Juilliard

Student Health Insurance Plan

2017-2018

Designed exclusively for the students of The Juilliard School
Underwritten by Atlanta International Insurance Company (AIIC) | Flushing, NY

Policy Number: AIIC1718NYSHIP13
Group Number: ST0567SH
Effective: 9/1/2017 – 9/1/2018

CHP Student HEALTH

For Questions About:	Please Contact:
Insurance Benefits	Juilliard Health Services 212-799-5000 x.282 www.juilliard.edu/campus-life/health-counseling-services
Insurance Enrollment and Waiver	Juilliard Student Accounts 212-799-5000 ext. 231
Claims Processing, ID Cards, Preferred Provider Listings	CHP Student Health 2077 Roosevelt Avenue Springfield, MA 01104 877-657-5030 www.chpstudenthealth.com
Preferred Provider Listings	CHP Student Health or www.cigna.com
Prescription Drug Providers	CIGNA PBM www.cigna.com

Important Information About Your Health Plan

Am I Eligible?

All full-time students are automatically enrolled in the Juilliard Student Health Insurance Plan. All students are strongly encouraged to remain enrolled in the Student Health Insurance Plan.

Domestic students who are enrolled in 6 or more credits while at The Juilliard School will be automatically enrolled in and charged premium for the Plan.

International students who are enrolled in 6 or more credits while at The Juilliard School will be automatically enrolled in and charged premium for the Juilliard School Student Health Insurance Plan. The plan benefits meet the medical insurance requirements for international students holding "J" visas. Enrollment is mandatory for all international students, including students from Canada. The premium for coverage will be added to the student's tuition bill and coverage may not be waived under any circumstances.

How Do I Waive?

Students who are currently insured under a comparable U.S. health insurance plan, including Medicaid, may waive coverage under the Plan with proof of such existing coverage. The comparable U.S. health insurance plan must include coverage for medical services in New York City. The premium for coverage will be added to the student's tuition bill and will remain unless a successful waiver is completed by the waiver deadline of August 14, 2017. The waiver form is available on WebAdvisor.

Enrollment is mandatory for all international students, including students from Canada. The premium for coverage will be added to the student's tuition bill and coverage may not be waived under any circumstances.

A Message From Juilliard

Dear Full-Time Student:

While you are a student at The Juilliard School, your health is one of our foremost priorities. As a performing artist, you have unique physical and emotional health concerns. We strive to ensure the delivery of excellent health care for our students, all of whom use their bodies as vital instruments, whether in the concert hall, on the stage or in the dance studio. Further, we recognize that the cost of medical care in New York City can be quite high, and we want to be sure that you have adequate insurance protection and access to good health care. Towards that end, The Juilliard School offers on-campus Health and Counseling Services. Additionally, we have endeavored to provide student health insurance that is affordable and which offers excellent benefits.

1. Juilliard offers coverage under the Student Health Insurance Plan in compliance with New York insurance regulations and meets or exceeds the minimum insurance standards for student health insurance plans as established by the Affordable Care Act. The plan provides unlimited medical expense benefits for all covered injuries or sicknesses per coverage year. In addition, a prescription drug benefit is included. A $967 charge for the Student Health Insurance Plan has been added to your Fall and Spring Semester's tuition bills.
2. US citizens and permanent residents may waive enrollment in the Student Health Insurance Plan by providing documentation of other health insurance coverage, including Medicaid. The coverage provided by the alternative policy should be equal or greater to the coverage provided by the Student Health Insurance Plan as listed on the waiver form. Determination of adequacy of other coverage is the responsibility of the student or the Parent/Guardian of a minor student.
   a.) Complete the Student Health Insurance waiver form.
   b.) Return the Student Health Insurance waiver form to the Student Accounts Office at Juilliard with a copy of the front and back of the health insurance card from the alternative source. The form can be mailed with your Fall Semester tuition payment, but it must be received by the Student Accounts Office at Juilliard no later than August 14, 2017.
   c.) Enrollment is mandatory for all international students, including students from Canada. International students may not waive the Student Health Insurance Plan.
3. IMPORTANT LIMITATION NOTICE: When at school, in the absence of a Medical Emergency, and during Juilliard Health Services' normal business hours, the student's first visit for each condition must be to Health Services. A clinician there will provide a referral to an outside provider when deemed medically necessary. Students need new referrals every academic year. Expenses incurred for medical treatment received without the requisite referral may be covered at the non-preferred level of benefits.
4. Persons insured under this plan may choose to be treated within or outside of the Cigna Network. The network consists of hospitals, physicians, and other health care providers organized in a network for the purpose of delivering quality health care at affordable rates. In order to use the services of a participating provider, you must present the identification card that is mailed to all Insured Students and be referred by Health Services as explained in 3. above.
5. Juilliard Health Services will make every effort to refer you to a provider who is in the school insurance network. However, such a referral does not guarantee that all treatments, tests or medications you might receive from the provider are covered under the school insurance policy. If the outside provider advises you that tests and special treatments or surgery are warranted to diagnose and/or treat you, you should call the claim administrator, Consolidated Health Plans at (877) 657-5030 to clarify any coverage limitations. Juilliard Health Services makes no representation about coverage under any health insurance policy by referring you to an outside provider.
6. Your insurance ID card will be mailed directly to your student box. Please watch for it and after you receive it, keep it with you at all times. You can print your card online at www.chpstudent.com.

