School of Visual Arts

("the Policyholder")

2017-2018
Student Health Plan

("the Plan")

Designed Exclusively for the Students of:

School of Visual Arts

New York, NY

2017 - 2018

Underwritten by:

Atlanta International Insurance Company (AIIC)
Flushing, NY

Policy Number: AIIC1718NYSHIP08

Group Number: ST0654SH

Effective: 8/25/2017 – 8/25/2018

CHP Student HEALTH

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Where to Find Help

For Questions About:	Please Contact:
Insurance Benefits **Enrollment** **Waiver**	**University Health Plans, a Risk Strategies Company** 15 Pacella Park Drive Randolph, MA 02368 Phone: (800) 437-6448 Fax: (617) 472-6419 www.universityhealthplans.com or email us at info@univhealthplans.com
Claims Processing **ID Cards** **Preferred Provider Listings** **ID card Requests**	**Consolidated Health Plans** 2077 Roosevelt Avenue Springfield, Massachusetts 01104 (877) 657-5030 www.chpstudent.com
Preferred PPO Provider Listings	**Consolidated Health Plans** **or** **www.cigna.com**
Prescription Drug Providers	**Cigna PBM** **www.cigna.com**

Am I Eligible?

If You are a full-time or part-time student, School of Visual Arts (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, enrolling in the Fall, You will be enrolled for the Annual Coverage Term. If You are a full-time or part-time student enrolling in the Fall but are not registered for Spring classes, You will be enrolled for the Fall Coverage Term only.

Coverage for Dependents

You, the Student, to whom the Certificate is issued, are covered under the Certificate. Members of Your family may also be covered depending on the type of coverage You selected.

In **Section V** of the Certificate, see the provision entitled **Who is Covered**.

How Do I Waive?

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. If You do not complete a waiver form by the applicable waiver deadline date, 10/2/17, You will be enrolled in the Plan and will be responsible for the Health Insurance Plan Cost.

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 12/6/17, and for Spring, it is 4/6/18. 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 which is 2/4/18 for Spring. 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.

Effective Dates & Costs

All time periods begin and end at 12:01 A.M., local time, at the Policyholder's address.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	8/25/17	8/25/18	10/2/17
Fall	8/25/17	2/24/18	10/2/17
Spring (for new students to the School in the Spring semester only)	1/3/18	8/25/18	2/4/18

Rates for Undergraduate and International Students
Dependent rates are in addition to the student rate.

	Annual	Fall	Spring
Student*	$2,140	$1,070	$1,346
Spouse*	$2,140	$1,070	$1,346
Each Child*	$2,140	$1,070	$1,346
3 or more Children*	$6,420	$3,210	$4,038

The above rates include an administrative service fee

Preferred Provider Organization (PPO) Network

By enrolling in this Insurance Program, you have the Cigna PPO Network of participating Providers with access to quality health care at discounted fees. To find a complete listing of the Network's participating Providers, go to www.cigna.com, or contact Consolidated Health Plans toll-free at (877) 657-5030, or www.chpstudent.com for assistance.

Preauthorization Procedure

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

Preauthorization Procedure.
If You seek coverage for services that require Preauthorization, You must call Us at the number on Your ID card.

You must contact Us to request Preauthorization as follows:

- At least two (2) 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.

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.

In **Section II** of the Certificate, see other provisions for **Preauthorization**. Also, in **Section XIII**, see other provisions for **Preauthorization** under Prescription Drug Coverage.

Exclusions and Limitations

No coverage is available under this Certificate for the following:

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

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

C. Conversion Therapy.
We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for any individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

D. Cosmetic Services.
We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

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

F. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, 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 this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

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

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

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

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

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

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

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

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

O. Services Provided by a Family Member.
We do not Cover services performed by You or a member of Your immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

P. Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Q. Services with No Charge.
We do not Cover services for which no charge is normally made.

R. Vision Services.
We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Pediatric Vision Care section of this Certificate.

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

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

Schedule of Benefits

SCHEDULE OF BENEFITS
School of Visual Arts

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible Individual	$100		
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) Medications Administered in Office	$10 Copayment 0% Coinsurance not subject to Deductible 0% Coinsurance not subject to Deductible	$10 Copayment 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	$10 Copayment 0% Coinsurance not subject to Deductible	$10 Copayment 30% Coinsurance not subject to Deductible	See benefit for description
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	30% Coinsurance not subject to Deductible	See benefit for description
• Adult Annual Physical Examinations	Covered in full	30% Coinsurance not subject to Deductible	
• Adult Immunizations	Covered in full	30% Coinsurance not subject to Deductible	
• Routine Gynecological Services/Well Woman Exams	Covered in full	30% Coinsurance not subject to Deductible	
• Mammography Screenings	Covered in full	30% Coinsurance not subject to Deductible	
• Sterilization Procedures for Women	Covered in full	30% Coinsurance not subject to Deductible	
• Vasectomy	Covered in full	30% Coinsurance not subject to Deductible	
• Bone Density Testing*	Covered in full	30% Coinsurance not subject to Deductible	
• Screening for Prostate Cancer	Covered in full	30% Coinsurance not subject to Deductible	
• All other preventive services required by USPSTF and HRSA.	Covered in full	30% Coinsurance not subject to Deductible	
*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)	
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	0% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services	0% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Emergency Department	10% Coinsurance after Deductible	10% Coinsurance after Deductible	See benefit for description

