You can now review the SUNY Oswego Student Health Plan brochure. Please note that information included in this brochure is subject to change subsequent to regulatory approval of the policy by the New York Department of Financial Services.

SUNY Oswego
(“the Policyholder”)

2016 – 2017
Student Health Plan
(“the Plan”)

Administrator Group Number: S214016
Underwriter Reference Number: CAS9151538

Insurance underwritten by: National Union Fire Insurance Company of Pittsburgh, Pa., with its principal place of business in New York, NY (“Us,” “We,” “Our”)

This is only a brief description of the coverage available under policy series S30749NUFIC-PPO-NY (Rev. 4-15). The Policy contains definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy. If there is any conflict between contents of this brochure and the Policy, the Policy shall govern in all cases. The Policy is on file for review at SUNY Oswego. A Certificate of Coverage will be available to You in Your online account at www.studentinsurance.com/Schools/NY/Oswego. In addition, the Policy and Certificate of Coverage are available upon request. Insurance and services provided by member companies of American International Group, Inc. For additional information, please visit our website at www.AIG.com.

(Revision 8/17/16)
MARY WALKER HEALTH CENTER
The staff of Mary Walker Health Center is delighted to extend support to You in a non-judgmental and caring manner. Their collaborating physician is board certified in family medicine and their nurse practitioners are also board certified and specialized providers in the area of college health. The staff is highly experienced in responding to the medical and health concerns of the University’s diverse population of students. Mary Walker Health Center was recently re-accredited by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) for another three years.

The mission of the Mary Walker Health Center is to assist You in maintaining an optimal state of health. They are strong advocates of a healthy lifestyle and encourage You to take advantage of their resources.

HOW YOUR COVERAGE WORKS
SUNY Oswego (referred to as the “Policyholder”) has endorsed a Policy from Us. We will provide the benefits described in this brochure to covered Members of SUNY Oswego, that is, to an eligible Student. You should keep this brochure with Your other important papers so that it is available for Your future reference.

Covered Services
You will receive Covered Services under the terms and conditions of the Certificate only when the Covered Service is

- Medically Necessary;
- Provided by a Participating Provider for in-network coverage;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits; and
- Received while Your coverage is in force.
Magnacare PPO Network and PHCS/MultiPlan PPO Network Participating Providers

To find out if a Provider is a Magnacare PPO Network Participating Provider or PHCS/Multiplan PPO Network Participating Provider:

- Check Your Provider directories, available at Your request;
- Call 1-888-560-7427
- Visit Our website www.studentinsurance.com/Schools/NY/Oswego or www.magnacare.com or www.multiplan.com

The Role of Primary Care Physicians

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

For purposes of Cost-Sharing, if You seek services from a PCP (or a Physician covering for a PCP) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost-Sharing shown in the Schedule of Benefits when the services provided are related to specialty care.

Sometimes Providers in Our Provider directory are not available. You should call the Provider to make sure he or she is accepting new patients. To see a Provider, You should call the Provider’s office and tell the Provider that You are a SUNY Oswego Student Health Plan Member, and explain the reason for Your visit. You should have Your ID card available. The Provider’s office may ask You for Your Member ID number. When You go to the Provider’s office, You should bring Your ID card with You.

Out-of-Network Services

We Cover the services of Non-Participating Providers. However, some services are only Covered when You go to a Participating Provider. See the Schedule of Benefits for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.

Medical Necessity

We Cover benefits described in this brochure as long as the health care service, procedure, treatment, test, device, prescription drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:

- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment:
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example We will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis.

ELIGIBILITY

All full-time students of SUNY Oswego will be automatically enrolled in and charged for the SUNY Oswego Student Health Plan ("the Plan") unless coverage under the Plan is waived by showing proof of insurance under a comparable health insurance plan by the Fall semester waiver deadline date.

