radiology facility.
******copay applies when performed in specialist office

Where Can I Obtain More Information About The Plan?	
Enroll Dependents - complete an online enrollment form	Wellfleet Group, LLC www.wellfleetstudent.com
Resident Students - Waive Coverage	Complete waiver form and return to Health and Wellness
Insurance Benefits Claim Processing ID Cards	Wellfleet Group, LLC www.wellfleetstudent.com
Find Network Provider	Wellfleet Student or Cigna www.cigna.com

The following Value-Added Services are not part of the Policy and are not underwritten by Wellfleet New York Insurance Company. The services are provided by Independent vendors and are included if the student participates in the student health plan.

- Vision discount program through Davis Vision
- Medical travel assistance through Assist America
- 24-hour nurse line through AHH

Exclusions and Limitations

No coverage is available under this Certificate for the following:

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

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

C. Conversion Therapy.
We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for 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 this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

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

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

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

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

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

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

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

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

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

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

O. Services Provided by a Family Member.
We do not Cover services performed by 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 this Certificate.

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

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