BUFFALO STATE
The State University of New York

Student Health Insurance Plan

Plan Year 17/18

Designed Exclusively for the Students of:

SUNY Buffalo State

Buffalo, NY

2017 - 2018

Underwritten by:
Atlanta International Insurance Company
Flushing, NY

Policy Number: AIIC1718NYSHIP46

Group Number: ST0780SH

Effective: 8/13/2017 - 8/13/2018

Administered by:
Consolidated Health Plans
2077 Roosevelt Ave | Springfield, MA

CHP Student HEALTH

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Where to Find Help

For Questions About:	Please Contact:
Waiver Process Health Services **Student Health Center Referral**	**Weigel Health Center** **(716) 878-6711** Weigel@buffalostate.edu
Insurance Benefits Enrollment ID Cards Online Waiver Claims Processing	**Consolidated Health Plans** 2077 Roosevelt Avenue Springfield, Massachusetts 01104 (800) 633-7867 **www.chpstudent.com**
Preferred PPO Provider Listings	**Cigna** **www.cigna.com**
Prescription Drug Provider Listings	**Cigna PBM** **www.cigna.com**

Am I Eligible?

ALL FULL TIME domestic graduate and undergraduate students enrolling in Fall 2017 will be charged $1,662 for the plan on their tuition bill. (A student is considered full time if they are taking 12 or more credit hours). Coverage will begin August 13, 2017 and ends on August 13, 2018, at 12:01 A.M.

Students who have not exhausted their federal loan or federal work study eligibility can contact the financial aid office (716) 878-4902 to see if their eligibility can be increased to cover the cost of health insurance. Also, a Student Health Insurance Assistance Fund has been established to assist students who are having difficulty in meeting the cost of mandatory health insurance. Contact the Weigel Health Center at (716) 878-6711 for more information.

The Student Health Insurance Plan is also available to part-time students and to dependents of insured students during open enrollment. Enrollment forms are available at Weigel Health Center. Dependent rates are listed in the plan brochure.

Please contact the Health Center staff at (716) 878-6711 or stop in for assistance with enrollment or the waiver process.

Coverage for Dependents

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

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

How Do I Waive/Enroll?

Students with existing insurance who do not wish to be on the plan, must complete the on-line waiver at: https://consolidatedhealthplan.com/SUNY-Buffalo/waiver **to avoid charges**. **The deadline to complete the online waiver is September 30, 2017.** Students who previously waived the SUNY Buffalo State Health Insurance **are required** to complete the waiver **annually**. Students who waive the insurance, then lose their private insurance

coverage, **are not automatically enrolled** into the school's insurance, and must contact the health center to request enrollment.

The Student Health Insurance Plan is also available to part-time students and to dependents of insured students during open enrollment. Enrollment forms are available at Weigel Health Center. Dependent rates are listed in the plan brochure.

Please contact the Health Center staff at (716) 878-6711 or stop in for assistance with enrollment or the waiver process.

Effective Dates & Costs

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

Coverage Period	Coverage Start Date	Coverage End Date	Waiver Deadline Date/ Dependent Enrollment Deadline Date
Annual	8/13/17	8/13/18	9/30/17
Spring	1/22/18	8/13/18	2/24/18
Summer	5/29/18	8/13/18	6/30/18

Rates for Full-Time, Part-Time Undergraduate, Graduate, International Students and Dependents
Dependent rates are in addition to the student rate.

	Annual	Spring (available to new Students in the Spring)	Summer (available to new Students in the Summer)
Student*	$1,662	$938	$370
Spouse*	$1,632	$908	$340
Each Child*	$1,632	$908	$340
3 or more Children*	$4,896	$2,724	$1,020

The above rates include an administrative service fee

Preferred Provider Organization (PPO) Network

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

Services Subject to Preauthorization

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

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

You must contact Us to request Preauthorization as follows:

- At least two (2) weeks prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.

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

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

Special Enrollment Periods

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

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

You, Your Spouse or Child can also enroll 31 days from exhaustion of Your COBRA or continuation coverage or if You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption.

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

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

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

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

Definitions

Acute: The onset of disease or injury, or a change in Your condition that would require prompt medical attention.

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

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

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

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

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

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

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

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

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

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

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

Dependents: The Student's Spouse and Children.