Urgent Care Center	0% Coinsurance not subject to Deductible	$10 Copayment 30% Coinsurance not subject to Deductible	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Acupuncture	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services	 $10 Copayment 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 $10 Copayment 30% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office	 $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible	 $10 Copayment 30% Coinsurance not subject to Deductible $10 Copayment 30% Coinsurance not subject to Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Autologous Blood Banking	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefits for description
Cardiac and Pulmonary Rehabilitation Performed in a Specialist Office Performed as Outpatient Hospital Services Performed as Inpatient Hospital Services	 $10 Copayment 0% Coinsurance after Deductible 10% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing	 $10 Copayment 30% Coinsurance after Deductible 40% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing	See benefits for description
Chemotherapy Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services	 $10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible 10% Coinsurance after Deductible	 $10 Copayment 30% Coinsurance not subject to Deductible $10 Copayment 30% Coinsurance not subject to Deductible 40% Coinsurance after Deductible	See benefit for description

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Chiropractic Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Clinical Trials	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $10 Copayment 0% Coinsurance after Deductible $10 Copayment 0% Coinsurance after Deductible 10% Coinsurance after Deductible	 $10 Copayment 30% Coinsurance after Deductible $10 Copayment 30% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services	 $10 Copayment 0% Coinsurance after Deductible $10 Copayment 0% Coinsurance after Deductible 10% Coinsurance after Deductible	 $10 Copayment 30% Coinsurance after Deductible $10 Copayment 30% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	60 visits per condition, per lifetime; per Plan Year (combined therapies)
Home Health Care	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40 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 benefit for description

Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	$10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	$10 Copayment 30% Coinsurance not subject to Deductible $10 Copayment 30% Coinsurance not subject to Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Inpatient Medical Visits	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	$10 Copayment 0% Coinsurance not subject to Deductible $10 Copayment 0% Coinsurance not subject to Deductible 10% Coinsurance after Deductible	$10 Copayment 30% Coinsurance not subject to Deductible $10 Copayment 30% Coinsurance not subject to Deductible 40% Coinsurance after Deductible	See benefit for description
Medications administered in Office • Performed in a PCP • Performed in Specialist Office	0% Coinsurance not subject to Deductible 0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible	

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Maternity and Newborn Care • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	$10 Copayment 30% Coinsurance not subject to Deductible	See benefit for description One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing	Covered for duration of breast feeding
• Inpatient Hospital Services and Birthing Center	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Physician and Midwife Services for Delivery	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Breast Pump	Covered in full	40% Coinsurance after Deductible	
• 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 benefit for description
Preadmission Testing	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Diagnostic Radiology Services			See benefit for description
• 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 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 • Performed as Outpatient Hospital Services	 $10 Copayment 0% Coinsurance not subject to Deductible 10% Coinsurance after Deductible	 $10 Copayment 30% Coinsurance not subject to Deductible 40% Coinsurance after Deductible	See benefit for description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	60 visits per condition, per lifetime; per Plan Year (combined therapies) Speech and physical therapy are only Covered following a Hospital stay or surgery
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 benefit for description
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
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 benefit description

Assistive Communication Devices for Autism Spectrum Disorder	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin (90-day supply) • Diabetic Education	See the Prescription Drug Cost-Sharing $10 Copayment 0% Coinsurance not subject to Deductible	See the Prescription Drug Cost-Sharing $10 Copayment 30% Coinsurance not subject to Deductible	See benefit for description
Durable Medical Equipment and Braces	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
External Hearing Aids	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
Cochlear Implants	10% Coinsurance after Deductible	40% Coinsurance after Deductible	One per ear per time Covered
Hospice Care • Inpatient • Outpatient	10% Coinsurance after Deductible 10% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible	210 days per Plan Year Five (5) visits for family bereavement counseling
Medical Supplies	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Prosthetic Devices • External • Internal	10% Coinsurance after Deductible 10% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible	One (1) prosthetic device, per limb, per lifetime Unlimited; See benefit for description
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 benefit for description
Observation Stay	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	200 days per Plan Year
Inpatient Habilitation Services (Physical Speech and Occupational Therapy)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	60 days per Plan Year
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	60 days per Plan Year
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 benefit for description
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 benefit for description

