



# Student Health Insurance Plan

Plan Year  
18/19

*Designed Exclusively for the Students of:*

## Salve Regina University

Newport, RI  
(“the Policyholder”)

2018 - 2019

***Underwritten by:***

Atlanta International Insurance Company  
Flushing, NY  
(the Company”)

Policy Number: AIIC1819RISHIP43

Group Number: ST0903SH

Effective: 08/15/2018 – 08/14/2019



***Administered by:***

Consolidated Health Plans  
2077 Roosevelt Ave | Springfield, MA



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## Where to Find Help

For Questions About:	Please Contact:
<b>Insurance Benefits</b> <b>Enrollment</b> <b>Waiver</b>	<b>University Health Plans, a Risk Strategies Company</b> 15 Pacella Park Drive Randolph, MA 02368 Phone: (800) 437-6448 Fax: (617) 472-6419 <a href="http://www.universityhealthplans.com">www.universityhealthplans.com</a> or email us at <a href="mailto:info@univhealthplans.com">info@univhealthplans.com</a>
<b>Claims Processing</b> <b>ID Cards</b> <b>Preferred Provider Listings</b> <b>ID card Requests</b>	<b>Consolidated Health Plans</b> 2077 Roosevelt Avenue Springfield, Massachusetts 01104 (877) 657-5030 <a href="http://www.chpstudenthealth.com">www.chpstudenthealth.com</a>
<b>Preferred PPO Provider Listings</b>	<b>Consolidated Health Plans</b> or <a href="http://www.phcs.com">www.phcs.com</a>
<b>Prescription Drug Providers</b>	OptumRx <a href="http://www.optumrx.com">www.optumrx.com</a>

## Am I Eligible?

You are eligible for Coverage under the Certificate. Coverage does not include Dependent coverage.

All registered full-time undergraduate students and part-time resident students of Salve Regina University are automatically enrolled in and charged the premium for the Student Health Insurance Plan ("the Plan"), unless proof of comparable coverage is provided.

Students must attend classes for the first 31 days beginning with the first day for which coverage is effective. Any student withdrawing from the College during the first 31 days after the Effective Date of coverage shall not be covered under the insurance plan. A full refund of premium will be made, minus the cost of any claim benefits paid by the Certificate. Students who graduate or withdraw from the College after 31 days, whether involuntarily or voluntarily, will remain covered under the Certificate for the term purchased and no refund will be allowed.

Students withdrawing due to a medical withdrawal due to a Sickness or Injury, must submit documentation or certification of the medical withdrawal to Us at least 30 days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable, or 30 days after the date of the medical leave from school. Students will remain covered under the Certificate for the term purchased and no refund will be allowed.

We maintain the right to investigate eligibility status and attendance records to verify that the Certificate eligibility requirements have been met. If We discover that the Certificate eligibility requirements have not been met, Our only obligation is refund of premium less any claims paid.

Eligibility requirements must be met each time Premium is paid to renew Coverage.

### Who is Eligible

All registered full-time Undergraduate students and part-time resident students taking credits are required to have health insurance coverage, either through the Plan or through another individual or family plan. Students are automatically enrolled in the Plan at registration and the premium is added to the student's tuition fees unless proof of comparable coverage is provided by completing the waiver.

**Who is not Eligible**

The following students are not eligible to enroll in the insurance plan:

- students enrolled exclusively in online courses or whose enrollment consists entirely of short-term courses;
- students taking home study, correspondence television courses, or courses taken for audit do not fulfill the eligibility requirements that the student actively attend classes. The online restriction does not apply to students who are completing their degree requirements while engaged in practical training.

**How Do I Waive/Enroll?**

If You are eligible to be covered under the Plan, You will be automatically enrolled and charged the premium, unless You waive coverage. Students who do not want to be enrolled in the Student HealthPlan can waive coverage if they can document proof of comparable coverage in another health insurance plan that will be in effect from 12:00 A.M. on August 15, 2018 through 11:59 P.M. on August 14, 2019. Recognizing that health insurance situations may change, students will be required to provide proof of comparable coverage each academic year in order to waive participation in the Plan. To document proof of comparable coverage, students need to complete the online Waiver Form and submit it by the deadline. Go to [www.universityhealthplans.com](http://www.universityhealthplans.com) to submit the online Waiver Form.

The online Waiver process is the only accepted process for waiving participation in the Plan. The deadline for processing the online waiver is August 1, 2018 for students enrolling in the annual or fall coverage period and January 15, 2019 for students newly enrolling at the University in the spring term. Students who do not submit the online Waiver Form by the deadline will be automatically enrolled in the Plan and the fee will remain on their student account bill.

**Eligible Students who DO NOT WANT to be enrolled** in the Plan must submit an online Waiver Form documenting proof of comparable coverage in another health insurance plan prior to the posted waiver deadline date.

**Special Enrollment - Qualifying Life Event**

You can also enroll for coverage within 60 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 for You; or
7. A Child no longer qualifies for coverage as a Child under the other health plan.

You can also enroll 60 days from exhaustion of Your COBRA or continuation coverage or become a Dependent through marriage, birth, adoption or placement for adoption.

We must receive notice and Premium payment within 60 days of the loss of coverage. The effective date of Your coverage will depend on when We receive proof of Your loss of coverage under another health plan and appropriate premium payment. Your coverage shall take effect on the latest of the following dates: (1) this Policy Effective Date; (2) the day after the date for which you lose your coverage providing premium for Your coverage has been paid; (3) the date the Policyholder's term of coverage begins; or (4) the date You become a member of an eligible class of persons.

In addition, You can also enroll for coverage within 60 days of the occurrence of one of the following event:

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 the loss of coverage. The effective date of Your coverage will depend on when We receive proof of Your loss of coverage under another health plan and appropriate premium payment. Your coverage shall take effect on the latest of the following dates: (1) this Policy Effective Date; (2) the day after the date for which you lose your coverage providing premium for Your coverage has been paid; (3) the date the Policyholder's term of coverage begins; or (4) the date You become a member of an eligible class of persons.