To waive coverage under the Plan, students must complete the waiver form, available at SUNY Oswego Auxiliary Services, and return it to SUNY Oswego Auxiliary Services, 507 Culkin Hall, Oswego, NY 13126 by the Fall semester waiver deadline date below.
All part-time students of SUNY Oswego are eligible to enroll for coverage in the Plan on a voluntary basis. To do this, eligible students should contact the Student Accounts Office at (315) 312-2225 by the Fall semester enrollment deadline date below to request that the charge for the Plan be added to their tuition bills.

The Policy becomes effective at 12:01 a.m. on August 1, 2016 and ends at 12:01 a.m. on August 1, 2017.

WHO IS COVERED

You, the Student, are covered under the Certificate.
We offer the following types of coverage:
1. **Individual.** If You selected individual coverage, then You are covered.

Coverage under the Certificate will begin as follows:
1. If You, the Student, elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by SUNY Oswego. SUNY Oswego cannot impose waiting periods that exceed 90 days.
2. If You, the Student, do not elect coverage upon becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, You must wait until the Policyholder’s next open enrollment period to enroll, except as provided below.

You can also enroll for coverage within 30 days of the loss of coverage in a health plan if coverage was terminated because You are no longer eligible for coverage under the other health plan due to:
1. Termination of employment;
2. Termination of the other health plan;
3. Death of the spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward a health plan were terminated; or
7. A child no longer qualifies for coverage as a child under another health plan.

You can also enroll 30 days from exhaustion of Your COBRA or continuation coverage.

We must receive notice and Premium payment within 30 days of the loss of coverage. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

In addition, You can also enroll for coverage within 60 days of the occurrence of one of the following events:
1. You lose eligibility for Medicaid or a state child health plan.
2. You become eligible for Medicaid or a state child health plan.

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

TERMINATION OF COVERAGE

Coverage under the Certificate will automatically be terminated on the first of the following to apply:
1. The Student has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.
2. The date on which the Student ceases to meet the eligibility requirements as defined by the Policyholder. We will provide written notice to the Student at least 30 days prior to when the coverage will cease.
3. Upon the Student’s death, coverage will terminate.
4. The end of the month during which the Student provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.
5. If a Student has performed an act that constitutes fraud the Student has or made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Student. However, if a Student makes an intentional misrepresentation of material fact in writing on his or her enrollment application, we will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Certificate.

6. The date that the Policyholder’s Policy is terminated. If We terminate and/or decide to stop offering a particular class of policies, without regard to claims experience or health related status, to which the Certificate belongs, We will provide the Policyholder and Students at least 90 days’ prior written notice.

7. If We elect to terminate or cease offering student accident and health insurance coverage in this state, We will provide written notice to the Policyholder and Student at least 180 days prior to when the coverage will cease.

8. The Policyholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

9. For such other reasons that are acceptable to the superintendent and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

EXTENSION OF BENEFITS

When Your coverage under the Certificate ends, benefits stop. If You are totally disabled on the date Your coverage under the Certificate terminates, continued benefits may be available for the treatment of the injury or sickness that is the cause of the total disability. If You are pregnant on the date Your coverage under the Certificate terminates, continued benefits may be available for Your maternity care.

For purposes of this section, “total disability” means You are prevented because of injury or disease from engaging in any work or other gainful activity. Total disability for a minor means that the minor is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

A. When You May Continue Benefit.

1. If You are totally disabled on the date Your coverage under the Certificate terminates, We will continue to pay for Your care under the Certificate during an uninterrupted period of total disability until the first of the following:
   - The date You are no longer totally disabled; or
   - 90 days from the date extended benefits began (if Your benefits are extended based on termination of Student status).

2. If You are pregnant on the date Your coverage under the Certificate terminates, We will continue to pay for Your maternity care under the Certificate through delivery and any post-partum services directly related to the delivery.

B. Limits on Extended Benefits.

We will not pay extended benefits:
   - For any Member who is not totally disabled or pregnant on the date coverage under the Certificate ends; or
   - Beyond the extent to which We would have paid benefits under the Certificate if coverage had not ended.