Please feel free to contact Juilliard Health Services at (212) 799-5000 ext. 282 with any questions or concerns.

Sincerely,
Juilliard Health and Counseling Services

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2077 Roosevelt Avenue
Springfield, MA 01104

Effective Dates & Costs

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

*The above rates include an administrative service fee.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	9/1/17	9/1/18	8/14/17

Rates for Undergraduate and International Students		
	Annual	Per Semester Charge
Student*	$1,934	$967**

**For Students, one-half of the Annual premium ($967) will be billed on the Fall semester tuition bill; the balance ($967) will be billed on the Spring/Summer semester tuition bill. Should a Covered Student withdraw from the University, the insurance under the Plan shall remain in effect until the end of the period for which the premium has been paid.

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. Your Participating Provider is responsible for requesting Preauthorization for in-network services.

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

Student Health Services Referral Requirement

The Certificate has a gatekeeper, usually known as a Primary Care Physician ("PCP"). The Certificate requires that the Student Health Services act as a Primary Care Physician ("PCP"). You need a Referral from Student Health Services before receiving care.

If a Member obtains a Referral, their Cost-Sharing may be lower. See the **Schedule of Benefits** section for **Cost-Sharing**.

Services Not Requiring a Referral from the Student Health Services. The Student Health Services is responsible for determining the most appropriate treatment for a Member's health care needs. You do not need a Referral from the Student Health Services to a Participating Provider for the following services:

- Primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, treatment of Acute gynecologic conditions, or for any care related to a pregnancy from a qualified Participating Provider of such services;
- Emergency Services;
- Pre-Hospital Emergency Medical Services and emergency ambulance transportation;
- Maternal depression screening;
- Urgent Care;
- When the Student Health Center is closed;
- When outside of New York City.
- Laboratory Services

In **Section II** of the **Certificate**, see other provisions under **The Role of Primary Care Physicians**.

Exclusions & Limitations

No coverage is available under the Certificate for the following:

A. Aviation
B. Convalescent and Custodial Care
C. Conversion Therapy
D. Cosmetic Services
E. Dental Services
F. Experimental or Investigational Treatment
G. Felony Participation
H. Foot care
I. Government Facility
J. Medically Necessary
K. Medicare or Other Government Program
L. Military Service
M. No-Fault Auto Insurance
N. Services Not Listed
O. Services Provided by a Family Member
P. Services Separately Billed by Hospital Employees
Q. Services with no Charge
R. Vision Services
S. War
T. Workers' Compensation

In Section XXII of the Certificate, see details of Exclusions and limitations.