## Effective Dates & Costs

All time periods begin at 12:00 A.M. local time and end at 11:59 P.M. local time at the Policyholder's address.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/15/2018	08/14/2019	08/01/2018
Fall	08/15/2018	01/14/2019	08/01/2018
Spring (students new to the University for the spring term)	01/15/2019	08/14/2019	01/15/2019

### Rates for Full-time Undergraduate and Part-time Resident Students

	Annual	Fall	Spring (students new to the University for the spring term only)
Student*	\$2,079	\$889	\$1,220

*\*The above rates include an administrative service fee*

**Effective Dates:** Insurance under the Certificate will become effective on the later of:

1. The Policy Effective Date;
2. The beginning date of the term for which premium has been paid;
3. The day after the Enrollment Form (if applicable) and premium payment is received by the Company, its authorized agent or the School;
4. The day after the date of postmark if the Enrollment Form is mailed;
5. For International Students or scholars, the date the Insured Person departs his or her Home Country to travel to the Country of Assignment. The scheduled arrival in the Country of Assignment must be not more than 48 hours later than the departure from the Home Country.

The enrollment Period will run from the start of the quarter or semester for which coverage is desired.

## Termination of Benefits

**Termination Dates:** Your insurance will terminate on the earliest of:

1. The date the Certificate terminates for all Insured Persons; or
2. The end of the period of coverage for which premium has been paid; or
3. The date You cease to be eligible for the insurance; or
4. The date You enter military service or
5. For International Students, the date they cease to meet Visa requirements; or
6. For International Students, the date they depart the Country of Assignment for his/her Home Country (except for scheduled school breaks); or
7. On any premium due date the Policyholder fails to pay the required premium for You except as the result of an inadvertent error and subject to any Grace Period provision.

## Refund of Premium

Premiums received by Us are fully earned upon receipt. Refund of premium will be considered only:

1. For any student who does not attend school during the first thirty-one (31) days of the period for which coverage is purchased. Such a student will not be covered under the Policy and a full refund of the premium will be made minus any claims paid.

2. For Insured Persons entering the Armed Forces of any country. Such persons will not be covered under the Policy as of the date of his/her entry into the service. A pro rata refund of Premium (less any claims paid) will be made for such person upon written request received by Us within 90 days of withdrawal from school.
3. For International Students, We will refund a pro rata portion of the premium actually paid (less any claims paid) for any individual who:
  - o Withdraws from School during their first semester; and
  - o Returns to their Home Country on a permanent basis.
 A written request must be sent to us within 60 days of such departure.

No other refunds will be allowed.

## Extension of Benefits

Coverage under the Certificate ceases on the Termination Date. However, coverage for You will be extended as follows:

If You are Hospital Confined for Covered Injury or Covered Sickness on the date Your insurance terminates, we will continue to pay benefits for up to 90 days from the Termination Date while such Confinement continues.

Dependents that are newly acquired during Your Extension of Benefits period are not eligible for benefits under this provision.

## Definitions

These are key words used in the Certificate. They are used to describe the Policyholder's rights as well as Ours. Reference should be made to these words as the Certificate is read.

**Accident** means a sudden, unforeseeable external event which directly and from no other cause, results in an Injury to the Insured Person.

**Ambulance Service** means transportation to and from a Hospital by a licensed Ambulance whether ground, air or water Ambulance, in a Medical Emergency.

**Ambulatory Surgical Center** means a facility which meets licensing and other legal requirements.

Which:

1. Is equipped and operated to provide medical care and Treatment by a Physician;
2. Does not provide services or rooms for overnight stays;
3. Has a medical staff that is supervised full-time by a Physician;
4. Has full-time services of a licensed Registered Nurse at all times when patients are in the facility;
5. Has at least one operating room. One recovery room and is equipped to support any surgery performed;
6. Has x-ray and lab diagnostic facilities;
7. Maintains a medical record for each patient; and
8. Has a written agreement with at least one Hospital for the immediate transfer of patients who develop complications or need Confinement.

**Anesthetist** means a Physician or Nurse who administers anesthesia during a surgical procedure. He or she may not be an employee of the Hospital where the procedure is performed.

**Assistant Surgeon** means a Physician who assists the Surgeon who actually performs a surgical procedure.

**Brand-Name Prescription Drug** means a Prescription Drug whose manufacture and sale is controlled by a single company because of a patent or similar right. Refer to the Formulary for the tier status.

**Certificate:** The Certificate issued by Us, including the Schedule of Benefits and any attached riders.

**Coinsurance** means the percentage of Covered Medical Expenses that We pay. The Coinsurance percentage is stated in the Schedule of Benefits. The Coinsurance is separate and not part of the Deductible and Copayment.

**Complications of Pregnancy** means conditions that require Hospital Confinements before the pregnancy ends. Whose diagnoses are distinct from but caused or affected by pregnancy. These conditions are acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar conditions as severe as these.

Complications of Pregnancy also include non-elective cesarean section, termination of an ectopic pregnancy, and spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.)

Complications of Pregnancy do not include false labor, occasional spotting or Physician prescribed rest during the period of pregnancy, morning Sickness, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.

**Confinement/Confined** means an uninterrupted stay following admission to a health care facility. The readmission to a health care facility for the same or related condition, within a seventy-two (72) hour period, will be considered a continuation of the Confinement. Confinement does not include observation, which is a review or assessment of eighteen (18) hours or less, of an Insured Person's condition that does not result in admission to a Hospital or health care facility.

**Copayment** means a specified dollar amount You must pay for specified Covered Medical Expenses. Any Copayment amounts are shown in the Schedule of Benefits.

**Country of Assignment** means the country in which an Eligible International Student, scholar or visiting faculty member is:

1. Temporarily residing; and
2. Actively engaged in education or educational research related activities that are sponsored by the National Association for Foreign Student Affairs or its Member Organizations.

