

You can now review the DRAFT School of Visual Arts Student Health Plan brochure. Please note that information included in this DRAFT brochure is subject to change subsequent to regulatory approval of the policy by the New York Department of Financial Services.

School of Visual Arts

(“the Policyholder”)

2016 – 2017

Student Health Plan

(“the Plan”)

Administrator Group Number: S210315
Underwriter Reference Number: CAS9151400

Insurance underwritten by: National Union Fire Insurance Company of Pittsburgh, Pa., with its principal place of business in New York, NY (“Us,” “We,” “Our”)

This is only a brief description of the coverage available under policy series S30749NUFIC-PPO-NY (Rev. 4-15). The Policy contains definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy. If there is any conflict between contents of this brochure and the Policy, the Policy shall govern in all cases. The Policy is on file for review at School of Visual Arts (“SVA”). A Certificate of Coverage will be available to You in Your online account at <https://consolidatedhealthplan.com/group/372/home>. In addition, the Policy and Certificate of Coverage are available upon request. Travel Assistance services provided by Travel Guard Group, Inc. (“Travel Guard”). Insurance and services provided by member companies of American International Group, Inc. For additional information, please visit our website at www.AIG.com.

(Revised 8/24/16)



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HOW YOUR COVERAGE WORKS

School of Visual Arts (“SVA”) (referred to as the “Policyholder”) has endorsed a Policy from Us. We will provide the benefits described in this brochure to covered Members of SVA, that is, to an eligible Student and his or her Covered Dependents. You should keep this brochure with Your other important papers so that it is available for Your future reference.

COVERED SERVICES

You will receive Covered Services under the terms and conditions of the Plan only when the Covered Service is

- Medically Necessary;
- Provided by a Participating Provider for in-network coverage;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits; and
- Received while Your coverage is in force.

CIGNA PPO NETWORK PARTICIPATING PROVIDERS

To find out if a Provider is a Cigna PPO Network Participating Provider:

- Check Your Provider directory, available at Your request;
- Call 1-800-633-7867 (Consolidated Health Plans); or
- Visit www.chpstudent.com or www.cigna.com

CIGNA PHARMACY BENEFIT MANAGER PARTICIPATING PHARMACIES

To find out if a pharmacy is a Cigna participating pharmacy:

- Call 1-800-633-7867; or
- Visit Cigna’s website at www.cigna.com or www.chpstudent.com

THE ROLE OF PRIMARY CARE PHYSICIANS:

The Plan does not have a gatekeeper, usually known as a Primary Care Physician (“PCP”). You do not need a Referral from Student Health Center before receiving care.

For purposes of Cost-Sharing, if You seek services from a PCP (or a Physician covering for a PCP) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost-Sharing shown in the Schedule of Benefits when the services provided are related to specialty care.

Sometimes Providers in Our Provider directory are not available. You should call the Provider to make sure he or she is accepting new patients. To see a Provider, call his or her office and tell the Provider that You are a SVA Student Health Plan Member, and explain the reason for Your visit. Have Your ID card available. The Provider’s office may ask You for Your Member ID number. When You go to the Provider’s office, bring Your ID card with You.

OUT-OF-NETWORK SERVICES:

We Cover the services of Non-Participating Providers. However, some services are only Covered when You go to a Participating Provider. See the Schedule of Benefits for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.

SERVICES SUBJECT TO PREAUTHORIZATION:

Our Preauthorization is required before You receive certain Covered Services. You are responsible for requesting Preauthorization for the in-network and out-of-network services listed in the Schedule of Benefits.

If You seek coverage for services that require Preauthorization or notification, You must call Us at 1-800-633-7867.

You must contact Us to request Preauthorization as follows:

- At least one (1) weeks prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.

You must contact Us to provide notification as follows:

- As soon as reasonably possible when air ambulance services are rendered for an Emergency Condition.
- If You are hospitalized in cases of an Emergency Condition, You must call Us within 48 hours after Your admission or as soon thereafter as reasonably possible.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

MEDICAL NECESSITY:

We Cover benefits described in this brochure as long as the health care service, procedure, treatment, test, device, prescription drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:

- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example We will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis.

ELIGIBILITY

SVA is making available a Student Health Plan underwritten by National Union Fire Insurance Company of Pittsburgh, Pa. and administered by Consolidated Health Plans to all full-time and part-time students at SVA.

If You are a full-time or part-time student, SVA requires You to have health insurance that is comparable to the SVA Student Health Plan. To make sure You have sufficient coverage, You will be automatically enrolled in the Plan and billed by Student Accounts for the Health Insurance Plan Cost unless You waive coverage under the Plan, by the Waiver Deadline (below) by providing proof that You have other health insurance coverage that meets this requirement. If You are a full-time or part-time student, other than a full-time or part-time December Graduate student, enrolling in the Fall, You will be enrolled for the Annual Coverage Term. If You are a full-time or part-time December Graduate student enrolling in the Fall, You will be enrolled for the Fall Coverage Term only.

