Adelphi University
2020-2021 Student Health Plan
Group No: ST1375SH

Policy No: WNY2021NYSHIP14

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

Who Is Eligible To Enroll?

All domestic students living in Adelphi University residence halls and all international students will be automatically enrolled in and charged premium for the insurance, unless proof of comparable health insurance is provided by the appropriate deadline.
All registered non-resident hall domestic students are eligible to enroll for coverage in the Plan on a voluntary basis by completing the online enrollment process by the appropriate deadline.
Domestic students living in residence halls and international students: The premium for coverage added to the student's tuition bill will remain unless a successful waiver is completed by the applicable waiver deadline.

Waiver/Enrollment Deadlines	
Annual Enrollment/Waiver Deadline	**10/1/2020**
Spring Enrollment/Waiver Deadline	**3/1/2021**

Cost and Periods of Coverage*			
	Annual 8/10/2020-8/9/2021	**Fall 8/10/2020-12/31/2020**	**Spring 1/1/2021-8/9/2021**
Student	$2,991	$1,184	$1,807
*The above rates include an administrative fee.			

Where Can I Obtain More Information About The Plan?	
Waive or Enroll	Gallagher Student Health 1. Go to www.gallagherstudent.com/adelphi 2. Log In 3. Click on the "Enroll" or the "Waive" button. 4. Complete the form and submit
Insurance Benefits Claim Processing	Gallagher Student Health www.gallagherstudent.com/adelphi
Find Network Provider	Cigna PPO www.cigna.com
Find Prescription Drug Provider	Wellfleet Rx/KPP www.wellfleetstudent.com

HEALTH INSURANCE BENEFIT SUMMARY*		
BENEFIT	**NETWORK**	**NON-NETWORK**
Benefit Maximum	Unlimited	
Annual Deductible	$150 Individual	$300 Individual
Out-of-Pocket Maximum	$7,350 Individual	$7,350 Individual
Coinsurance	20% of PA	40% of U&R
Preventive Care	Covered in full	30% Coinsurance not subject to Deductible
Hospital Room & Board (Inpatient)**	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Primary Care/Specialist Office Visits (or Home Visits)	$35 Copayment 0% Coinsurance after Deductible	$30 Copayment 30% Coinsurance after Deductible
Emergency Services Expense	$250 Copayment 20% Coinsurance after Deductible	$250 Copayment 20% Coinsurance after Deductible
Urgent Care Center	$75 Copayment 20% Coinsurance after Deductible	$75 Copayment 40% Coinsurance after Deductible
Diagnostic X-ray & Laboratory	$35 Copayment 0% Coinsurance after Deductible	$30 Copayment 30% Coinsurance after Deductible
Outpatient Prescription Drugs 30-day supply Tier 1 Tier 2 Tier 3	 $20 Copayment 20% Coinsurance not subject to Deductible $40 Copayment 40% Coinsurance not subject to Deductible $60 Copayment 40% Coinsurance not subject to Deductible	 $20 Copayment 20% Coinsurance after Deductible $40 Copayment 40% Coinsurance after Deductible $60 Copayment 40% 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 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.		
**All inpatient confinements require pre-certification. The phone number can be found on the back of the Insured's ID card. The call should be made prior to Hospital Confinement. In the case of an emergency, the call should take place as soon as reasonably possible		

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:
Gallagher Student Health
500 Victory Road
Quincy, MA 02171

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

- Medical travel assistance through Travel Guard
- 24/7 Behavioral Health Hotline/Care Connect

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 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 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 You or 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 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.