2016 – 2017 STUDENT HEALTH PLAN COST*

<table>
<thead>
<tr>
<th>Annual**</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/1/16 – 8/1/17</td>
</tr>
<tr>
<td>Student</td>
</tr>
</tbody>
</table>

*Includes administrative fees.

**The cost for the Annual Coverage Term will be billed in two installments of $700.00. The first installment will be billed by the College for the Fall Semester and the second installment will be billed by the College for the Spring Semester. Should You withdraw from SUNY Oswego, coverage under the Plan will terminate as of the last day for which premiums were paid.
## SUNY Oswego 2016-2017 Student Health Plan

**SUNY Oswego Student Health Plan Schedule of Benefits**

This Plan would satisfy the Platinum Level – Actuarial Value 91.12%

Aggregate Maximum Benefit per Injury or Sickness per Plan Year: UNLIMITED

<table>
<thead>
<tr>
<th>COST-SHARING</th>
<th>PARTICIPATING PROVIDER MEMBER RESPONSIBILITY FOR COST-SHARING</th>
<th>NON-PARTICIPATING PROVIDER MEMBER RESPONSIBILITY FOR COST-SHARING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible Individual</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Out-of-Pocket Limit Individual</td>
<td>$6,350</td>
<td>$6,350</td>
</tr>
</tbody>
</table>

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

#### Primary Care Office Visits (or Home Visits)

- **Participating Provider**
  - $15 Copayment
  - 10% Coinsurance after Deductible
- **Non-Participating Provider**
  - $15 Copayment
  - 25% Coinsurance after Deductible
- Limit: See coverage description in the Certificate

#### Specialist Office Visits (or Home Visits)

- **Participating Provider**
  - 10% Coinsurance after Deductible
- **Non-Participating Provider**
  - 25% Coinsurance after Deductible
- Limit: See coverage description in the Certificate

### Preventive Care

#### Well Child Visits and Immunizations*

- Covered in full
- 25% Coinsurance after Deductible
- Limit: See coverage description in the Certificate

#### Adult Annual Physical Examinations*

- Covered in full
- 25% Coinsurance after Deductible
- Limit: See coverage description in the Certificate

#### Adult Immunizations*

- Covered in full
- 25% Coinsurance after Deductible
- Limit: See coverage description in the Certificate

#### Routine Gynecological Services/ Well Woman Exams*

- Covered in full
- 25% Coinsurance after Deductible
- Limit: See coverage description in the Certificate

#### Mammography Screenings*

- Covered in full
- 25% Coinsurance after Deductible
- Limit: See coverage description in the Certificate

#### Sterilization Procedures for Women*

- Covered in full
- 25% Coinsurance after Deductible
- Limit: See coverage description in the Certificate

#### Vasectomy

- Covered in full
- 25% Coinsurance after Deductible
- Limit: See coverage description in the Certificate

#### Bone Density Testing*

- Covered in full
- 25% Coinsurance after Deductible
- Limit: See coverage description in the Certificate
### Screening for Prostate Cancer
- Covered in full
- 25% Coinsurance after Deductible
- See coverage description in the Certificate

### All other preventive services required 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)
- 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)
- See coverage description in the Certificate

### EMERGENCY CARE

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Participating Provider Responsibility for Cost-Sharing</th>
<th>Non-Participating Provider Responsibility for Cost-Sharing</th>
<th>Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Hospital Emergency Medical Services (Ambulance Services)</td>
<td>10% Coinsurance after Deductible</td>
<td>10% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Non-Emergency Ambulance Services</td>
<td>10% Coinsurance after Deductible</td>
<td>10% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>10% Coinsurance after Deductible</td>
<td>10% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
</tbody>
</table>