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Schedule of Benefits

Student Health PPO Schedule of Benefits
Platinum | The Juilliard School

COST-SHARING	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
Medical Deductible • Individual	$0	$0	$100	
Out-of-Pocket Limit • Individual	$5,000	$5,000	$10,000	
Accidental Death and Dismemberment Benefits $10,000 **Annual Maximum**			See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how We calculate the Allowed Amount. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount.	
OFFICE VISITS	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	0% Coinsurance; not subject to Deductible	$10 Copayment, 10% Coinsurance With Referral; not subject to Deductible	$10 Copayment, 25% Coinsurance after Deductible	See benefit for description

Specialist Office Visits (or Home Visits) **Referral required**	0% Coinsurance; not subject to Deductible	$10 Copayment, 10% Coinsurance With Referral; not subject to Deductible	$10 Copayment, 25% Coinsurance after Deductible	See benefit for description
PREVENTIVE CARE	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	Covered in full	$10 Copayment, 25% Coinsurance after Deductible	See benefit for description
• Adult Annual Physical Examinations*	Covered in full	Covered in full	$10 Copayment, 25% Coinsurance after Deductible	
• Adult Immunizations*	Covered in full	Covered in full	$10 Copayment, 25% Coinsurance after Deductible	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Covered in full	$10 Copayment, 25% Coinsurance after Deductible	
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	Covered in full	$10 Copayment, 25% Coinsurance after Deductible	
• Sterilization Procedures for Women*	Covered in full	Covered in full	$10 Copayment, 25% Coinsurance after Deductible	
• Vasectomy	Covered in full	Covered in full	$10 Copayment, 25% Coinsurance after Deductible	
• Bone Density Testing*	Covered in full	Covered in full	$10 Copayment, 25% Coinsurance after Deductible	
• Screening for Prostate Cancer	Covered in full	Covered in full	$10 Copayment, 25% Coinsurance after Deductible	

• All other preventive services required by USPSTF and HRSA. *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Covered in Full Use Cost-Sharing for appropriate service (Primary Care Office Visit Specialist Office Visit Diagnostic Radiology Services Laboratory Procedures and Diagnostic Testing)	Covered in Full Use Cost-Sharing for appropriate service (Primary Care Office Visit Specialist Office Visit Diagnostic Radiology Services Laboratory Procedures and Diagnostic Testing)	$10 Copayment, 25% Coinsurance after Deductible Use Cost-Sharing for appropriate service (Primary Care Office Visit Specialist Office Visit Diagnostic Radiology Services Laboratory Procedures and Diagnostic Testing)	
EMERGENCY CARE	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	10% Coinsurance	10% Coinsurance	10% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services	10% Coinsurance	10% Coinsurance	10% Coinsurance after Deductible	See benefit for description
Emergency Department	10% Coinsurance	10% Coinsurance	10% Coinsurance	See benefit for description
Urgent Care Center	10% Coinsurance	10% Coinsurance	25% Coinsurance After Deductible	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services	10% Coinsurance 10% Coinsurance	$10 Copayment, 10% Coinsurance $10 Copayment, 10% Coinsurance	$10 Copayment, 25% Coinsurance after Deductible $10 Copayment, 25% Coinsurance after Deductible	See benefit for description

Referral Required				
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office **Referral Required**	0% Coinsurance; not subject to Deductible 0% Coinsurance; not subject to Deductible	$10 Copayment, 10% Coinsurance $10 Copayment, 10% Coinsurance	$10 Copayment, 25% Coinsurance after Deductible $10 Copayment 25% Coinsurance after Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee **Referral Required**	10% Coinsurance	10% Coinsurance	25% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings) **Referral Required**	10% Coinsurance	10% Coinsurance	25% Coinsurance after Deductible	See benefit for description
Autologous Blood Banking **Referral Required**	10% Coinsurance	10% Coinsurance	25% 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 **Referral Required**	0% Coinsurance; not subject to Deductible 0% Coinsurance; not subject to Deductible Included as part of inpatient Hospital service Cost-Sharing	$10 Copayment, 10% Coinsurance $10 Copayment, 10% Coinsurance Included as part of inpatient Hospital service Cost-Sharing	$10 Copayment, 25% Coinsurance after Deductible $10 Copayment, 25% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing	See benefits for description