If You have other health insurance coverage that is comparable to the SVA Student Health Plan and, therefore, You do not wish to be enrolled in the Plan, You must complete the online waiver form and provide proof of comparable health insurance coverage at www.sva.edu/uhp by the applicable waiver deadline date shown below. If You do not complete a waiver form by the applicable waiver deadline date, You will be enrolled in the Plan and will be responsible for the Health Insurance Plan Cost.

| Coverage Term | Student Waiver Deadline Dates |
|---------------|-------------------------------|
| Annual / Fall | 10/6/16 |
| Spring | 02/9/17 |

If You have other comparable health insurance coverage but miss the Annual / Fall waiver deadline date, You may complete and submit an appeal form along with proof of Your comparable health insurance coverage by contacting University Health Plans at 1-800-437-6448 or info@univhealthplans.com. The deadline to submit a waiver appeal for Fall is 12/10/16 and for Spring is 4/6/17. If approved, the appeal form is for the Fall Coverage Term only. If You wish to waive coverage for the Spring Coverage Term, You must complete an online waiver form and provide proof of comparable health insurance coverage by the Spring waiver deadline date shown above. Waiver submissions may be audited by SVA, University Health Plans, and/or their contractors or representatives. You may be required to provide, upon request, any coverage documents and/or other records demonstrating that You meet the Policyholder's requirements for waiving coverage under the Plan. By submitting the waiver form, You agree that Your current health insurance plan may be contacted for confirmation that Your coverage is in force for the applicable Plan Year and that it meets the Policyholder's waiver requirements.

DEPENDENT ENROLLMENT

A student enrolled in the Plan may also enroll his or her eligible Dependents. Eligible Dependents are Your Spouse and Children. Eligible Dependents must be enrolled for the same coverage term for which You enroll. To enroll Your eligible Dependents in coverage under the Plan, You must contact University Health Plans at 1-800-437-6448 or info@univhealthplans.com to obtain an enrollment form and submission instructions by the applicable enrollment deadline date shown below:

| Coverage Term | Dependent Enrollment Deadline Dates |
|---------------|-------------------------------------|
| Annual / Fall | 10/6/16 |
| Spring | 02/9/17 |

The Policy becomes effective at 12:01 a.m. on August 25, 2016 and ends at 11:59 p.m. on August 24, 2017.

WHO IS COVERED

You, the enrolled Student, are covered under the Plan. Members of Your family may also be covered depending on the type of coverage You selected.

We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.
2. **Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your spouse are covered.
3. **Parent and Child/Children.** If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.
4. **Family.** If You selected family coverage, then You and Your Spouse and Your Child or Children, as described below, are covered.

If You selected parent and child/children or family coverage, Children covered under the Plan include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a permanent legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Foster Children and grandchildren are not covered.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Student and all other prospective or covered Members in relation to eligibility for coverage under the Plan at any time.

Coverage under the Plan will begin as follows:

1. If You, the Student, elect coverage before becoming eligible, or within 31 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by SVA. SVA cannot impose waiting periods that exceed 90 days.
2. If You, the Student, marry while covered, and We receive notice of such marriage within 31 days thereafter, coverage for Your Spouse starts on the first day of the month following such marriage.
3. If You, the Student, have a newborn or adopted newborn Child and We receive notice of such birth within 31 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise, coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 31 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within 31 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice and the premium payment, provided that You pay any additional Premium when due.

You, and Your Spouse or Child can also enroll for coverage within 31 days of the loss of coverage in a health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other health plan due to:

1. Termination of employment;
2. Termination of the other health plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward a health plan were terminated; or
7. A Child no longer qualifies for coverage as a Child under another health plan.

You, Your Spouse or Child can also enroll 31 days from exhaustion of Your COBRA or continuation coverage.

We must receive notice and Premium payment within 31 days of the loss of coverage. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

In addition, You, and Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. You or Your Spouse or Child loses eligibility for Medicaid or a state child health plan.
2. You or Your Spouse or Child become eligible for Medicaid or a state child health plan.

We must receive notice and Premium payment within 60 days of one of these events. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

The Plan covers domestic partners of Students as Spouses. If You selected family coverage, Children covered under the Plan also include the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists; or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
 - a. The affidavit must be notarized and must contain the following:
 - The partners are both 18 years of age or older and are mentally competent to consent to contract;
 - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
 - The partners have been living together on a continuous basis prior to the date of the application;
 - Neither individual has been registered as a member of another domestic partnership within the last six (6) months; and
 - b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
 - c. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
 - A joint bank account;
 - A joint credit card or charge card;
 - Joint obligation on a loan;
 - Status as an authorized signatory on the partner's bank account, credit card or charge card;
 - Joint ownership of holdings or investments;
 - Joint ownership of residence;
 - Joint ownership of real estate other than residence;
 - Listing of both partners as tenants on the lease of the shared residence;
 - Shared rental payments of residence (need not be shared 50/50);
 - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
 - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
 - Shared household budget for purposes of receiving government benefits;
 - Status of one (1) as representative payee for the other's government benefits;
 - Joint ownership of major items of personal property (e.g., appliances, furniture);
 - Joint ownership of a motor vehicle;
 - Joint responsibility for child care (e.g., school documents, guardianship);
 - Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
 - Execution of wills naming each other as executor and/or beneficiary;
 - Designation as beneficiary under the other's life insurance policy;
 - Designation as beneficiary under the other's retirement benefits account;
 - Mutual grant of durable power of attorney;
 - Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
 - Affidavit by creditor or other individual able to testify to partners' financial interdependence;
 - Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

TERMINATION OF COVERAGE

Coverage under the Plan will automatically be terminated on the first of the following to apply:

1. The Student has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.
2. The date on which the Student ceases to meet the eligibility requirements as defined by the Policyholder. We will provide written notice to the Student at least 30 days prior to when the coverage will cease.
3. Upon the Student's death, coverage will terminate unless the Student has coverage for Dependents. If the Student has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.
4. For Spouses in cases of divorce, the date of the divorce.
5. For Children, until the end of the month in which the Child turns 26 years of age.
6. For all other Dependents, the end of the month in which the Dependent ceases to be eligible.
7. The end of the month during which the Student provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.
8. If a Student or the Student's Dependent has performed an act that constitutes fraud or the Student has made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Student and/or the Student's Dependent, as applicable.
9. The date that the Policyholder's Policy is terminated. If We terminate and/or decide to stop offering a particular class of group policies, without regard to claims experience or health related status, to which the Certificate belongs, We will provide the Policyholder and Students at least 90 days prior written notice.
10. If We elect to terminate or cease offering student accident and health insurance coverage in this state, We will provide written notice to the Policyholder and Student at least 180 days prior to when the coverage will cease.
11. The Policyholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.
12. For such other reasons that are acceptable to the superintendent and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

EXTENSION OF BENEFITS

When Your coverage under the Plan ends, benefits stop. If You are totally disabled on the date Your coverage under the Plan terminates, continued benefits may be available for the treatment of the injury or sickness that is the cause of the total disability. If You are pregnant on the date Your coverage under the Plan terminates, continued benefits may be available for Your maternity care.

For purposes of this section, "total disability" means You are prevented because of injury or disease from engaging in any work or other gainful activity. Total disability for a minor means that the minor is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

When You May Continue Benefit.

1. If You are totally disabled on the date Your coverage under the Plan terminates, We will continue to pay for Your care under the Plan during an uninterrupted period of total disability until the first of the following:
 - The date You are no longer totally disabled; or
 - 90 days from the date extended benefits began (if Your benefits are extended based on termination of Student status).
2. If You are pregnant on the date Your coverage under the Plan terminates, We will continue to pay for Your maternity care under the Plan through delivery and any post-partum services directly related to the delivery.

Limits on Extended Benefits.

We will not pay extended benefits:

- For any Member who is not totally disabled or pregnant on the date coverage under the Plan ends; or
- Beyond the extent to which We would have paid benefits under the Plan if coverage had not ended.

CONTINUATION OF COVERAGE

Qualifying Events.

You, the Student, Your Spouse and Your Children may be able to temporarily continue coverage under the Plan in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to the termination of Your Student status You may continue coverage. Coverage may be continued for You, and Your Spouse and any of Your covered Children.
2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
 - Termination of the Student's status as a Student;
 - Divorce or legal separation from the Student; or
 - Death of the Student.
3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
 - Termination of the Student's status as a Student;
 - Loss of covered Child status under the plan rules; or
 - Death of the Student.

If You want to continue coverage, You must request continuation from Us in writing and make the first Premium payment within the 60-day period following the later of:

1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by Policyholder.

Continued coverage under this section will terminate at the earliest of the following:

1. The date 90 days after the Student's coverage would have terminated because of termination of Student status;
2. If You are a covered Spouse or Child, the date 90 days after coverage would have terminated due to the death of the Student, divorce or legal separation, the Student's eligibility for Medicare, or the failure to qualify under the definition of "Children";
3. The date You become covered by an insured or uninsured arrangement that provides hospital, surgical or medical coverage;
4. The date You become entitled to Medicare;
5. The date to which Premiums are paid if You fail to make a timely payment; or
6. The date the Policy terminates. However, if the Policy is replaced with similar coverage, You have the right to become covered under the new Policy for the balance of the period remaining for Your continued coverage.

2016-2017 STUDENT HEALTH PLAN COST*

| Coverage Term | Annual** 8/25/16 – 8/24/17 | Fall 8/25/16 – 2/23/17 | Spring 1/6/17 – 8/24/17 |
|--------------------------------------------------|-------------------------------|---------------------------|--------------------------------------------------------------------|
| | | | (for new students to the School in the Spring semester only) |
| Students (other than December Graduate Students) | \$1,940 | N/A | \$1,228 |
| December Graduate Students | N/A | \$970 | N/A |
| Spouse | \$1,940 | \$970 | \$1,228 |
| Each Child*** | \$1,940 | \$970 | \$1,228 |

*The Student Health Plan Cost includes administrative fees.

**For students, other than December Graduate students, the cost for the Annual Coverage Term will be billed in two installments. The first installment will be billed by Student Accounts for the Fall Semester and the second installment will be billed by Student Accounts for the Spring Semester. Should You withdraw from SVA, coverage under the Plan will terminate as of the last day for which premiums were paid. Insurance for Your covered Dependents will end when Your insurance ends.

***Premium is charged per child, up to 3 times the premium fee, after which no further premium is charged for additional children.

SCHOOL OF VISUAL ARTS STUDENT HEALTH INSURANCE PLAN SCHEDULE OF BENEFITS

This Plan would satisfy the platinum Level – Actuarial Value 90.33%.