### PROFESSIONAL SERVICES AND OUTPATIENT CARE

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Participating Provider Responsibility for Cost-Sharing</th>
<th>Non-Participating Provider Responsibility for Cost-Sharing</th>
<th>Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Imaging Services</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Performed in a Freestanding Radiology Facility or Office Setting</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Performed as Outpatient Hospital Services</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Allergy Testing and Treatment</td>
<td>$15 Copayment</td>
<td>$15 Copayment</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Performed in a PCP Office</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Performed in a Specialist Office</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Ambulatory Surgical Center Facility Fee</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Anesthesia Services (all settings)</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Autologous Blood Banking</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Cardiac and Pulmonary Rehabilitation</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Performed in a Specialist Office</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Performed as Outpatient Hospital Services</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Service Description</td>
<td>Inpatient Hospital Service</td>
<td>Outpatient Hospital Service</td>
<td>Additional Information</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
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</tr>
<tr>
<td>Chemotherapy</td>
<td>Included as part of inpatient Hospital service Cost-Sharing</td>
<td>Included as part of inpatient Hospital service Cost-Sharing</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Performed in a PCP Office</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Performed in a Specialist Office</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Performed as Outpatient Hospital Services</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Clinical Trials</td>
<td>Use Cost-Sharing for appropriate service</td>
<td>Use Cost-Sharing for appropriate service</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>$15 Copayment 10% Coinsurance after Deductible</td>
<td>$15 Copayment 10% Coinsurance after Deductible 25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Performed in a PCP Office</td>
<td>$15 Copayment 10% Coinsurance after Deductible</td>
<td>$15 Copayment 10% Coinsurance after Deductible 25% Coinsurance after Deductible</td>
<td></td>
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<tr>
<td>Performed in a Specialist Office</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Performed as Outpatient Hospital Services</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>$15 Copayment 10% Coinsurance after Deductible</td>
<td>$15 Copayment 10% Coinsurance after Deductible 25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Performed in a PCP Office</td>
<td>$15 Copayment 10% Coinsurance after Deductible</td>
<td>$15 Copayment 10% Coinsurance after Deductible 25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Performed in a Freestanding Center or Specialist Office Setting</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Performed as Outpatient Hospital Services</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>40 visits per Plan Year See coverage description in the Certificate</td>
</tr>
<tr>
<td>Infertility Services</td>
<td>Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory &amp; Diagnostic Procedures)</td>
<td>Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory &amp; Diagnostic Procedures)</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>$15 Copayment 10% Coinsurance after Deductible</td>
<td>$15 Copayment 10% Coinsurance after Deductible 25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Performed in a PCP Office</td>
<td>$15 Copayment 10% Coinsurance after Deductible</td>
<td>$15 Copayment 10% Coinsurance after Deductible 25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Performed in Specialist Office</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>Notes</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Performed as Outpatient Hospital Services</td>
<td></td>
<td></td>
<td>Home infusion counts toward home health care visit limit</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Inpatient Medical Visits</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Laboratory Procedures</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Performed in a PCP Office</td>
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<td></td>
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</tr>
<tr>
<td>Performed in a Freestanding Laboratory Facility or Specialist Office</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Performed as Outpatient Hospital Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity and Newborn Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal Care</td>
<td>Covered in full</td>
<td>25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Services and Birthing Center</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early</td>
</tr>
<tr>
<td>Physician and Midwife Services for Delivery</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Breast Pump</td>
<td>Covered in full</td>
<td>25% Coinsurance after Deductible</td>
<td>Covered for duration of breast feeding</td>
</tr>
<tr>
<td>Postnatal Care</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital Surgery Facility Charge</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Preadmission Testing</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Diagnostic Radiology Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed in a PCP Office</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed in a Freestanding Radiology Facility or Specialist Office</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed as Outpatient Hospital Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapeutic Radiology Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed in a Freestanding Radiology Facility or Specialist Office</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed as Outpatient Hospital Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>Speech and physical therapy are only Covered following a Hospital stay or surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Service Description</td>
<td>Participating Provider Member Responsibility for Cost-Sharing</td>
<td>Non-Participating Provider Member Responsibility for Cost-Sharing</td>
<td>Limitation</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Second Opinions on the Diagnosis of Cancer, Surgery and Other</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)</td>
<td></td>
<td></td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Inpatient Hospital Surgery</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital Surgery</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Surgery Performed at an Ambulatory Surgical Center</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Office Surgery</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>ADDITIONAL SERVICES, EQUIPMENT AND DEVICES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABA Treatment for Autism Spectrum Disorder</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Assistive Communication Devices for Autism Spectrum Disorder</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Diabetic Equipment, Supplies and Self-Management Education</td>
<td></td>
<td></td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Diabetic Equipment, Supplies and Insulin (Up to a 90-day supply)</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Diabetic Education</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment and Braces</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>External Hearing Aids</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>Single purchase once every 3 years</td>
</tr>
<tr>
<td>Cochlear Implants</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>One per ear per time Covered</td>
</tr>
</tbody>
</table>

