



# St. John's University

("the Policyholder")

## 2016 – 2017 Student Health Plan

("the Plan")

Administrator Group Number: S207801

Underwriter Reference Number: CAS9151403

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 St. John's University. A Certificate of Coverage will be available to You in Your online account at

<https://consolidatedhealthplan.com/group/61/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](http://www.AIG.com).



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## HOW YOUR COVERAGE WORKS

St. John's University (referred to as the "Policyholder") has endorsed a Policy from Us. We will provide the benefits described in this brochure to covered Members of St. John's University, that is, to an eligible Student. 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.

## MAGNACARE PPO NETWORK PARTICIPATING PROVIDERS

To find out if a Provider is a MagnaCare 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](http://www.chpstudent.com) or [www.magnacare.com](http://www.magnacare.com)

## OPTUMRX PHARMACY BENEFIT MANAGER PARTICIPATING PHARMACIES

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

- Call 1-800-633-7867; or
- Visit OptumRx's website at [www.optum.com](http://www.optum.com) or [www.chpstudent.com](http://www.chpstudent.com)

## THE ROLE OF PRIMARY CARE PHYSICIANS:

The Plan does not have a gatekeeper, usually known as a Primary Care Physician ("PCP").

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 St. John's University 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.

## SERVICES SUBJECT TO PREAUTHORIZATION:

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) week 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

St. John's University 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 registered domestic and international undergraduate and graduate students of St. John's University. If You are a registered resident domestic undergraduate or graduate student, You will be automatically enrolled in and charged for coverage under the Plan unless You provide proof of comparable coverage and complete an online waiver form at [www.universityhealthplans.com](http://www.universityhealthplans.com) by the appropriate waiver deadline date listed below. If You are a full-time international undergraduate and graduate student with a current passport and student Visa (J-1 or F-1) who is temporarily located outside Your home country and You are actively engaged in education or educational research activities at St. John's University, You are required to be insured under the Plan and will be automatically enrolled in and charged the coverage on Your tuition bill.

Coverage Term	Waiver Deadline Dates
Annual	9/9/16
Spring	2/8/17

If You are a registered non-resident domestic undergraduate or graduate student, You are eligible to enroll in the Plan on a voluntary basis. To enroll, go to [www.universityhealthplans.com](http://www.universityhealthplans.com) and complete the on-line enrollment process. The enrollment form and cost for coverage under the Plan must be received by the appropriate enrollment deadline date listed below.

Coverage Term	Enrollment Deadline Dates
Annual	10/11/16
Spring	2/8/17

The Policy becomes effective at 12:01 a.m. on August 15, 2016 and ends at 11:59 p.m. on August 14, 2017.

## WHO IS COVERED

You, the enrolled Student, are covered under the Plan.

We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.

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 St. John's University. St. John's University cannot impose waiting periods that exceed 90 days.
2. If You, the Student, do not elect coverage upon becoming eligible or within 31 days of becoming eligible for other than a special enrollment period, You must wait until the Policyholder's next open enrollment period to enroll, except as provided below.

You can also enroll for coverage within 30 days of the loss of coverage in a health plan if coverage was terminated because You 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 can also enroll 30 days from exhaustion of Your COBRA or continuation coverage.

We must receive notice and Premium payment within 30 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 can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. You lose eligibility for Medicaid or a state child health plan.
2. You 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.

## 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.
4. 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.
5. If a Student 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.
6. 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.
7. 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.
8. 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.
9. 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.

## 2016-2017 STUDENT HEALTH PLAN COST\*

	<b>Annual</b> 8/15/16 – 8/14/17	<b>Spring</b> 1/1/17 – 8/14/17
Student	\$1,639	\$1,025

\*The Student Health Plan Cost includes premiums under the Student Health Plan and administrative fees.

## ST. JOHN'S UNIVERSITY STUDENT HEALTH PLAN SCHEDULE OF BENEFITS

THIS PLAN WOULD SATISFY THE PLATINUM LEVEL – ACTUARIAL VALUE 91.16%.