AGGREGATE MAXIMUM BENEFIT PER PLAN YEAR: UNLIMITED

| COST-SHARING | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | |
|------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|------------------------------------------------|
| Deductible Individual | \$100 (You have a combined In-Network and Out-of-Network Deductible. Cost-Sharing for Out-of-Network services applies toward Your in-Network Deductible.) | | |
| Out-of-Pocket Limit Individual Family | \$6,350 \$12,700 | Unlimited Unlimited | |
| 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 Copayment 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | See coverage description in the Certificate |
| Medications Administered in Office | 0% Coinsurance not subject to Deductible | 30% Coinsurance not subject to Deductible | |
| Specialist Office Visits (or Home Visits) | \$10 Copayment 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | See coverage description in the Certificate |
| Medications Administered in Office | 0% Coinsurance not subject to Deductible | 30% Coinsurance not subject to Deductible | |
| 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 | Not Covered | See coverage description in the Certificate |
| Adult Annual Physical Examinations* | Covered in full | Not Covered | See coverage description in the Certificate |
| Adult Immunizations* | Covered in full | Not Covered | See coverage description in the Certificate |
| Routine Gynecological Services/ Well Woman Exams* | Covered in full | Not Covered | See coverage description in the Certificate |
| Mammography Screenings* | Covered in full | Not Covered | See coverage description in the Certificate |
| Sterilization Procedures for Women* | Covered in full | Not Covered | See coverage description in the Certificate |
| Vasectomy | Covered in full | Not Covered | See coverage description in the Certificate |
| Bone Density Testing* | Covered in full | Not Covered | See coverage description in the Certificate |

| | | | |
|--------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|
| Screening for Prostate Cancer | Covered in full | Not Covered | See coverage description in the Certificate |
| All other preventive services required by USPSTF and HRSA. | Covered in full | Not Covered | See coverage description in the Certificate |
| *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA. | Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | |

| | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------|---------------------------------------------|
| EMERGENCY CARE | | | |
| Pre-Hospital Emergency Medical Services (Ambulance Services) | 0% Coinsurance after Deductible | 0% Coinsurance after Deductible | See coverage description in the Certificate |
| Non-Emergency Ambulance Services | 0% Coinsurance after Deductible | 0% Coinsurance after Deductible | See coverage description in the Certificate |
| Emergency Department | 10% Coinsurance after Deductible | 10% Coinsurance after Deductible | See coverage description in the Certificate |
| Urgent Care Center | 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | See coverage description in the Certificate |
| PROFESSIONAL SERVICES and OUTPATIENT CARE | | | |
| Acupuncture | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate |
| Advanced Imaging Services | | | See coverage description in the Certificate |
| Performed in a Freestanding Radiology Facility or Office Setting | \$10 Copayment 10% Coinsurance after Deductible | \$10 Copayment 30% Coinsurance after Deductible | |
| Performed as Outpatient Hospital Services | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | |
| Allergy Testing and Treatment | | | See coverage description in the Certificate |
| Performed in a PCP Office | \$10 Copayment 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | |
| Performed in a Specialist Office | \$10 Copayment 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | |
| Ambulatory Surgical Center Facility Fee | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate |

| | | | |
|----------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------|
| Anesthesia Services (all settings) | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate |
| Autologous Blood Banking | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate |
| Cardiac and Pulmonary Rehabilitation | | | See coverage description in the Certificate |
| Performed in a Specialist Office | \$10 Copayment 0% Coinsurance after Deductible | \$10 Copayment 30% Coinsurance after Deductible | |
| Performed as Outpatient Hospital Services | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | |
| Performed as Inpatient Hospital Services | Included as part of inpatient Hospital service Cost- Sharing | Included as part of inpatient Hospital service Cost- Sharing | |
| Chemotherapy | | | See coverage description in the Certificate |
| Performed in a PCP Office | \$10 Copayment 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | |
| Performed in a Specialist Office | \$10 Copayment 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | |
| Performed as Outpatient Hospital Services | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | |
| Chiropractic Services | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate |
| Clinical Trials | Use Cost-Sharing for appropriate service | Use Cost-Sharing for appropriate service | See coverage description in the Certificate |
| Diagnostic Testing | | | See coverage description in the Certificate |
| Performed in a PCP Office | \$10 Copayment 0% Coinsurance after Deductible | \$10 Copayment 30% Coinsurance after Deductible | |
| Performed in a Specialist Office | \$10 Copayment 0% Coinsurance after Deductible | \$10 Copayment 30% Coinsurance after Deductible | |
| Performed as Outpatient Hospital Services | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | |

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| Dialysis | | | See coverage description in the Certificate |
| Performed in a PCP Office | \$10 Copayment 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | |
| Performed in a Freestanding Center or Specialist Office Setting | \$10 Copayment 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | |
| Performed as Outpatient Hospital Services | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | |
| Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate Up to 60 visits per condition, Plan Year (combined therapies) |
| Home Health Care | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate Up to 70 visits per Plan Year |
| Infertility Services | 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 coverage description in the Certificate |
| Infusion Therapy | | | See coverage description in the Certificate |
| Performed in a PCP Office | \$10 Copayment 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | |
| Performed in Specialist Office | \$10 Copayment 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | |
| Performed as Outpatient Hospital Services | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | |
| Home Infusion Therapy | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | |
| Inpatient Medical Visits | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate |
| Laboratory Procedures | | | See coverage description in the Certificate |
| Performed in a PCP Office | \$10 Copayment 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | |
| Performed in a Freestanding Laboratory Facility or Specialist Office | \$10 Copayment 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | |
| Performed as Outpatient Hospital Services | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | |

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| Maternity and Newborn Care | | | |
| Prenatal Care | Covered in full | \$10 Copayment 30% Coinsurance not subject to Deductible | See coverage description in the Certificate |
| Inpatient Hospital Services and Birthing Center | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | One (1) home care visit is covered at no Cost- Sharing if mother is discharged from Hospital early |
| Physician and Midwife Services for Delivery | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | |
| Breast Pump | Covered in full | 40% Coinsurance after Deductible | Covered for duration of breast feeding |
| Postnatal Care | \$10 Copayment 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | |
| Outpatient Hospital Surgery Facility Charge | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate |
| Preadmission Testing | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate |
| Diagnostic Radiology Services | | | |
| Performed in a PCP Office | \$10 Copayment 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | See coverage description in the Certificate |
| Performed in a Freestanding Radiology Facility or Specialist Office | \$10 Copayment 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | |
| Performed as Outpatient Hospital Services | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | |
| Therapeutic Radiology Services | | | |
| Performed in a Freestanding Radiology Facility or Specialist Office | \$10 Copayment 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | See coverage description in the Certificate |
| Performed as Outpatient Hospital Services | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | |
| Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) | \$10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate Up to 60 visits per condition, per Plan Year (combined therapies) Speech and physical therapy are only Covered following a Hospital stay or surgery |

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| Second Opinions on the Diagnosis of Cancer, Surgery and Other | 0% Coinsurance after Deductible | 40% 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 coverage description in the Certificate |
| Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy) | | | See coverage description in the Certificate If Covered multiple surgical procedures are performed through the same incision, We will pay for the procedure with the highest Allowed Amount and 50% of the amount We would otherwise pay under the Plan for the secondary procedures, except for secondary procedures that, according to nationally-recognized coding rules, are exempt from multiple surgical procedure reductions. We will not pay anything for a secondary procedure that is billed with a primary procedure when that secondary procedure is incidental to the primary procedure. |
| Inpatient Hospital Surgery | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | If Covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay: <ul style="list-style-type: none"> • For the procedure with the highest Allowed Amount; and • 50% of the amount We would otherwise pay for the other procedures. |
| Outpatient Hospital Surgery | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | |
| Surgery Performed at an Ambulatory Surgical Center | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | |
| Office Surgery | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | |
| 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 | 40% Coinsurance after Deductible | See coverage description in the Certificate |
| Assistive Communication Devices for Autism Spectrum Disorder | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate |

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| Diabetic Equipment, Supplies and Self-Management Education | | | See coverage description in the Certificate |
| Diabetic Equipment, Supplies and Insulin (30-day supply) | See the Prescription Drug Cost-Sharing | See the Prescription Drug Cost-Sharing | |
| Diabetic Education | \$10 Copayment 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | |
| Durable Medical Equipment and Braces | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate |
| External Hearing Aids | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | Single purchase once every 3 years |
| Cochlear Implants | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | One per ear per time Covered |
| Hospice Care | | | 210 days per Plan Year |
| Inpatient | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | Five (5) visits for family bereavement counseling |
| Outpatient | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | |
| Medical Supplies | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate |
| Prosthetic Devices | | | See coverage description in the Certificate |
| External | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | |
| Internal | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | |
| 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. | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate |
| Observation Stay | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate |
| Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate Up to 200 days per Plan Year |
| Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate Up to 60 consecutive days per condition |

| 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) Preauthorization Required. However, Preauthorization is Not Required for emergency admissions. | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate |
| Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) | \$10 Copayment 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | See coverage description in the Certificate |
| Inpatient Substance Use Services (for a continuous confinement when in a Hospital) Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions. | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate |
| Outpatient Substance Use Services | \$10 Copayment 0% Coinsurance not subject to Deductible | \$10 Copayment 30% Coinsurance not subject to Deductible | Unlimited; Up to 20 visits per Plan Year may be used for family counseling |
| PRESCRIPTION DRUGS | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | |
| Retail Pharmacy | | | |
| 30-day supply Tier 1 | \$10 Copayment 0% Coinsurance not subject to Deductible | 30% Coinsurance not subject to Deductible | See coverage description in the Certificate |
| Tier 2 | \$20 Copayment 0% Coinsurance not subject to Deductible | 30% Coinsurance not subject to Deductible | FDA-approved contraceptive methods prescribed by a Participating Provider are not subject to Copayments, Deductibles or Coinsurance. |
| Tier 3 | \$30 Copayment 0% Coinsurance not subject to Deductible | 30% Coinsurance not subject to Deductible | |