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Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Referral Required**	0% Coinsurance; not subject to Deductible 0% Coinsurance; not subject to Deductible 0% Coinsurance; not subject to Deductible	$10 Copayment, 10% Coinsurance $10 Copayment, 10% Coinsurance $10 Copayment, 10% Coinsurance	$10 Copayment, 25% Coinsurance after Deductible $10 Copayment, 25% Coinsurance after Deductible $10 Copayment, 25% Coinsurance after Deductible	See benefit for description
Chiropractic Services **Referral Required**	0% Coinsurance; not subject to Deductible	10% Coinsurance	$10 Copayment, 25% Coinsurance after Deductible	See benefit for description
Clinical Trials **Preauthorization**	Use Cost-Sharing for appropriate service	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 **Referral Required**	0% Coinsurance; not subject to Deductible 0% Coinsurance; not subject to Deductible 0% Coinsurance; not subject to Deductible	$10 Copayment, 10% Coinsurance $10 Copayment, 10% Coinsurance $10 Copayment, 10% Coinsurance	$10 Copayment, 25% Coinsurance after Deductible $10 Copayment, 25% Coinsurance after Deductible $10 Copayment, 25% Coinsurance after Deductible	See benefit for description

Dialysis • Performed in a PCP Office	0% Coinsurance; not subject to Deductible	$10 Copayment, 10% Coinsurance	$10 Copayment, 25% Coinsurance after Deductible	See benefit for description
• Performed in a Freestanding Center or Specialist Office Setting	0% Coinsurance; not subject to Deductible	$10 Copayment, 10% Coinsurance	$10 Copayment, 25% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services **Referral Required**	0% Coinsurance; not subject to Deductible	$10 Copayment, 10% Coinsurance	$10 Copayment, 25% Coinsurance after Deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Referral Required**	0% Coinsurance; not subject to Deductible	$10 Copayment, 10% Coinsurance	$10 Copayment, 25% Coinsurance after Deductible	Unlimited visits
Home Health Care **Referral Required**	10% Coinsurance	10% Coinsurance	25% Coinsurance after Deductible	Unlimited visits
Infertility Services **Referral Required**	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)	Use Cost-Sharing for appropriate service (Office Visit Diagnostic Radiology Services Surgery Laboratory & Diagnostic Procedures)	See benefit for description

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Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy **Referral Required**	0% Coinsurance; not subject to Deductible 0% Coinsurance; not subject to Deductible 0% Coinsurance; not subject to Deductible 0% Coinsurance; not subject to Deductible	$10 Copayment, 10% Coinsurance 10 Copayment, 10% Coinsurance $10 Copayment, 10% Coinsurance $10 Copayment, 10% Coinsurance	$10 Copayment, 25% Coinsurance after Deductible $10 Copayment, 25% Coinsurance after Deductible $10 Copayment, 25% Coinsurance after Deductible $10 Copayment, 25% Coinsurance after Deductible	See benefit for description
Inpatient Medical Visits **Referral Required**	10% Coinsurance	10% Coinsurance	25% 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 **Referral Required**	0% Coinsurance; not subject to Deductible 0% Coinsurance; not subject to Deductible 0% Coinsurance; not subject to Deductible	$10 Copayment, 10% Coinsurance $10 Copayment, 10% Coinsurance $10 Copayment, 10% Coinsurance	$10 Copayment, 25% Coinsurance after Deductible $10 Copayment, 25% Coinsurance after Deductible $10 Copayment 25% Coinsurance after Deductible	See benefit for description
Medications administrated in Office • Performed in a PCP • Performed in Specialist Office **Referral Required**	0% Coinsurance; not subject to Deductible 0% Coinsurance; not subject to Deductible	$10 Copayment, 10% Coinsurance $10 Copayment, 10% Coinsurance	$10 Copayment, 25% Coinsurance after Deductible $10 Copayment, 25% Coinsurance after Deductible	

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Maternity and Newborn Care				See benefit for description
• Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	Covered in full	25% Coinsurance after Deductible	
• 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)	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	
• Inpatient Hospital Services and Birthing Center	10% Coinsurance	10% Coinsurance	25% Coinsurance after Deductible	
• Physician and Midwife Services for Delivery	10% Coinsurance	10% Coinsurance	25% Coinsurance after Deductible	One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early
• Breast Pump	Covered in full	Covered in full	25% Coinsurance after Deductible	
• Postnatal Care	Covered in full	Covered in full	25% Coinsurance after Deductible	Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	10% Coinsurance	10% Coinsurance	25% Coinsurance after Deductible	See benefit for description
Preadmission Testing **Referral Required**	0% Coinsurance; not subject to Deductible	$10 Copayment, 10% Coinsurance	$10 Copayment, 25% Coinsurance after Deductible	See benefit for description

Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services **Referral Required**	0% Coinsurance; not subject to Deductible 0% Coinsurance; not subject to Deductible 0% Coinsurance; not subject to Deductible	$10 Copayment, 10% Coinsurance $10 Copayment, 10% Coinsurance $10 Copayment, 10% Coinsurance	$10 Copayment, 25% Coinsurance after Deductible $10 Copayment, 25% Coinsurance after Deductible $10 Copayment, 25% Coinsurance after Deductible	See benefit for description
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services **Referral Required**	0% Coinsurance; not subject to Deductible 0% Coinsurance; not subject to Deductible	$10 Copayment, 10% Coinsurance $10 Copayment, 10% Coinsurance	$10 Copayment, 25% Coinsurance after Deductible $10 Copayment, 25% Coinsurance after Deductible	See benefit for description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Referral Required**	0% Coinsurance; not subject to Deductible	$10 Copayment, 10% Coinsurance	$10 Copayment, 25% Coinsurance after Deductible	Unlimited visits per Plan Year. Speech and physical therapy are only Covered following a Hospital stay or surgery
Second Opinions on the Diagnosis of Cancer, Surgery and Other **Referral Required**	0% Coinsurance; not subject to Deductible	$10 Copayment, 10% Coinsurance	$10 Copayment, 25% 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

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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 **Referral Required**	10% Coinsurance 0% Coinsurance; not subject to Deductible 0% Coinsurance; not subject to Deductible 0% Coinsurance; not subject to Deductible	10% Coinsurance 10% Coinsurance after Deductible 10% Coinsurance 10% Coinsurance	25% Coinsurance after Deductible 25% Coinsurance after Deductible 25% Coinsurance after Deductible 25% Coinsurance after Deductible	See benefit for description
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder **Referral Required**	0% Coinsurance; not subject to Deductible	10% Coinsurance	25% Coinsurance after Deductible	See benefit description
Assistive Communication Devices for Autism Spectrum Disorder **Referral Required**	10% Coinsurance	0% Coinsurance	25% Coinsurance after Deductible	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education Diabetic Equipment, Supplies and	10% Coinsurance	10% Coinsurance	25% Coinsurance after Deductible	See benefit for description See Prescription Drug benefit

Insulin (up to a 90 day supply) • Diabetic Education **Referral Required**	0% Coinsurance; not subject to Deductible	10% Coinsurance	25% Coinsurance after Deductible	
Durable Medical Equipment and Braces **Referral Required**	10% Coinsurance	10% Coinsurance	25% Coinsurance after Deductible	See benefit for description
External Hearing Aids **Referral Required**	10% Coinsurance	10% Coinsurance	25% Coinsurance after Deductible	
Cochlear Implants **Referral Required**	10% Coinsurance	10% Coinsurance	25% Coinsurance after Deductible	One per ear
Hospice Care • Inpatient • Outpatient **Referral Required**	10% Coinsurance 0% Coinsurance; not subject to Deductible	10% Coinsurance $10 Copayment, 10% Coinsurance	25% Coinsurance $10 Copayment, 25% Coinsurance after Deductible	Unlimited visits Five (5) visits for family bereavement counseling
Medical Supplies **Referral Required**	10% Coinsurance	10% Coinsurance	25% Coinsurance after Deductible	See benefit for description
Prosthetic Devices • External • Internal **Referral Required**	10% Coinsurance 10% Coinsurance	10% Coinsurance 10% Coinsurance	25% Coinsurance after Deductible 25% Coinsurance after Deductible	One (1) prosthetic device, per limb, per lifetime Unlimited See benefit for description

INPATIENT SERVICES and FACILITIES	Preferred Provider Member Responsibility for Cost-Sharing	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.**	10% Coinsurance	10% Coinsurance	25% Coinsurance after Deductible	See benefit for description
Observation Stay	10% Coinsurance	10% Coinsurance	25% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) **Referral Required**	10% Coinsurance	10% Coinsurance	25% Coinsurance after Deductible	Unlimited days See benefit for description
Inpatient Habilitation Services (Physical Speech and Occupational Therapy) **Referral Required**	10% Coinsurance	10% Coinsurance	25% Coinsurance after Deductible	Unlimited days See benefit for description
Inpatient Rehabilitation Services (Physical Speech and Occupational Therapy) **Referral Required**	10% Coinsurance	10% Coinsurance	25% Coinsurance after Deductible	Unlimited days See benefit for description