AGGREGATE MAXIMUM BENEFIT PER PLAN YEAR: UNLIMITED

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	
Deductible Individual	\$50	\$50	
Out-of-Pocket Limit Individual	\$3,500	\$3,500	
<b>OFFICE VISITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Primary Care Office Visits (or Home Visits)	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
Medications Administered in Office	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Specialist Office Visits (or Home Visits)	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
Medications Administered in Office	5% Coinsurance after Deductible	5% Coinsurance after Deductible	

<b>PREVENTIVE CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Well Child Visits and Immunizations*	Covered in full	0% Coinsurance not subject to Deductible	See coverage description in the Certificate
Adult Annual Physical Examinations*	Covered in full	0% Coinsurance not subject to Deductible	See coverage description in the Certificate
Adult Immunizations*	Covered in full	0% Coinsurance not subject to Deductible	See coverage description in the Certificate
Routine Gynecological Services/ Well Woman Exams*	Covered in full	0% Coinsurance not subject to Deductible	See coverage description in the Certificate
Mammography Screenings*	Covered in full	0% Coinsurance not subject to Deductible	See coverage description in the Certificate
Sterilization Procedures for Women*	Covered in full	0% Coinsurance not subject to Deductible	See coverage description in the Certificate
Vasectomy	Covered in full	0% Coinsurance not subject to Deductible	See coverage description in the Certificate
Bone Density Testing*	Covered in full	0% Coinsurance not subject to Deductible	See coverage description in the Certificate
Screening for Prostate Cancer	Covered in full	0% Coinsurance not subject to Deductible	See coverage description in the Certificate
All other preventive services required by USPSTF and HRSA.	Covered in full	0% Coinsurance not subject to Deductible	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)	
<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Pre-Hospital Emergency Medical Services (Ambulance Services)	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
Non-Emergency Ambulance Services	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
Emergency Department	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
Urgent Care Center	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate

<b>PROFESSIONAL SERVICES and OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Acupuncture	5% Coinsurance after Deductible	5% 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	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Performed as Outpatient Hospital Services	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Allergy Testing and Treatment	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
Performed in a PCP Office			
Performed in a Specialist Office	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Ambulatory Surgical Center Facility Fee	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
Anesthesia Services (all settings)	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
Autologous Blood Banking	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
Cardiac and Pulmonary Rehabilitation			See coverage description in the Certificate
Performed in a Specialist Office	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Performed as Outpatient Hospital Services	5% Coinsurance after Deductible	5% 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	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Performed in a Specialist Office	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Performed as Outpatient Hospital Services	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Chiropractic Services	5% Coinsurance after Deductible	5% 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	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Performed in a Specialist Office	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Performed as Outpatient Hospital Services	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Dialysis			See coverage description in the Certificate
Performed in a PCP Office	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Performed in a Freestanding Center or Specialist Office Setting	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Performed as Outpatient Hospital Services	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
Home Health Care	5% Coinsurance after Deductible	5% 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	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Performed in Specialist Office	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Performed as Outpatient Hospital Services	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Home Infusion Therapy	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Inpatient Medical Visits	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
Laboratory Procedures			See coverage description in the Certificate
Performed in a PCP Office	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Performed in a Freestanding Laboratory Facility or Specialist Office	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Performed as Outpatient Hospital Services	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Maternity and Newborn Care			See coverage description in the Certificate
Prenatal Care	Covered in full	5% Coinsurance after Deductible	
Inpatient Hospital Services and Birthing Center	5% Coinsurance after Deductible	5% 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	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Breast Pump	Covered in full	5% Coinsurance after Deductible	Covered for duration of breast feeding
Postnatal Care	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Outpatient Hospital Surgery Facility Charge	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
Preadmission Testing	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate

Diagnostic Radiology Services			See coverage description in the Certificate
Performed in a PCP Office	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Performed in a Freestanding Radiology Facility or Specialist Office	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Performed as Outpatient Hospital Services	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Therapeutic Radiology Services			See coverage description in the Certificate
Performed in a Freestanding Radiology Facility or Specialist Office	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Performed as Outpatient Hospital Services	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate  Speech and physical therapy are only Covered following a Hospital stay or surgery
Second Opinions on the Diagnosis of Cancer, Surgery and Other	5% Coinsurance after Deductible	5% 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
Inpatient Hospital Surgery	5% Coinsurance after Deductible	5% Coinsurance after Deductible	<p>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.</p> <p>If Covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:</p> <ul style="list-style-type: none"> <li>• For the procedure with the highest Allowed Amount; and</li> <li>• 50% of the amount We would otherwise pay for the other procedures.</li> </ul>
Outpatient Hospital Surgery	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Surgery Performed at an Ambulatory Surgical Center	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Office Surgery	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
<b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
ABA Treatment for Autism Spectrum Disorder	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
Assistive Communication Devices for Autism Spectrum Disorder	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
Diabetic Equipment, Supplies and Self-Management Education			See coverage description in the Certificate
Diabetic Equipment, Supplies and Insulin (Up to a 90-day supply)	See the Prescription Drug Cost-Sharing	See the Prescription Drug Cost-Sharing	
Diabetic Education	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Durable Medical Equipment and Braces	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
External Hearing Aids	5% Coinsurance after Deductible	5% Coinsurance after Deductible	Single purchase once every 3 years