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| Mail Order Pharmacy | | | |
| Up to a 90-day supply | | | See coverage description in the Certificate |
| Tier 1 | \$25 Copayment 0% Coinsurance not subject to Deductible | 30% Coinsurance not subject to Deductible | |
| Tier 2 | \$50 Copayment 0% Coinsurance not subject to Deductible | 30% Coinsurance not subject to Deductible | |
| Tier 3 | \$75 Copayment 0% Coinsurance not subject to Deductible | 30% Coinsurance not subject to Deductible | |
| Enteral Formulas | 10% Coinsurance after Deductible | 40% Coinsurance after Deductible | See coverage description in the Certificate |
| PEDIATRIC DENTAL and VISION CARE (for Members through the end of the month in which the Member turns 19 years of age) | | | |
| | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
| Pediatric Dental Care | | | |
| Preventive Dental Care | \$35 Copayment 0% Coinsurance not subject to Deductible | \$35 Copayment 0% Coinsurance not subject to 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) to 12-month intervals |
| Routine Dental Care | \$100 Copayment 0% Coinsurance not subject to Deductible | \$100 Copayment 0% Coinsurance not subject to Deductible | |
| Major Dental (Endodontics, Periodontics and Prosthodontics) | \$350 Copayment 0% Coinsurance not subject to Deductible | \$350 Copayment 0% Coinsurance not subject to Deductible | |
| Orthodontics | 50% Coinsurance not subject to Deductible | 50% Coinsurance not subject to Deductible | |
| Orthodontics and Major Dental Require Preauthorization | | | |
| Pediatric Vision Care | | | |
| Exams | 10% Coinsurance after Deductible | 10% Coinsurance after Deductible | One (1) exam per Plan Year |
| Lenses and Frames | 10% Coinsurance after Deductible | 10% Coinsurance after Deductible | One (1) prescribed lenses and frames per Plan Year |
| Contact Lenses | 10% Coinsurance after Deductible | 10% Coinsurance after Deductible | |

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| Emergency Medical Evacuation | N/A | N/A | Unlimited |
| Repatriation of Remains | N/A | N/A | Unlimited |
| Accidental Death and Dismemberment Benefits | N/A | N/A | \$10,000 |

EXERCISE FACILITY REIMBURSEMENT

We will partially reimburse the Student and each covered Dependent for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities which maintain equipment and programs that promote cardiovascular wellness. An eligible exercise facility must have at least two (2) pieces of equipment or activities that promote cardiovascular wellness from the following list:

- Fitness center, lap pool, water and/or land aerobics classes, spinning classes, dance, gymnastics and racquetball court.

Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual workout visits. We will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages, etc.).

In order to be eligible for reimbursement, You must:

- Be an active member of the exercise facility, and
- Complete 50 visits in a six (6)-month period.

In order to obtain reimbursement, at the end of the six (6)-month period, You must submit:

- Documentation of the visits from the facility. Each time You visit the exercise facility, a facility representative must sign and documentation of the visits.
- A copy of Your current facility bill which shows the fee paid for Your membership.
- A copy of the brochure that outlines the services the exercise facility offers.

Once We receive documentation of the visits and the bill, You will be reimbursed the lesser of \$200 for the Student and \$100 for each covered Dependent or the actual cost of the membership per six (6)-month period. Reimbursement must be requested within 120 days of the end of the six (6)-month period. Reimbursement will be issued only after You have completed each six-month period even if 50 visits are completed sooner.

ACCIDENTAL DEATH AND DISMEMBERMENT

We will pay the benefit below for injuries to a Member:

- a) caused by an Accident which happens while covered by the Plan; and
- b) which directly, and from no other cause, result in any of the losses listed below within 90 days of the Accident that caused the injury.

The amount of this benefit is shown in the table below.

| For Loss of | Maximum Amount |
|------------------------------------------|----------------|
| Life | \$10,000 |
| Both Hands or Both Feet..... | \$10,000 |
| Sight of Both Eyes..... | \$10,000 |
| One Hand and One Foot..... | \$10,000 |
| One Hand and the Sight of One Eye | \$10,000 |
| One Foot and the Sight of One Eye | \$10,000 |
| One Hand or One Foot..... | \$5,000 |
| The Sight of One Eye | \$5,000 |
| Thumb and Index Finger of Same Hand..... | \$2,500 |

"Loss" of a hand or foot means complete severance through or above the wrist or ankle joint. "Loss" of sight of an eye means the total, irrevocable loss of the entire sight in that eye. "Loss" of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits. "Severance" means the complete separation and dismemberment of the part from the body.

If a Member suffers more than one loss as a result of the same Accident, We will pay only for the loss with the largest benefit.

REPATRIATION OF REMAINS AND MEDICAL EVACUATION

Repatriation of Remains - Maximum Amount: Unlimited

If You suffer loss of life due to injury or Emergency Condition while outside Your home country, We will pay for Covered expenses reasonably incurred to transport Your body to a mortuary near Your place of primary residence, but not exceeding the Maximum Amount per Member.

Covered expenses means the most economical transportation of the remains by the most direct and economical conveyance and route possible.

Travel Guard must make all arrangements and must authorize all expenses in advance for this benefit to be payable. We reserve the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact Travel Guard in advance.

Please see page 24 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.

Emergency Medical Evacuation - Maximum Amount: Unlimited

We will pay for Covered emergency medical evacuation expenses reasonably incurred if You suffer an injury or Emergency Condition that warrants Your emergency medical evacuation while outside Your home country but not exceeding the Maximum Amount per Member for all emergency medical evacuations due to all injuries from the same accident or all Emergency Conditions from the same or related causes.

The Physician ordering the emergency medical evacuation must certify that the severity of Your injury or Emergency Condition warrants Your emergency medical evacuation. All Transportation arrangements made for the emergency medical evacuation must be by the most direct and economical conveyance and route possible.