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 benefit for description
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**	**Limits**
Retail Pharmacy			
30-day supply Tier 1 Tier 2 Tier 3	 $10 Copayment 0% Coinsurance not subject to Deductible $20 Copayment 0% Coinsurance not subject to Deductible $30 Copayment 0% Coinsurance not subject to Deductible	 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible	See benefit for description
Mail Order Pharmacy			
Up to a 90-day supply Tier 1 Tier 2 Tier 3	 $25 Copayment 0% Coinsurance not subject to Deductible $50 Copayment 0% Coinsurance not subject to Deductible $75 Copayment 0% Coinsurance not subject to Deductible	 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible 30% Coinsurance not subject to Deductible	See benefit for description
Enteral Formulas	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

WELLNESS BENEFITS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
Exercise Facility Reimbursement	Up to $200 per six (6) month period; up to an additional $100 per 6-month period for Covered Dependents	Up to $200 per six (6) month period; up to an additional $100 per 6-month period for Covered Dependents	See Benefit description
PEDIATRIC DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care *through the end of the month in which the Member turns 19 years of age*			One (1) dental exam and cleaning per six (6)-month period
• Preventive Dental Care	$35 Copayment 0% Coinsurance not subject to Deductible	$35 Copayment 0% Coinsurance not subject to Deductible	Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at six (6) month intervals
• Routine Dental Care	0% Coinsurance not subject to Deductible	0% Coinsurance not subject to Deductible	
• Major Dental (Endodontics, Periodontics and Prosthodontics)	0% Coinsurance not subject to Deductible	0% Coinsurance not subject to Deductible	
• Orthodontics **Orthodontics and Major Dental Require Preauthorization**	50% Coinsurance not subject to Deductible	50% Coinsurance not subject to Deductible	
Pediatric Vision Care *through the end of the month in which the Member turns 19 years of age*			One (1) exam per Plan Year
• Exams	10% Coinsurance after Deductible	10% Coinsurance after Deductible	One (1) prescribed lenses and frames per Plan Year
• Lenses and Frames	10% Coinsurance after Deductible	10% Coinsurance after Deductible	
• Contact Lenses	10% Coinsurance after Deductible	10% Coinsurance after Deductible	

Non-emergency Care While Traveling Outside of the United States	30% coinsurance of - Actual Cost		
Emergency Medical Evacuation	0% coinsurance of - Actual Cost		Unlimited
Repatriation of Remains	0% coinsurance of - Actual Cost		Unlimited
Accidental Death and Dismemberment Benefits	N/A	N/A	$10,000 See Benefit for Description

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If, as the result of a covered Accident, You sustain any of the following losses, We will pay the benefit shown. The Loss must occur within 90 days of the Accident.

Loss of Life ..... The Principal Sum
Loss of hand ..... One-Half the Principal Sum
Loss of Foot ..... One-Half the Principal Sum
Loss of either one hand, one foot or sight of one eye..... One-half the Principal Sum
Loss of more than one of the above losses due to one Accident.....The Principal Sum

Loss of hand or foot means the complete severance through or above the wrist or ankle joint. Loss of eye means the total permanent loss of sight in the eye. The principal sum is the largest amount payable under this benefit for all losses resulting from any one Accident.

Claim Procedures

In the event of either an Injury or a Sickness:

1. Report to a Physician, Hospital or the School's Student Health Services.
2. Claims for services 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 it as soon as reasonably possible.
3. Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, Social Security number or student ID number and name of the University under which the student is insured. A Company claim form is not required for filing a claim.
   Bills should be received by the Company within 120 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

CIGNA
PO Box 188061
Chattanooga, TN 37422 – 8061
Electronic Payor ID: 62308

For information about the Cigna Prescription Drug Program please visit www.cigna.com.

Grievances, Utilization Review, and Appeals

Claims Administrator:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
Toll Free (877) 657-5030
www.chpstudent.com
Group Number: ST0654SH

Value Added Services

The following services are not part of the Plan Underwritten by Atlanta International Insurance Company. These value-added options are provided by Consolidated Health Plans.

VISION DISCOUNT PROGRAM
For Vision Discount Benefits please go to:
www.chpstudent.com

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

Consolidated Health Plans provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at 1-877-657-5030. **If you are traveling and need assistance in North America, call the Assistance Center toll-free at: 877.305.1966 *or* if you are in a foreign country, call collect at: 715.295.9311**. When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

This plan is underwritten by:
Atlanta International Insurance Company
Flushing, NY
As Policy form: NY SHIP POL (2016)

For a copy of the Company's privacy notice you may go to:
www.consolidatedhealthplan.com/about/hipaa
(Please indicate the school you attend with your written request)
or
Request one from the SVA Student Health and Counseling Services

Representations of the Plan must be approved by the Company.

This is not the Certificate. Rather, it is a brief description of the benefits and other provisions of the Certificate. The Certificate is governed by the laws and regulations of the state in which it is issued and is subject to any necessary State approvals. Any provisions of the Certificate, as described in this brochure, that may be in conflict with the laws of the state where the school is located will be administered to conform with the requirements of that state's laws, including those relating to mandated benefits.