Durable Medical Equipment ("DME"): Durable Medical Equipment is equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

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

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

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such

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

Exclusions: Health care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

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

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

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

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

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to Article 40 of the New York Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

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

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

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

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a Hospital that usually doesn't require an overnight stay.

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

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

In-Network Deductible: The amount You owe before We begin to pay for Covered Services received from a Participating Provider. The In-Network Deductible applies before any Copayments or Coinsurance are applied. The In-Network Deductible may not apply to all Covered Services. You may also have an In-Network Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

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

Medically Necessary: See the How Your Coverage Works section of the certificate for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

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

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

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

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

Out-of-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Non-Participating Providers. The Out-of-Network Deductible applies before any Copayments or Coinsurance are applied. The Out-of-Network Deductible may not apply to all Covered Services. You may also have an Out-of-Network Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

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

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

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

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

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

Policyholder: The institution of higher education that has entered in to an Agreement with Us.

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

Premium: The amount that must be paid for Your health insurance coverage.

Prescription Drugs: A medication, product or device that has been approved by the Food and Drug Administration ("FDA") and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

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

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

Referral: An authorization given to one Participating Provider in order to arrange for additional care for You. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form. Except as provided in the Access to Care and Transitional Care section of the certificate or as otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider. A Referral is not required but is needed in order for You to pay the lower Cost-Sharing for certain services listed in the Schedule of Benefits section of the certificate.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Schedule of Benefits: The section of the certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York, in which we provide coverage. Our Service area consists of: Albany; Allegany; Bronx; Broome; Cattaraugus; Cayuga; Chautauqua; Chemung; Chenango; Clinton; Columbia; Cortland; Delaware; Dutchess; Erie; Essex; Franklin; Fulton; Genesee; Greene; Hamilton; Herkimer; Jefferson; Kings; Lewis; Livingston; Madison; Monroe; Montgomery; Nassau; New York; Niagara; Oneida; Onondaga; Ontario; Orange; Orleans; Oswego; Otsego; Putnam; Queens; Rensselaer; Richmond; Rockland; St. Lawrence; Saratoga; Schenectady; Schoharie; Schuyler; Seneca; Steuben; Suffolk; Sullivan; Tioga; Tompkins; Ulster; Warren; Washington; Wayne; Westchester; Wyoming; Yates County.

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

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

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

Student: The person to whom the certificate is issued.

Student Health Center: Any organization, facility, or clinic, operated, maintained, or supported by the school which provides health care services to a Student and has received accreditation by either the Accreditation Association of Ambulatory Health Care (AAAHC) or the Joint Commission for the ambulatory health care provided within their student health services.

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

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

Urgent Care Center: A licensed Facility (other than a Hospital) that provides Urgent Care.

Us, We, Our: Atlanta International Insurance Company and anyone to whom We legally delegate performance, on Our behalf, under the certificate.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

You, Your: The Member.

Exclusions and Limitations

No coverage is available under the certificate for the following:

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

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

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

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

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

F. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of the certificate, or when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of the certificate for a further explanation of Your Appeal rights.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Schedule of Benefits

Atlanta International Insurance Company
SCHEDULE OF BENEFITS
SUNY Buffalo State College

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible • Individual	$0	$0	
Out-of-Pocket Limit • Individual • Family	$3,500 $7,000	$7,000 $14,000	
Accidental Death and Dismemberment Benefits $10,000 Annual Maximum			
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$10 Copayment 0% Coinsurance	10% Coinsurance	See benefit for description
Specialist Office Visits (or Home Visits)	$10 Copayment 0% Coinsurance	10% Coinsurance	See benefit for description
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
• Well Child Visits and Immunizations*	Covered in full	30% Coinsurance	
• Adult Annual Physical Examinations*	Covered in full	30% Coinsurance	
• Adult Immunizations*	Covered in full	30% Coinsurance	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	30% Coinsurance	

• Mammography Screenings and Diagnostic Imaging for the Detection of Breast Cancer*	Covered in full	30% Coinsurance	See benefit for description
• Sterilization Procedures for Women*	Covered in full	30% Coinsurance	
• Vasectomy	20% Coinsurance	30% Coinsurance	
• Bone Density Testing*	Covered in full	30% Coinsurance	
• Screening for Prostate Cancer	Covered in full	30% Coinsurance	
• 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)	30% Coinsurance Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	0% Coinsurance	0% Coinsurance	See benefit for description
Non-Emergency Ambulance Services	0% Coinsurance	0% Coinsurance	See benefit for description
Emergency Department Copayment waived if Hospital admission	$75 Copayment 20% Coinsurance	$75 Copayment 20% Coinsurance	See benefit for description
Urgent Care Center	20% Coinsurance	30% Coinsurance	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Acupuncture	$10 Copayment 0% Coinsurance	10% Coinsurance	See Benefit for description
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting	 $10 Copayment 0% Coinsurance	 10% Coinsurance	See benefit for description