Second opinions on diagnosis of cancer are covered at participating Cost-Sharing for non-participating Specialist when a referral is obtained.
### Hospice Care

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>10% Coinsurance after Deductible</th>
<th>25% Coinsurance after Deductible</th>
<th>210 days per Plan Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>Five (5) visits for family bereavement counseling</td>
</tr>
</tbody>
</table>

### Medical Supplies

| 10% Coinsurance after Deductible | 25% Coinsurance after Deductible | See coverage description in the Certificate |

### Prosthetic Devices

| External | 10% Coinsurance after Deductible | 25% Coinsurance after Deductible | See coverage description in the Certificate |
| Internal | 10% Coinsurance after Deductible | 25% Coinsurance after Deductible | Unlimited |

### INPATIENT SERVICES AND FACILITIES

<table>
<thead>
<tr>
<th>PARTICIPATING PROVIDER MEMBER RESPONSIBILITY FOR COST-SHARING</th>
<th>NON-PARTICIPATING PROVIDER MEMBER RESPONSIBILITY FOR COST-SHARING</th>
<th>LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Observation Stay</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
</tr>
</tbody>
</table>

### MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

<table>
<thead>
<tr>
<th>PARTICIPATING PROVIDER MEMBER RESPONSIBILITY FOR COST-SHARING</th>
<th>NON-PARTICIPATING PROVIDER MEMBER RESPONSIBILITY FOR COST-SHARING</th>
<th>LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Mental Health Care (for a continuous confinement when in a Hospital)</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)</td>
<td>$15 Copayment 10% Coinsurance after Deductible</td>
<td>$15 Copayment 25% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Inpatient Substance Use Services (for a continuous confinement when in a Hospital)</td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Outpatient Substance Use Services</td>
<td>$15 Copayment 10% Coinsurance after Deductible</td>
<td>$15 Copayment 25% Coinsurance after Deductible</td>
</tr>
</tbody>
</table>
### PRESCRIPTION DRUGS

<table>
<thead>
<tr>
<th>30-day supply</th>
<th>PARTICIPATING PROVIDER MEMBER RESPONSIBILITY FOR COST-SHARING</th>
<th>NON-PARTICIPATING PROVIDER MEMBER RESPONSIBILITY FOR COST-SHARING</th>
<th>LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>$10 Copayment not subject to Deductible</td>
<td>$10 Copayment not subject to Deductible</td>
<td>See coverage description in the Certificate</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$10 Copayment not subject to Deductible</td>
<td>$10 Copayment not subject to Deductible</td>
<td>(FDA-approved contraceptive methods prescribed by a Provider are not subject to Copayments, Deductibles or Coinsurance.)</td>
</tr>
</tbody>
</table>

You must pay for the Prescription Drug at the time it is dispensed and then file a claim for reimbursement with Us.