Travel Guard must make all arrangements and must authorize all expenses in advance for any emergency medical evacuation benefits to be payable. We reserve the right to determine the benefits payable, including reductions, if it is not reasonably possible to contact Travel Guard in advance.

Please see page 24 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.

DEFINITIONS

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of the Certificate for a description of how the Allowed Amount is calculated. If your Non-Participating Provider charges more than the Allowed Amount, You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

Ambulatory Surgical Center: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Certificate: The Certificate issued by the School of Visual Arts Student Health Plan, including the Schedule of Benefits and any attached riders.

Child, Children: The Student's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this brochure.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of the Certificate.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a prescription drug deductible) that You owe before We begin to pay for a particular Covered Service.

Dependents: The Student's Spouse and Children.

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; a comprehensive care center for eating disorders pursuant to Article 27-J of the New York Public Health Law; and a Facility defined in New York Mental Hygiene Law Sections 1.03(10) and (33), certified by the New York State Office of Alcoholism and Substance Abuse Services, or certified under Article 28 of the New York Public Health Law (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under the Plan.

Home Health Agency: An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitatory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

In-Network Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the Covered Service that You are required to pay to a Participating Provider. The amount can vary by the type of Covered Service.

In-Network Copayment: A fixed amount You pay directly to a Participating Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

In-Network Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Participating Providers. This limit never includes Your Premium or services We do not Cover.

Member: The Student or a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a grievance or emergency department visit or admission, "Member" also means the Member's designee.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide services to You. You will pay more to see a Non-Participating Provider.

Out-of-Network Coinsurance: Your share of the costs of a Covered Service calculated as a percent of the Allowed Amount for the service that You are required to pay to a Non-Participating Provider. The amount can vary by the type of Covered Service.

Out-of-Network Copayment: A fixed amount You pay directly to a Non-Participating Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Out-of-Network Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Non-Participating Providers. This limit never includes Your Premium, Balance Billing charges or services We do not Cover. You are also responsible for all differences, if any, between the Allowed Amount and the Non-Participating Provider's charge for out-of-network services regardless of whether the Out-of-Pocket Limit has been met.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website at www.chpstudent.com or www.cigna.com or upon Your request to Us. The list will be revised from time to time by Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: The 12-month period beginning on the effective date of the Policy; or any anniversary date thereafter, during which the Policy is in effect.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits.

Primary Care Physician ("PCP"): A participating Physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, Health Care Professional or Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are Covered under the Plan that is licensed, registered, certified or accredited as required by state law.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a participating Specialist) in order to arrange for additional care for a Member.

Skilled Nursing Facility: An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Us to meet the standards of any of these authorities.

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse: The person to whom the Student is legally married, including a same sex Spouse. Spouse also includes a domestic partner.

Student: The person to whom the Certificate is issued.

UCR (Usual, Customary and Reasonable): The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Us, We, Our: National Union Fire Insurance Company of Pittsburgh, Pa. and anyone to whom We legally delegate performance, on Our behalf, under the Policy.

You, Your: The Member.

EXCLUSIONS AND LIMITATIONS

No coverage is available under the Plan 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. **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 brochure. 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.
- D. **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 this brochure.
- E. **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, or 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 Plan for non-investigational treatments. See the utilization review and external appeal sections of the Certificate for a further explanation of Your appeal rights.
- F. **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).
- G. **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.
- H. **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.
- I. **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.
- J. **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).
- K. **Military Service.** We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.
- L. **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.
- M. **Services Not Listed.** We do not Cover services that are not listed in the Certificate as being Covered.
- N. **Services Provided by a Family Member.** We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.
- O. **Services Separately Billed by Hospital Employees.** We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.
- P. **Services With No Charge.** We do not Cover services for which no charge is normally made.
- Q. **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.
- R. **War.** We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.
- S. **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.

CERTIFICATE OF CREDITABLE COVERAGE

Coverage under the Plan is creditable coverage under Federal Law. When coverage terminates, the Member can request a Certificate of Creditable Coverage, which is evidence of coverage under the Plan. In order to obtain a Certificate of Creditable Coverage, please visit our website at www.chpstudent.com.

TRAVEL GUARD®

Description of Travel Assistance Services for Students

Wherever your travels may take you, in the event of a medical emergency or unexpected travel problem, Travel Guard is never more than a phone call away. Our state-of-the-art service centers deliver global service 24 hours a day, 7 days a week, 365 days a year.

How to contact Travel Guard:

Inside the United States and Canada, dial toll-free +1-877-249-5362

Outside the U.S. and Canada:

- Request an international operator.
- Request the operator to place a collect call to the U.S. at +1-715-295-9625.

Email us at assistance@aig.com

When to contact Travel Guard:

- If you require medical assistance or have a medical emergency.
- If you need assistance with a non-medical situation such as lost luggage, lost documents or other travel issues.