• Performed as Outpatient Hospital Services	20% Coinsurance	30% Coinsurance	
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office	 $10 Copayment 0% Coinsurance $10 Copayment 0% Coinsurance	 10% Coinsurance 10% Coinsurance	See benefit for description
Ambulatory Surgical Center Facility Fee	20% Coinsurance	30% Coinsurance	See benefit for description
Anesthesia Services (all settings)	20% Coinsurance	30% Coinsurance	See benefit for description
Autologous Blood Banking	20% Coinsurance	30% Coinsurance	See benefit for description
Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	 $10 Copayment 0% Coinsurance 20% Coinsurance Included as part of inpatient Hospital service Cost-Sharing	 10% Coinsurance 30% Coinsurance Included as part of inpatient Hospital service Cost-Sharing	See benefit for description
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $10 Copayment 0% Coinsurance $10 Copayment 0% Coinsurance 20% Coinsurance	 10% Coinsurance 10% Coinsurance 30% Coinsurance	See benefit for description
Chiropractic Services	20% Coinsurance	30% Coinsurance	See benefit for description
Clinical Trials	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office	 $10 Copayment 0% Coinsurance $10 Copayment 0% Coinsurance	 10% Coinsurance 10% Coinsurance	See benefit for description

• Performed as Outpatient Hospital Services	20% Coinsurance	30% Coinsurance	
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services	 $10 Copayment 0% Coinsurance $10 Copayment 0% Coinsurance 20% Coinsurance	 10% Coinsurance 10% Coinsurance 30% Coinsurance	See benefit for description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$10 Copayment 20% Coinsurance	$10 Copayment 30% Coinsurance	60 Visits per Plan Year
Home Health Care	20% Coinsurance	30% Coinsurance	
Infertility Services	Use Cost-Sharing for appropriate service (Office Visit, Diagnostic Radiology Services, Surgery, Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit, Diagnostic Radiology Services, Surgery, Laboratory & Diagnostic Procedures)	See benefit for description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	 $10 Copayment 0% Coinsurance $10 Copayment 0% Coinsurance 20% Coinsurance 20% Coinsurance	 10% Coinsurance 10% Coinsurance 30% Coinsurance 30% Coinsurance	See benefit for description
Inpatient Medical Visits	20% Coinsurance	30% Coinsurance	See benefit for description
Laboratory Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	 $10 Copayment 0% Coinsurance $10 Copayment 0% Coinsurance 20% Coinsurance	 10% Coinsurance 10% Coinsurance 30% Coinsurance	See benefit for description

Medications administrated in Office • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office	 0% Coinsurance 0% Coinsurance	 10% Coinsurance 10% Coinsurance	
Maternity and Newborn Care • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA • Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA • Inpatient Hospital Services and Birthing Center • Physician and Midwife Services for Delivery • Breast Pump • Postnatal Care	 Covered in full Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing) 20% Coinsurance 20% Coinsurance Covered in full 20% coinsurance	 30% coinsurance Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing) 30% coinsurance 30% coinsurance 30% coinsurance 30% coinsurance	See benefit for description One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	20% coinsurance	30% coinsurance	See benefit for description
Preadmission Testing	20% coinsurance	30% coinsurance	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	 $10 Copayment 0% Coinsurance $10 Copayment 0% Coinsurance 20% Coinsurance	 10% Coinsurance 10% Coinsurance 30% Coinsurance	See benefit for description

Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 $10 Copayment 0% Coinsurance 20% Coinsurance	 10% Coinsurance 30% Coinsurance	See benefit for description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$10 Copayment 20% Coinsurance	$10 Copayment 30% Coinsurance	60 visits per Plan Year
Second Opinions on the Diagnosis of Cancer, Surgery and Other	20% Coinsurance	30% Coinsurance Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.	See benefit for description
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery	 20% Coinsurance 20% Coinsurance 20% Coinsurance 20% Coinsurance	 30% Coinsurance 30% Coinsurance 30% Coinsurance 30% Coinsurance	See benefit for description
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	20% Coinsurance	30% Coinsurance	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	20% Coinsurance	30% Coinsurance	See benefit for description

Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin (up to a 90-day supply) • Diabetic Education	See the Prescription Drug Cost-Sharing 20% Coinsurance	See the Prescription Drug Cost-Sharing 30% Coinsurance	See benefit for description See Prescription Drug Benefit
Durable Medical Equipment and Braces	20% Coinsurance	30% Coinsurance	See benefit for description
External Hearing Aids	20% Coinsurance	30% Coinsurance	
Cochlear Implants	20% Coinsurance	30% Coinsurance	One per ear per time Covered
Hospice Care • Inpatient • Outpatient	20% Coinsurance 20% Coinsurance	30% Coinsurance 30% Coinsurance	Five (5) visits for family bereavement counseling
Medical Supplies	20% Coinsurance	30% Coinsurance	See benefit for description
Prosthetic Devices • External • Internal	20% Coinsurance 20% Coinsurance	30% Coinsurance 30% Coinsurance	One (1) prosthetic device per limb per lifetime Unlimited See benefit for description
Shoe Inserts	20% Coinsurance	30% Coinsurance	See benefit for description
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care) **Preauthorization Required. However, Preauthorization is not required for emergency admissions.**	20% Coinsurance	30% Coinsurance	See benefit for description
Observation Stay	20% Coinsurance	30% Coinsurance	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) **Preauthorization Required.**	20% Coinsurance	30% Coinsurance	200 days per Plan Year See benefit for description

Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization Required.**	20% Coinsurance	30% Coinsurance	
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization Required.**	20% Coinsurance	30% Coinsurance	60 days per Plan Year See benefit for description
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) **Preauthorization Required. However, Preauthorization is Not Required for emergency admissions.**	20% Coinsurance	30% Coinsurance	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	20% Coinsurance	30% Coinsurance	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital **Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions or for Participating OASAS-certified Facilities.**	20% Coinsurance	30% Coinsurance	See benefit for description
Outpatient Substance Use Services	20% Coinsurance	30% Coinsurance	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.**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**

Retail Pharmacy			
30-day supply Tier 1 Tier 2 Tier 3	 $10 Copayment 0% Coinsurance $25 Copayment 0% Coinsurance $25 Copayment 0% Coinsurance	 30% Coinsurance 30% Coinsurance 30% Coinsurance	See benefit for description
Enteral Formulas	20% Coinsurance	30% Coinsurance	See benefit for description
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Up to $200 per six (6) month period; up to an additional $100 per six (6) month period	Up to $200 per six (6) month period; up to an additional $100 per six (6) month period	See benefit for description
PEDIATRIC DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive Dental Care • Routine Dental Care • Major Dental (Endodontics, Periodontics, Oral Surgery and Prosthodontics) • Orthodontics **Orthodontics and Major Dental Require Preauthorization**	 0% Coinsurance 30% Coinsurance 50% Coinsurance 50% Coinsurance	 0% Coinsurance 30% Coinsurance 50% Coinsurance 50% Coinsurance	One (1) dental exam and cleaning per six (6) month period Full mouth x-rays or panoramic x-rays at 36 months intervals and bitewing x-rays at six (6) month intervals
Pediatric Vision Care • Exams • Lenses and Frames • Contact Lenses	 20% Coinsurance 20% Coinsurance 20% Coinsurance	 20% Coinsurance 20% Coinsurance 20% Coinsurance	 One (1) exam per Plan Year One (1) prescribed lenses and frames per Plan Year
Non-emergency Care While Traveling Outside of the United States	30% Coinsurance		$1,000 Annual Limit

Emergency Medical Evacuation	0% coinsurance of Actual Cost	0% coinsurance of Actual Cost	
Repatriation of Remains	0% coinsurance of Actual Cost	0% coinsurance of Actual Cost	
Accidental Death and Dismemberment Benefits	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.

Claim Procedures

In the event of either an Injury or a Sickness:

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

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

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

Grievances, Utilization Review, and Appeals

Claims Administrator:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
Toll Free (877) 657-5030
www.chpstudent.com
Group Number: ST0780SH

Value Added Services

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

VISION DISCOUNT PROGRAM

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

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

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

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

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