**Covered Injury or Injury** means a bodily injury due to an unforeseeable, external event which results independently of disease, bodily infirmity or any other cause. All injuries sustained in any one (1) Accident, all related conditions and recurrent symptoms of these injuries are considered a single Injury.

**Covered Medical Expense** means those Medically Necessary charges for any Treatment, service or supplies that are:

1. Not more than the Usual and Reasonable charges therefore;
2. Not more than the charges that would have been made in the absence of this insurance;
3. Not more than the Preferred Allowance; and
4. Incurred while Your Certificate is in force, except with respect to any expenses payable under the Extension of Benefits Provision.

**Covered Sickness** means an illness, disease or condition including pregnancy and Complications of Pregnancy that impairs Your normal function of mind or body and which is not the direct result of an Injury which results in Covered Medical Expenses. Covered Sickness includes Mental Health Disorders and Substance Use Disorders.

**Custodial Care** means care that is mainly for the purpose of meeting non-medical personal needs. This includes help with activities of daily living and taking medicines. Activities of daily living include: bathing, dressing or grooming, eating, toileting, walking and getting in and out of bed. Custodial Care can usually be provided by someone without professional and medical skills or training.

**Deductible** means the dollar amount of Covered Medical Expenses which must be paid by each Insured Person before benefits are payable. The amount of the Deductible will be shown in the Schedule of Benefits.

**Durable Medical Equipment** means a device which:

1. Is primarily and routinely used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of Sickness or Injury and is able to withstand repeated use;
2. Is used exclusively by You;
3. Is routinely used in a Hospital but can be used effectively in a non-medical facility;
4. Can be expected to make a meaningful contribution to treating Your Sickness or Injury; and
5. Is prescribed by a Physician and the device is Medically Necessary for rehabilitation.



Durable Medical Equipment does not include:

1. Comfort and convenience items;
2. Equipment that can be used by Immediate Family Members other than You;
3. Health exercise equipment; and
4. Equipment that may increase the value of Your residence.

**Effective Date** means the date coverage becomes effective.

**Elective Surgery or Elective Treatment** means those health care services or supplies not medically necessary for the care and Treatment of a Covered Injury or Covered Sickness. Elective surgery does not include Plastic, Cosmetic, or Reconstructive Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

**Eligible Student** means a student who meets all eligibility requirements of the School named as the Policyholder or Dependent of the Insured Student.

**Emergency Medical Condition** means Covered Sickness or Injury for which immediate medical Treatment is sought at the nearest available facility. The Condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious risk;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

**Emergency Services** means, with respect to an Emergency Medical Condition: transportation services, including but not limited to ambulance services, and covered inpatient and outpatient Hospital services furnished by a Hospital or Physician qualified to furnish those services that are needed to evaluate or Stabilize an Emergency Medical Condition.

**Essential Health Benefits** mean benefits that are defined in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes the following categories of Covered Services:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and Substance Use Disorder services, including behavioral health Treatment;
6. Prescription drugs;
7. Rehabilitative and Habilitative services and devices;
8. Lab services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

**Experimental/Investigative** means the service or supply has not been shown in scientifically valid clinical trials and research studies to be safe and effective for a particular indication. For further explanation, see the Medically Necessary/Medical Necessity provision

**Formulary** means a list of medicines designed to manage prescription costs without affecting the quality of care. This is done by identifying and encouraging use of the most clinically and cost effective medicines. The Formulary indicates the type of drug and tier status.

**Gender Dysphoria** means a conflict between Your physical gender and the gender with which You identify. The identity conflict must continue over at least 6 months and You must meet the defined term of Gender Dysphoria as described by the American Psychiatric Association.



**Generic Prescription Drug** means any Prescription Drug that is not a Brand-Name Prescription Drug. Refer to the Formulary for the tier status.

**Habilitation/Habilitative Services** means health services that help You keep, learn, or improve skills and functions for daily living. Habilitative Services may include such services as Physical Therapy, occupational and speech therapy.

**Home Country** means Your country of citizenship. If You have dual citizenship, Your Home Country is the country of the passport You used to enter the United States. Your Home Country is considered the Home Country for any Dependent of Yours while insured under the Certificate.

**Home Health Care Agency** means an agency that:

1. is constituted, licensed and operated under the provision of Title XVIII of the Federal Social Security Act, or qualified to be so operated if application was made, and certified by the jurisdiction in which the Home Health Care plan is established; and
2. is engaged primarily in providing skilled nursing facility services and other therapeutic services in the Insured Person's Home under the supervision of a Physician or a Nurse; and
3. maintains clinical records on all patients.

**Home Health Care** means the continued care and treatment of an Insured Person if:

1. institutionalization of the Insured Person would have been required if Home Health Care was not provided; and
2. the Insured Person's physician establishes and approves in writing the plan of treatment covering the Home Health Care service; and
3. Home Health Care is provided by:
  - a. a Hospital that has a valid operating certificate and is certified to provide Home Health Care services; or
  - b. a public or private health service or agency that is licensed as a Home Health Agency under title 19, subtitle 4 of the General Health Article to provide coordinated Home Health Care.

**Hospice** means a coordinated plan of home and Inpatient care which treats the terminally ill patient and family as a unit. It provides care to meet the special needs of the unit during the final stages of a terminal illness and during the bereavement. Care is provided by a team of: trained medical personnel, homemakers, and counselors. The team acts under an independent Hospice administration. It helps the unit cope with: physical, mental, spiritual, social, and economic stresses.

**Hospital** means a facility which provides diagnosis, Treatment, and care of persons who need acute Inpatient Hospital care under the supervision of Physicians and provides 24-hour nursing service by Registered Nurses on duty or call. It must be licensed as a general acute care Hospital according to state and local laws. Hospital shall also include a psychiatric health facility for the Treatment of mental or psychoneurotic disorders. Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital also includes an Ambulatory Surgical Center or ambulatory medical center; and a birthing facility certified and licensed as such under the laws where located]. It shall also include Rehabilitative facilities if such is required for Treatment of physical disability.