Cochlear Implants	5% Coinsurance after Deductible	5% Coinsurance after Deductible	One per ear per time Covered
Hospice Care			
Inpatient	5% Coinsurance after Deductible	5% Coinsurance after Deductible	210 days per Plan Year
Outpatient	5% Coinsurance after Deductible	5% Coinsurance after Deductible	Five (5) visits for family bereavement counseling
Medical Supplies	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
Prosthetic Devices			See coverage description in the Certificate
External	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Internal	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
Shoe Inserts	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate

<b>INPATIENT SERVICES and FACILITIES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
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Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
<b>Preauthorization Required. However, Preauthorization is not required for emergency admissions.</b>			
Observation Stay	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate Up to 200 days per Plan Year
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate

<b>MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
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Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
<b>Preauthorization Required. However, Preauthorization is not required for emergency admissions.</b>			

Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
<b>Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.</b>			
Outpatient Substance Use Services	5% Coinsurance after Deductible	5% Coinsurance after Deductible	Unlimited; Up to 20 visits per Plan Year may be used for family counseling
<b>PRESCRIPTION DRUGS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Retail Pharmacy</b>			
30-day supply Tier 1	\$15 Copayment 0% Coinsurance not subject to Deductible	\$15 Copayment 0% Coinsurance not subject to Deductible	See coverage description in the Certificate
Tier 2	\$30 Copayment 0% Coinsurance not subject to Deductible	\$30 Copayment 0% Coinsurance not subject to Deductible	FDA-approved contraceptive methods prescribed by a Provider are not subject to Copayments, Deductibles or Coinsurance.
Tier 3	\$45 Copayment 0% Coinsurance not subject to Deductible	\$45 Copayment 0% Coinsurance not subject to Deductible	
Enteral Formulas	5% Coinsurance after Deductible	5% Coinsurance after Deductible	See coverage description in the Certificate
<b>PEDIATRIC DENTAL and VISION CARE (for Members through the end of the month in which the Member turns 19 years of age)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Pediatric Dental Care			
Preventive Dental Care	0% Coinsurance not subject to Deductible	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	30% Coinsurance after Deductible	30% Coinsurance after Deductible	
Major Dental (Endodontics, Periodontics and Prosthodontics)	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
Orthodontics	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
<b>Orthodontics and Major Dental Require Preauthorization</b>			

Pediatric Vision Care			
Exams	5% Coinsurance after Deductible	5% Coinsurance after Deductible	One (1) exam per Plan Year
Lenses and Frames	5% Coinsurance after Deductible	5% Coinsurance after Deductible	One (1) prescribed lenses and frames per Plan Year
Contact Lenses	5% Coinsurance after Deductible	5% Coinsurance after Deductible	
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	\$5,000

## EXERCISE FACILITY REIMBURSEMENT

We will partially reimburse the Student 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 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.

<b>For Loss of</b>	<b>Maximum Amount</b>
Life .....	\$5,000
Both Hands or Both Feet.....	\$5,000
Sight of Both Eyes.....	\$5,000
One Hand and One Foot .....	\$5,000
One Hand and the Sight of One Eye .....	\$5,000
One Foot and the Sight of One Eye .....	\$5,000
One Hand or One Foot.....	\$2,500
The Sight of One Eye .....	\$2,500
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 21 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 21 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 St. John's University Student Health Plan, including the Schedule of Benefits and any attached riders.

**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.

**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 rehabilitative 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 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](http://www.chpstudent.com) or [www.magnacare.com](http://www.magnacare.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.

**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](http://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](mailto: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](http://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](http://www.aig.com/travel) and [www.travelguard.com](http://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:  
Consolidated Health Plans  
2077 Roosevelt Avenue  
Springfield, MA 01104
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. to 5:00 p.m.**

### **CLAIMS**

**1-800-633-7867**

**Submit claims to this address:**

Consolidated Health Plans  
2077 Roosevelt Avenue  
Springfield, MA 01104

## **COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS**

**Consolidated Health Plans**

**1-800-633-7867**

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

## **MEMBER SERVICES**

**Consolidated Health Plans**

**1-800-633-7867**

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

## WEBSITE

[www.chpstudent.com](http://www.chpstudent.com)

## PLAN ADMINISTRATOR

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

[www.chpstudent.com](http://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](mailto:info@universityhealthplans.com)

[www.universityhealthplans.com](http://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](http://www.AIG.com).

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