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	Preferred Provider Member Responsibility for Cost-Sharing	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) **Referral Required. However, Preauthorization is Not Required for emergency admissions.**	10% Coinsurance	10% Coinsurance	25% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) **Referral Required**	0% Coinsurance; not subject to Deductible	$10 Copayment, 10% Coinsurance	$10 Copayment, 25% Coinsurance after Deductible	See benefit for description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) **Referral Required. However, Preauthorization is Not Required for Emergency Admissions or for Participating OASAS-certified Facilities.**	10% Coinsurance	10% Coinsurance	25% Coinsurance after Deductible	See benefit for description
Outpatient Substance Use Services **Referral Required**	0% Coinsurance; not subject to Deductible	$10 Copayment, 10% Coinsurance	$10 Copayment, 25% Coinsurance after Deductible	Unlimited days per Plan Year may be used for family counseling See benefit for description

PRESCRIPTION DRUGS *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and obtained at a participating pharmacy	Preferred Provider Member Responsibility for Cost-Sharing	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 $25 Copayment $25 Copayment	 $10 Copayment $25 Copayment $25 Copayment	See benefit for description
Up to a 90-day supply for Maintenance Drugs Tier 1 Tier 2 Tier 3		 $30 Copayment $75 Copayment $75 Copayment	 $30 Copayment after Deductible $75 Copayment after Deductible $75 Copayment after Deductible	See benefit for description
Enteral Formulas Tier 1 Tier 2 Tier 3		 $10 Copayment $25 Copayment $25 Copayment	 $10 Copayment $25 Copayment $25 Copayment	See benefit for description

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Springfield, MA 01104

WELLNESS BENEFITS	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
Gym Reimbursement	Not applicable	Up to $200 per six (6) month period up to an additional $100 per six (6) month period for Spouse	Up to $200 per six (6) month period up to an additional $100 per six (6) month period for Spouse	See Benefit description
PEDIATRIC DENTAL and VISION CARE	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care				
• Preventive Dental Care	10% Coinsurance	10% Coinsurance	10% Coinsurance	One (1) dental exam and cleaning per six (6)-month period
• Routine Dental Care	10% Coinsurance	10% Coinsurance	10% Coinsurance	
• Major Dental (Endodontics, Periodontics, Oral Surgery and Prosthodontics)	10% Coinsurance	10% Coinsurance	10% Coinsurance	Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at six (6) month intervals
• Orthodontics	10% Coinsurance	10% Coinsurance	10% Coinsurance	
Pediatric Vision Care				
• Exams	10% Coinsurance	10% Coinsurance	10% Coinsurance	One (1) exam per Plan Year
• Lenses and Frames	10% Coinsurance	10% Coinsurance	10% Coinsurance	One (1) prescribed lenses and frames per Plan Year
• Contact Lenses	10% Coinsurance	10% Coinsurance	10% Coinsurance	

Non-emergency Care While Traveling Outside of the United States		25% Coinsurance of Actual Cost; not subject to Deductible		$1,000
Emergency Medical Evacuation		0% coinsurance; not subject to Deductible		$1,000,000 Annual Limits Combined with Repatriation Benefit.
Repatriation of Remains		0% coinsurance; not subject to Deductible		$1,000,000 Annual Limits Combined with Medical Evacuation Benefit.
Accidental Death and Dismemberment Benefits	N/A	N/A	N/A	$10,000 Principal Sum

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.

Administered by: Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104

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.

*ASK MAYO CLINIC

Students who enroll and maintain medical coverage in this insurance plan have access to a 24-hour nurse line administered by Ask Mayo Clinic. This program provides:

- Phone-based, reliable health information in response to health concerns and questions; and
- Assistance in decisions on the appropriate level of care for an injury or sickness.

Appropriate care may include self-care at home, a call to a physician, or a visit to the emergency room.

Calls are answered 24 hours a day, 365 days a year by experienced registered nurses who have been specifically trained to handle telephone health inquiries.

This program is not a substitute for doctor visits or emergency response systems. Ask Mayo Clinic does not answer health plan benefit questions. Health benefit questions should be referred to the Plan Administrator. The Ask Mayo Clinic 24-hour nurse line toll free number will be on the ID card.

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 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.