Facilities primarily treating drug addiction or Alcoholism that are licensed to provide these services are also included. Hospital does not include a place primarily for rest, the aged, a place for educational or Custodial Care or Hospice.

**Immediate Family Member** means You and Your spouse, parent, child, or sibling of You or Your spouse.

**Insured Person** means an Insured Student or Dependent of an Insured Student while insured under the Certificate.

**Insured Student** means a student of the Policyholder who is eligible and insured for coverage under the Certificate.

**International Student** means an international student:

1. With a current passport and a student Visa;

2. Who for the time being outside of his or her Home Country; and
3. Is actively engaged as a student or in educational research activities through the Policyholder.

In so far as the Certificate is concerned, permanent residents or those who have applied for Permanent Residency Status are not considered to be an International Student.

**Loss** means medical expense caused by an Injury or Sickness which is covered by the Certificate.

**Medically Necessary or Medical Necessity** means health care services that a Physician, exercising prudent clinical judgment, would provide to an Insured Person. This is for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the Insured Person's illness, injury or disease; and
3. not primarily for the convenience of the Insured Person, Physician or other health care provider. And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or Treatment of that Insured Person's illness, injury or disease.

The fact that any particular Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

**Mental Health Disorder** means a condition or disorder that largely limits the life activities of the Insured Person. Mental Health Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization.

**Morbidly Obese** means a body mass index (\*BMI) greater than 40 kg/m<sup>2</sup> or a BMI greater than 35 kg/m<sup>2</sup> with at least one clinically significant obesity related disease. Such as diabetes mellitus, obstructive sleep apnea, coronary artery disease, or hypertension for which these complications or diseases are not controlled by best practice medical management.

**Non-Preferred Providers** have not agreed to any pre-arranged fee schedules.

**Non-Preferred Drug** means a drug that makes up the formulary drug list and may have a higher out-of-pocket cost.

**Nurse** means a licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who:

1. Is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
2. Provides medical services which are within the scope of the Nurse's license or certificate and who does not ordinarily reside in Your home or is not related to You by blood or marriage.

**Organ Transplant** means the moving of an organ from one body to another or from a donor site to another location of the person's own body, to replace the recipient's damaged, absent or malfunctioning organ.

**Out-of-Pocket Maximum:** means the most You will pay during a Policy Year before Your Coverage begins to pay 100% of the allowed amount. This limit will never include Premium, balance-billed charges or health care the Certificate does not cover.

**Physical Therapy** means any form of the following:

1. Physical or mechanical therapy;
2. Diathermy;
3. Ultra-sonic therapy;
4. Heat Treatment in any form; or
5. Manipulation or massage.

**Physician** means a health care professional practicing within the scope of his or her license and is duly licensed by the appropriate state regulatory agency to perform a particular service which is covered under the Certificate, and who is not:

1. The Insured Person;
2. An Immediate Family Member; or
3. A person employed or retained by the Insured Person.

**Preadmission Testing** means tests done in conjunction with and within 5 days of a scheduled surgery where an operating room has been reserved before the tests are done.

**Preferred Allowance** means the amount a Preferred Provider will accept as payment in full or Covered Medical Expenses.

**Preferred Drug** means a formulary drug that is within a select subset of therapeutic classes, which make up the formulary drug list.

**Preferred Providers** are Physicians, Hospitals and other healthcare providers who have contracted with Us to provide specific medical care at negotiated prices.

**Qualifying Life Event** means an event that qualifies a Student to apply for coverage for him/herself due to a Qualifying Life Event under the Certificate.

**Rehabilitative** means the process of restoring Your ability to live and work after a disabling condition by:

1. Helping You achieve the maximum possible physical and mental fitness;
2. Helping You regain the ability to care for yourself;
3. Aiding with relearning skills needed in everyday activities. This is done with occupational training and guidance with mental readjustment.

**Reservist** means a member of a reserve component of the Armed Forces of the United States. Reservists also includes a member of the State National Guard and the State Air National Guard.

**School or College** means the college or university attended by the Insured Student.

**Skilled Nursing Facility** means a facility, licensed, and operated as set forth in applicable state law, which:

1. Mainly provides inpatient care and Treatment for persons who are recovering from an illness or injury;
2. Provides care supervised by a Physician;
3. Provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. Is not a place primarily for the care of the aged, Custodial or Domiciliary Care, or Treatment of alcohol or drug dependency; and
5. Is not a rest, educational, or custodial facility or similar place.

**Sound, Natural Teeth** means natural teeth. The major portion of a tooth must be present, regardless of fillings, and not carious, abscessed or defective. Sound, Natural Teeth will not include capped teeth.

**Stabilize or Stabilization** means, with respect to an Emergency Medical Condition, to provide such medical Treatment of the condition as may be necessary to assure, within reasonable medical odds that no material decline of the condition is likely to result from or during the transfer of the person from a facility.

**Student Health Center or Student Infirmary** means an on-campus or designated by the Policyholder facility that provides:

1. Medical care and Treatment to Sick or Injured students; and
2. Nursing services.

A Student Health Center or Student Infirmary does not include:

1. Medical, diagnostic and Treatment facilities with major surgical facilities on its premises or available on a pre-arranged basis; or

## 2. Inpatient care.

**Substance Use Disorder** means any condition or disorder that largely limits the life activities of the Insured Person. Substance Use Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization.

**Surgeon** means a Physician who actually performs surgeries.

**Telemedicine** means the delivery of clinical health care services by means of real time two-way electronic audiovisual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, Treatment, and care management of a patient's health care while such patient is at an originating site and the health care provider is at a distant site, consistent with applicable federal laws and regulations. Telemedicine does not include an audio-only telephone conversation, email message or facsimile transmission between the provider and patient, or an automated computer program used to diagnose and/or treat ocular or refractive conditions.