Helpful information to have available when you call Travel Guard:

- Policy number or school name
- Nature of your call and/or emergency
- Current location
- Contact phone number and email address
- Secondary point of contact
- Date of birth

Travel Medical Assistance

From physician referrals to coordinating medical evacuations, we help traveling students address their medical needs with expediency and expert care:

- Coordinate medical evacuation arrangements
- Physician/hospital/dental/vision care referral details, when medical attention is required including assistance with appointments
- Coordination of repatriation arrangements for the return of mortal remains in accordance with local governmental procedures
- Assistance with emergency prescription replacement while abroad
- Dispatch of doctor or specialist
- In-patient and out-patient medical case management
- Arrangements of visitor to bedside of hospitalized insured
- Eyeglasses and corrective lens replacement assistance

General Travel Assistance

Flight delays, inclement weather, lost or stolen luggage and other travel hassles are an unfortunate reality of travel today. We keep traveling students on the move with a variety of travel assistance services:

- Lost or stolen documents assistance
- Embassy and consulate information and referrals
- Lost baggage search and luggage replacement assistance
- Emergency language interpretation and translation services
- Emergency return travel arrangements
- Flight and hotel re-bookings
- Immunization, visa and passport information
- Guaranteed hotel check-in
- Travel delay reports
- Emergency cash transfer assistance
- Legal referrals/bail bond assistance
- Foreign exchange, ATM and weather information
- Worldwide public holiday information
- Urgent message relay to family, friends or university associates

Travel Concierge Services

Whether it is finding local restaurants or concert tickets, our Concierge Desk is a direct line to a team of professional and personal assistants available to help your travels be more effective:

- Referrals for counselling services
- Restaurant or local activity assistance Recommendations for spring break
- Moving coordination assistance
- Locate laundry facilities, post offices or bus schedules
- Recommend local car maintenance assistance
- Concert and event ticketing
- Electronic and wireless device assistance
- Movie and theatre information and ticketing
- Assistance with locating low fuel prices
- Assistance with finding places to purchase room supplies
- Locating retail stores (including shopping, coffee shops with free wireless internet access)

Travel Assistance Website and Mobile App

You can access our secure website, an online resource to stay a step ahead with the latest travel, security and health information. Whether it's prior to travel, during the trip, or after the return home, our members-only assistance website provides student travelers access to in-depth travel, health and security information. You can connect to the travel assistance website from your computer, smartphone or tablet 24/7/365. Please visit www.aig.com/us/travelguardassistance.com for more information about the website and mobile app.

- Email alerts contain security developments, such as terror attacks, major strikes, disasters or disruptions and government warnings that may affect your travel destination(s) and specific travel dates.
- Country reports provide key information on political conditions, security issues, travel logistics and cultural considerations.
- The Travel Health section educates travelers on health-related concerns, precautions and requirements for destinations and ability to create personal travel health profiles.
- The Medical Translations tool translates medical terms and phrases into multiple languages.
- The Drug Brand Equivalency tool generates drug brand names and their equivalent names in multiple countries.
- Security Awareness Training provides online travel safety videos and knowledge tests provide basic tools and information to be an aware, organized and prepared traveler.

About AIG Travel and Travel Guard®

AIG Travel, Inc., a member of American International Group, Inc., is a worldwide leader in travel insurance solutions and assistance. Travel Guard[®] is the marketing name for its portfolio of travel insurance solutions and travel-related services, including assistance and security services, marketed to both leisure and business travelers around the globe. Services are provided through a network of wholly owned service centers located in Asia, Europe and the Americas. For additional information, please visit our websites at www.aig.com/travel and www.travelguard.com.

CLAIM FILING PROCEDURES

1. Claim must be submitted to Us for payment within 120 days after you receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120-day period, You must submit as soon as reasonably possible. Mail claims to:
Cigna
P.O. Box 188061
Chattanooga, TN 37422-8061
2. In the event that a PPO provider submits Your claim(s), please be sure that the Provider photocopies Your insurance card.
3. You should retain one copy of all claims information submitted for Your records. PAYMENTS UNDER THE PLAN FOR SERVICES PROVIDED BY A PARTICIPATING PROVIDER WILL BE MADE DIRECTLY BY US TO THE PROVIDER. IF YOU RECEIVE SERVICES FROM A NON-PARTICIPATING PROVIDER, WE RESERVE THE RIGHT TO PAY EITHER YOU OR THE PROVIDER REGARDLESS OF WHETHER AN ASSIGNMENT HAS BEEN MADE.

IMPORTANT TELEPHONE NUMBERS AND ADDRESSES:

Member Services Representatives are available Monday – Friday 8:00 a.m. – 5:00 p.m.

CLAIMS

Consolidated Health Plans

1-800-633-7867

Submit claims to this address:

Cigna
P.O. Box 188061
Chattanooga, TN 37422-8061

COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS

Consolidated Health Plans

1-800-633-7867

Member Services Representatives are available Monday – Friday 8:00 a.m. – 5:00 p.m.

MEMBER SERVICES

Consolidated Health Plans

1-800-633-7867

Member Services Representatives are available Monday – Friday 8:00 a.m. – 5:00 p.m.

WEBSITE

www.chpstudent.com

PLAN ADMINISTRATOR

Consolidated Health Plans
2077 Roosevelt Avenue
SPRINGFIELD, MA 01104
1-800-633-7867

www.chpstudent.com

BROKER FOR SCHOOL:

University Health Plans, Inc.
One Batterymarch Park
Quincy, MA 02169-7454
Phone: 1-800-437-6448

Email: info@universityhealthplans.com

www.universityhealthplans.com

At AIG, we value the trust our customers have placed in us. That is why protecting the privacy of your personal information is of paramount importance to us. For more information, please go to our website at www.AIG.com.

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