**Treatment** means the medical care of a Covered Injury or Covered Sickness by a Physician who is operating within the scope of his or her license. Such care includes diagnostic, medical, surgical or therapeutic services. It also includes medical advice, consults, recommendation, and/or the taking of drug, medicines or prescriptions.

**Urgent Care** means short-term medical care performed in an Urgent Care Facility for non-life-threatening conditions that can be mitigated or require care within forty-eight (48) hours of onset.

**Urgent Care Facility** means a Hospital or other licensed facility which provides diagnosis, Treatment, and care of Insured Persons who need acute care under the supervision of Physicians.

**Usual and Reasonable** means the average charge, in the absence of insurance, of the provider for a service or supply, but not more than the prevailing charge in the area for a:

1. Like service by a provider with similar training or experience; or
2. Supply that is identical or substantially equivalent.

**You, or Your(s)** means an Insured Person, Insured Student, or Dependent of an Insured Student while insured under the Certificate.

**Visa** means the document issued by the United States Government that permits a person to participate in the educational activities of a college, university or other institution of higher learning either as a student or in another academic capacity. An International Student must have and maintain a valid visa, either an F-1 (Academic), J-1 (Exchange) or M-1 (Vocational) to continue as a student in the United States.

**We, Us, or Our** means Atlanta International Insurance Company or its agent. Also referred to as the Company.

## Preferred Provider Organization (PPO) Network

By enrolling in this Insurance Plan, you have the PHCS 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.phcs.com](http://www.phcs.com), or contact Consolidated Health Plans toll-free at (877) 657-5030, or [www.chpstudenthealth.com](http://www.chpstudenthealth.com) for assistance.

### Benefit Payments for Preferred Providers and Non-Preferred Providers

The Certificate provides benefits based on the type of health care provider You select. The Certificate provides access to both Preferred Providers and Non-Preferred Providers. Different benefits may be payable for Covered Medical Expenses rendered by Preferred Providers versus Non-Preferred Providers, as shown in the Schedule of Benefits.

## Pre-certification Process

You are responsible for calling Us at the phone number found on the back of Your ID card and starting the Pre-Certification process. For Inpatient services or surgery, the call should be made at least 5 working days prior to Hospital Confinement or surgery. In the case of an emergency, the call should take place as soon as reasonably possible.

The following Inpatient services require Pre-Certification:

1. All Inpatient admissions, including length of stay, to a Hospital, Skilled Nursing Facility, a facility established primarily for the Treatment of substance abuse, or a residential Treatment facility;
2. All Inpatient maternity care after the initial 48/96 hours;
3. Surgery.

Pre-Certification is not required for a medical emergency or Urgent Care.

Additionally, no authorization requirement will apply to obstetrical or gynecological care provided by in-network providers.

Pre-Certification is not a guarantee that Benefits will be paid.

Your Physician will be notified of Our decision as follows:

1. For elective (non-emergency) admissions to a health care facility, We will notify the Physician and the health care facility by telephone and/or in writing of the number of Inpatient days, if any, approved;
2. For Confinement in a health care facility longer than the originally approved number of days, the treating Physician or the facility must contact Us before the last approved day. We will review the request for continued stay to determine Medical Necessity and notify the Physician or the health care facility of Our decision in writing or by phone;
3. For any other covered services requiring Pre-Certification, We will contact the Provider in writing or by telephone regarding Our decision.

Our agent will make this determination within seventy-two (72) hours for an urgent request and four (4) business days for non-urgent requests following receipt of all necessary information for review. Notice of an Adverse Determination made by Our agent will be in writing and will include:

1. The reasons for the Adverse Determination including the clinical rationale, if any.
2. Instructions on how to initiate standard or urgent appeal.
3. Notice of the availability, upon Your request, or Your designee, of the clinical review criteria relied upon to make the Adverse Determination. This notice will specify what, if any additional necessary information must be provided to, or obtained by, Our agent in order to render a decision on any requested appeal.

Failure by Our agent to make a determination within the time periods prescribed shall be deemed to be an Adverse Determination subject to an appeal.

If You have any questions about Your Pre-Certification status, You should contact Your Provider.

## Schedule of Benefits

### SCHEDULE OF BENEFITS

#### Preventive Services:

Preferred Provider: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of Preferred Allowance when services are provided through a Preferred Provider.

Non-Preferred Provider: Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through a Non-Preferred Provider.

#### Deductible (will not exceed the Out-of-Pocket Maximum)

Preferred Provider	Individual: \$0
Non-Preferred Provider	Individual: \$0

**Out-of-Pocket Maximum (including Deductible)**

Preferred Provider:	Individual	\$6,350
Non-Preferred Provider:	Individual	\$6,350

**Hospital Inpatient Facility Copayment:**

Preferred Provider	\$100 per Admission
Non-Preferred Provider	\$100 per Admission

**Coinsurance Amount:**

Preferred Provider:	100% of the Preferred Allowance (PA) for Covered Medical Expenses unless otherwise stated below. Up to \$5,000 then 80% of PA
Non-Preferred Provider:	100% of the Usual and Reasonable (U&R) charge for Covered Medical Expenses unless otherwise stated below. Up to \$5,000 then 80% of U&R

**Benefit Payment for Preferred Providers and Non-Preferred Providers**

The Certificate provides benefits based on the type of health care provider selected. The Certificate provides access to both Preferred Providers and Non-Preferred Providers. Different benefits may be payable for Covered Medical Expenses rendered by Preferred Providers versus Non-Preferred Providers, as shown in the Schedule of Benefits.

**Preferred Provider Organization:**

To locate a PHSC Preferred Provider in Your area, consult Your Provider Directory or visit Our website at [www.chpstudenthealth.com](http://www.chpstudenthealth.com).

**THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:**

1. THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;
2. ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND
3. DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY A PREFERRED OR NON-PREFERRED PROVIDER.
4. UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE WILL ALWAYS APPLY.

BENEFITS FOR COVERED INJURY/SICKNESS	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
<b>Inpatient Benefits</b>		
Hospital Room & Board Expenses and miscellaneous services and supplies. Subject to Semi-Private room rate unless intensive care unit is required. Pre-Certification required	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Preadmission Testing	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Physician’s Visits while Confined:	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Inpatient Surgery: Surgeon Services	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Anesthetist	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Assistant Surgeon	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Pre-Certification required		

Physical Therapy (inpatient) Pre-Certification required	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Skilled Nursing Facility Expense Benefit Pre-Certification required	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Mental Health Disorder Benefit	Same as any other Covered Sickness	
Substance Use Disorder Benefit	Same as any other Covered Sickness	
<b>Outpatient Benefits</b>		
Outpatient Surgery: Surgeon Services	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Anesthetist	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Assistant Surgeon	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Outpatient Surgery Miscellaneous (excluding not-scheduled surgery) – expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Rehabilitation and Habilitative Therapy including cardiac rehabilitation, pulmonary rehabilitation, Physical Therapy, occupational therapy and speech therapy	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Emergency Services Expenses	The Preferred Allowance stated above Copayment: \$100	Same as Preferred Provider for Covered Medical Expenses
In Office Physician's Visits	The Preferred Allowance stated above Copayment: \$20	The Usual and Reasonable Charge stated above Copayment: \$20
Urgent Care Centers or Facilities	The Preferred Allowance stated above Copayment: \$75	The Usual and Reasonable Charge stated above Copayment: \$75
Outpatient Facility Fee	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Diagnostic Imaging Services	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
CT Scan, MRI and/or PET Scans	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Laboratory Procedures (Outpatient)	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above



<p><b>Prescription Drugs Retail Pharmacy</b>                  No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy or Student Health Center.</p>		
Generic Non-Preferred Provider benefits are provided on a reimbursement basis. Claim forms must be received within 90 days.	100% of Preferred Allowance after copayment Copayment: \$10	100% of Usual and Reasonable Charge for Covered Medical Expenses after copayment Copayment: \$10
Preferred Drug Non-Preferred Provider benefits are provided on a reimbursement basis. Claim forms must be received within 90 days.	100% of Preferred Allowance after copayment Copayment: \$20	100% of Usual and Reasonable Charge for Covered Medical Expenses after copayment Copayment: \$20
Non-Preferred Drug Non-Preferred Provider benefits are provided on a reimbursement basis. Claim forms must be received within 90 days.	100% of Preferred Allowance after copayment Copayment: \$20	100% of Usual and Reasonable Charge for Covered Medical Expenses after copayment Copayment: \$20
Specialty Prescription Drugs Non-Preferred Provider benefits are provided on a reimbursement basis. Claim forms must be received within 90 days.	100% of Preferred Allowance after copayment Copayment: \$20	100% of Usual and Reasonable Charge for Covered Medical Expenses after copayment Copayment: \$20
Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery	The Preferred Allowance stated above Copayment: \$20	The Usual and Reasonable Charge stated above Copayment: \$20
Home Health Care/House Calls Expenses	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Hospice Care Coverage	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Private-Duty Nursing	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Mental Health Disorder Benefit	Same as any other Covered Sickness	
Substance Use Disorder Benefit	Same as any other Covered Sickness	
<b>Other Benefits</b>		
Allergy Testing	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Allergy Injections/Treatment	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Ambulance Service ground and/or air, water transportation	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Braces and Appliances	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above

Durable Medical Equipment	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Dialysis Treatment	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Maternity Benefit	Same as any other Covered Sickness	
Routine Newborn Care	Same as any other Covered Sickness	
Consultant/Specialist Physician Services when requested by the attending Physician	The Preferred Allowance stated above Copayment: \$20	The Usual and Reasonable Charge stated above Copayment: \$20
Accidental Injury Dental Treatment	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Sickness Dental Expense for Insured Persons over age 18 Subject to \$250 per tooth	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Sports Accident Expense - incurred as the result of the play or practice of Intercollegiate, sports Up to \$1,500 per Accident	100% of Preferred Allowance for Covered Medical Expenses	100% of Usual and Reasonable Charge for Covered Medical Expenses
Non-emergency Care While Traveling Outside of the United States	The Usual and Reasonable Charge stated above	
Medical Evacuation Expense	100% Usual and Reasonable Charge for Covered Medical Expenses	
Repatriation Expense	100% Usual and Reasonable Charge for Covered Medical Expenses	
Prevention and Early Detection Services	100% of Preferred Allowance Deductible Waived (if any)	100% of Usual and Reasonable Charge for Covered Medical Expenses
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)	See Benefit in the Certificate for limitations	See Benefit in the Certificate for limitations
Preventive Dental Care Limited to 2 dental exams every 12 months	100% of Preferred Allowance for Preventive Dental Care	100% of the Usual and Reasonable Charge for Preventive Services
The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care:		
Emergency Dental	50% Usual and Reasonable	50% Usual and Reasonable
Routine Dental Care	50% Usual and Reasonable	50% Usual and Reasonable
Endodontic Services	50% Usual and Reasonable	50% Usual and Reasonable
Prosthodontic Services	50% Usual and Reasonable	50% Usual and Reasonable
Medically Necessary	50% Usual and Reasonable	50% Usual and Reasonable
Orthodontic Care	50% Usual and Reasonable	50% Usual and Reasonable

Pediatric Vision Care Exam Benefit (to the end of the month in which the Insured Person turns age 19) Limited to 1 visit per Policy Year	100% of Preferred Allowance for Covered Medical Expenses Deductible Waived (if any)	The Usual and Reasonable Charge stated above
Pediatric Vision Care Hardware Benefit (to the end of the month in which the Insured Person turns age 19) Limited to 1 pair of prescribed lenses and frames or contact lenses in lieu of eyeglasses per Policy Year	100% of Preferred Allowance for Covered Medical Expenses Deductible Waived (if any)	The Usual and Reasonable Charge stated above
Adult Vision Care Exam Benefit (age 19 and older) Routine Eye Exam once every 12 months	100% of Preferred Allowance for Covered Medical Expenses Deductible Waived (if any)	The Usual and Reasonable Charge stated above
Chiropractic Care Benefit	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Gender Dysphoria Benefit	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Organ Transplant Benefit	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Bariatric Surgery	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Telemedicine or Telehealth Service	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Chemotherapy and Radiation Therapy	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Infusion Therapy	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Prosthetic and Orthotic Devices	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Tuberculosis screening, Quantiferon B tests including shots (other than covered under preventive services)	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Asthma Education	Same as any other Covered Sickness	
Hemophilia Services	Same as any other Covered Sickness	
Mandated Benefits		
Approved Clinical Trial	Same as any other Covered Sickness	
Autism Spectrum Disorder	Same as any other Covered Sickness	
Contraceptive Coverage	Same as any other Preventive Service	
Diabetes Treatment Coverage	Same as any other Covered Sickness	
Hair Prosthesis - Wigs	Same as any other Covered Prosthetic Device	
Hearing Aids	The Preferred Allowance stated above	The Usual and Reasonable Charge stated above
Human Leukocyte Antigen Testing Limited to one (1) test per lifetime	Same as any other Covered Sickness	
Infertility Treatment	Same as any other Covered Sickness	

Inherited Metabolic Disorder – PKU – Enteral Formula	Same as any other Covered Sickness
Lead Poisoning Screening Benefit	Same as any other Preventive Service
Lyme Disease Treatment	Same as any other Covered Service
Mammograms and Pap Smears	Same as any other Covered Sickness, unless considered a Preventive Service
Mastectomy Treatment and Hospital Stay	Same as any other Surgical Coverage
Prostate and Colorectal Exams	Same as any other Preventive Service
Smoking Cessation Programs	Same as any other Covered Sickness, unless considered a Preventive Service
Treatment of Mental Health and Substance Use Disorders	Same as any other Covered Sickness

## Medical Evacuation Expense

The maximum benefit for Medical Evacuation is shown in the Schedule of Benefits.

If:

- a. You are unable to continue Your academic program as the result of a Covered Injury or Covered Sickness;
- b. That occurs while you are covered under the Certificate,

We will pay the necessary Usual and Reasonable charges for evacuation to another medical facility or Your Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

Payment of this benefit is subject to the following conditions:

- a. You must have been in a Hospital due to a Covered Injury or Covered Sickness for a confinement of five or more consecutive days immediately prior to medical evacuation;
- b. Prior to the medical evacuation occurring, the attending Physician must have recommended, and We must have approved the medical evacuation;
- c. We must approve the Usual and Reasonable Expenses incurred prior to the medical evacuation occurring, if applicable;
- d. No benefits are payable for Usual and Reasonable Expenses after the date Your insurance ends. However, if on the date Your insurance ends, You are in the Hospital, this benefit continues in force until the earlier of the date the confinement ends or 31 days after the date of termination;
- e. Evacuation to Your Home Country ends any further insurance under the Certificate for You; and
- f. Transport must be by the most direct and economical route.

## Repatriation Expense

The maximum benefit for Medical Evacuation is shown in the Schedule of Benefits.

If You die while covered under the Certificate, We will pay a benefit. The benefit will be the necessary Usual and Reasonable charges for preparation, including cremation, and transportation of the remains to Your place of residence in Your Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

## Exclusions and Limitations

**Exclusion Disclaimer:** Any exclusion in conflict with the Patient Protection and Affordable Care Act will be administered to comply with the requirements of the Act.

The Certificate does not cover loss nor provide benefits for any of the following, except as otherwise provided by the benefits of the Certificate and as shown in the Schedule of Benefits.

1. **International Students Only** - Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible.
2. Treatment, service or supply which is not Medically Necessary for the diagnosis, care or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended or approved by the

- person's attending physician or dentist.
3. medical services rendered by provider employed for or contracted with the School, including team physicians or trainers, except as specifically provided in the Schedule of Benefits or as part of the Student Health Center benefits provided by this plan.
  4. professional services rendered by an Immediate Family Member or anyone who lives with You.
  5. weak, strained or flat feet, corns, calluses ingrown toenails except for Treatment because of Injury, infection or disease
  6. prescription contraceptive diaphragms are covered but limited to one (1) per Policy Year;
  7. expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
  8. charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services provided by Student Health Fees.
  9. any expenses in excess of Usual and Reasonable charges except as provided in the Certificate.
  10. loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
  11. loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority.
  12. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate, sports in excess of \$1,500 per Accident;
  13. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport;
  14. Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which You are required to pay.
  15. services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
  16. expenses payable under any prior Certificate which was in force for the person making the claim.
  17. Injury sustained as the result of Your operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.
  18. expenses incurred after:
    - The date insurance ends as to an Insured Person, except as specified in the Extension of Benefits provision; and
    - The end of the Policy Year specified in the Benefit Schedule.
  19. Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the Certificate.
  20. charges incurred for acupuncture in any form, unless otherwise specifically covered under the Certificate.
  21. Weight management. Weight reduction. Nutrition programs. Treatment for obesity except morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat. this does not apply to nutritional counseling or any screening or assessment specifically provided under the Preventive Care Services benefit, or otherwise specifically covered under the Certificate.
  22. charges for hair growth or removal unless otherwise specifically covered under the Certificate.
  23. expenses for radial keratotomy and services in connection with eye exam, eye glasses or contact lenses except as required for repair caused by a Covered Injury; office visit exam for the fitting of prescription contact lenses, eyeglasses or duplicate spare eyeglasses or lenses or frames, eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes or specifically covered under the Pediatric and Adult Vision Care Benefit.
  24. Racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are routinely used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles) or other hazardous sport or hobby.
  25. expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical Treatment within 24 hours of the Accident or results from Reconstructive Surgery.
    - As used in this provision, **Reconstructive Surgery** means surgery performed to correct or repair abnormal structures of the body. This can be caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible.
    - As used in this provision, **Plastic or Cosmetic Surgery** means surgery that is performed to alter or

- reshape normal structures of the body to improve the patient's appearance or alter their personal concept of body image.
26. You are:
    - committing or attempting to commit a felony,
    - being engaged in an illegal occupation, or
    - participation in a riot.
  27. elective abortions.
  28. braces and appliances, except as specifically provided in the Schedule of Benefits.
  29. congenital defects, except as provided for newborn or adopted children added after the Effective Date of coverage.
  30. Custodial Care service and supplies.
  31. expenses that are not recommended and approved by a Physician.
  32. sexual reassignment surgery, except as provided when Medically Necessary or when Treatment is covered under the Certificate. This exclusion does not include related mental health counseling.
  33. routine harvesting and storage of stem cells from newborn cord blood, donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal or artificial organs or tissues
  34. cosmetic procedures related to Gender Dysphoria including but not limited to rhinoplasty, face lift, facial bone reduction, lip enhancement or reduction, blepharoplasty, breast augmentation, body contouring, reduction thyroid chondroplasty, hair removal, voice modification surgery, skin resurfacing, chin implants, nose implants.
  35. Under the Prescription Drug Benefit shown in the Schedule of Benefits, any drug or medicine:
    - which does not, by federal or state law, require a prescription order, even if a prescription is written, except as specifically provided in the Prescription Drug Benefit section of this plan;
    - drugs with over-the-counter equivalents;
    - for the purpose of weight control;
    - sexual enhancements drugs;
    - dietary supplements;
    - cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, or Treatment of acne except as specifically provided in the Certificate;
    - refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
    - drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
    - purchased after coverage under the Certificate ends;
    - consumed or administered at the place where it is dispensed;
    - if the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
  36. non-chemical addictions.
  37. non-physical, occupational, speech therapies (art, dance, etc.).
  38. modifications made to dwellings.
  39. general fitness, exercise programs
  40. hypnosis.
  41. rolfing.
  42. biofeedback.

## Third Party Refund

When:

1. You are injured through the negligent act or omission of another person (the "third party"); and
2. benefits are paid under the Certificate as a result of that Injury,

We are entitled to a refund by You of all Certificate benefits paid as a result of the Injury.

The refund must be made to the extent that You receive payment for the Injury from the third party or that third party's insurance carrier. We may file a lien against that third-party payment. Reasonable pro rata charges, such as legal fees and court costs, may be deducted from the refund made to Us. You must complete and return the required forms to Us upon request.

## Coordination of Benefits

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one Plan.

The order of benefit determination rules govern the order in which each Plan will pay a claim. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

## Right of Recovery

If the amount of payments made by Our Agent or Us is more than it should have paid under the COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or group that may be responsible for the benefits or services provided for the Insured Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## 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. Written notice of a claim must be submitted to the address below within 90 days after the date of Injury or commencement of Sickness covered by the Certificate, or as soon thereafter as is 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 90 days of service.

**Claims Administrator:**  
**CONSOLIDATED HEALTH PLANS**  
 2077 Roosevelt Avenue  
 Springfield, MA 01104  
 Toll Free (877) 657-5030  
[www.chpstudenthealth.com](http://www.chpstudenthealth.com)  
**Group Number: ST0903SH**

**Servicing Agent:**  
 University Health Plans, Inc.  
 15 Pacella Park Drive  
 Randolph, MA 02368  
 Phone: (800) 437-6448  
 Fax: (617) 472-6419  
[www.universityhealthplans.com](http://www.universityhealthplans.com)

Please visit our website for frequently asked questions and answers regarding this plan, or email us at [info@univhealthplans.com](mailto:info@univhealthplans.com)

## Claim Appeal Process

The Insured Person, or Insured Person's Authorized Representative, has the right to file an internal appeal when the Company or its review agent gives notice of an adverse benefit determination regarding the health care services furnished to the Insured Person. The internal appeal process may be initiated by the Insured Person, or Insured Person's authorized representative, within at least 180 days of receipt of an adverse benefit determination.

The written internal appeal request should include:

1. A statement specifically requesting an Internal Appeal of the adverse benefit determination;



2. The Insured Person's Name and ID number (from the ID card);
3. The date(s) of service;
4. The provider's name;
5. The reason the claim should be reconsidered; and
6. Any written comments, documents, records, or other material relevant to the claim.

**Claims Administrator:**  
**2077 Roosevelt Avenue**  
**Springfield, Massachusetts 01104**  
**(877) 657-5030**  
[www.chpstudenthealth.com](http://www.chpstudenthealth.com)

**The Student Health Insurance Plan is underwritten by:**  
**Atlanta International Insurance Company**  
**Flushing, NY**  
**As Policy form: RI SHIP CERT (2018)**

**For a copy of the Company's privacy notice you may go to:**  
[www.consolidatedhealthplan.com/about/hipaa](http://www.consolidatedhealthplan.com/about/hipaa)  
 (Please indicate the school you attend with your written request)  
 or  
 Request one from the Health Office at your School

***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.

## Value Added Services

The following are not affiliated with Atlanta International Insurance Company and the 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.chpstudenthealth.com](http://www.chpstudenthealth.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 (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.



With CareConnect from CHP Student Health, students have 24/7 access to professional assistance to help manage personal concerns, emotional issues, transition and adjustment concerns, academic stress, career development, and the demands of daily and family obligations.

Members in need of assistance simply call the behavioral health hotline on their ID card, **(888) 857-5462**, or via the CHP Student Health mobile app for immediate access to a masters-level mental health professional. Students are run through a clinical assessment to determine if CareConnect counseling, health center referral, or other treatment is necessary. To access mobile features, students simply download their school's app in their device's app store.