Enteral Formulas

<table>
<thead>
<tr>
<th>Part</th>
<th>Participant Provider</th>
<th>Member Responsibility for Cost-Sharing</th>
<th>Non-Participant Provider</th>
<th>Member Responsibility for Cost-Sharing</th>
<th>Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>10% Coinsurance after Deductible</td>
<td>25% Coinsurance after Deductible</td>
<td>See coverage description in the Certificate</td>
<td></td>
</tr>
</tbody>
</table>

### PEDIATRIC DENTAL AND VISION CARE (for Members through the end of the month in which the Member turns 19 years of age)

<table>
<thead>
<tr>
<th>Pediatric Dental Care</th>
<th>PARTICIPATING PROVIDER MEMBER RESPONSIBILITY FOR COST-SHARING</th>
<th>NON-PARTICIPATING PROVIDER MEMBER RESPONSIBILITY FOR COST-SHARING</th>
<th>LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Dental Care</td>
<td>40% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
<td>One (1) dental exam and cleaning per six (6)-month period. Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at six (6) to 12-month intervals</td>
</tr>
<tr>
<td>Routine Dental Care</td>
<td>40% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Major Dental (Endodontics, Periodontics and Prosthodontics)</td>
<td>40% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
<td></td>
</tr>
<tr>
<td>Orthodontics</td>
<td>40% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pediatric Vision Care</th>
<th>PARTICIPATING PROVIDER MEMBER RESPONSIBILITY FOR COST-SHARING</th>
<th>NON-PARTICIPATING PROVIDER MEMBER RESPONSIBILITY FOR COST-SHARING</th>
<th>LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams</td>
<td>40% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
<td>One (1) exam per Plan Year</td>
</tr>
<tr>
<td>Lenses and Frames</td>
<td>40% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
<td>One (1) prescribed lenses and frames per Plan Year</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>40% Coinsurance after Deductible</td>
<td>40% Coinsurance after Deductible</td>
<td></td>
</tr>
</tbody>
</table>

### EXERCISE FACILITY REIMBURSEMENT

We will partially reimburse the Student for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities which maintain equipment and programs that promote cardiovascular wellness.

Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual workout visits. We will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages, etc.).

In order to be eligible for reimbursement, You must:
- Be an active member of the exercise facility, and
- Complete 50 visits in a six (6)-month period.
In order to obtain reimbursement, at the end of the six (6)-month period, You must submit:

- Documentation of the visits from the facility. Each time You visit the exercise facility, a facility representative must sign and date the documentation of the visits.
- A copy of Your current facility bill which shows the fee paid for Your membership.

Once We receive documentation of the visits and the bill, You will be reimbursed the lesser of $200 for the Student or the actual cost of the membership per six (6)-month period. Reimbursement must be requested within 120 days of the end of the six (6)-month period. Reimbursement will be issued only after You have completed each six (6)-month period even if 50 visits are completed sooner.

DEFINITIONS

**Allowed Amount:** means 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:** means a Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

**Balance Billing:** means 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:** means the Certificate issued by SUNY Oswego Student Health Plan, including the Schedule of Benefits and any attached riders.

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

**Copayment:** means 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:** means amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

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

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

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

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

**Emergency Services:** means a medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. “To stabilize” is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

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

**Health Care Professional:** means an appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist;
physician; 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:** means an organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

**Hospital:** means 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.

**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 Participating Providers. 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.

**Member:** means the Student for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a grievance or emergency department visit or admission, “Member” also means the Member’s designee.

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

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

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

**Out-of-Network 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 Your Premium, Balance Billing charges or services We do not Cover. You are also responsible for all differences, if any, between the Allowed Amount and the Non-Participating Provider’s charge for out-of-network services regardless of whether the Out-of-Pocket Limit has been met.

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

**Participating Provider:** means 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 www.studentinsurance.com/Schools/NY/Oswego or www.magnacare.com or www.multiplan.com or upon Your request to Us. The list will be revised from time to time by Us.

**Physician or Physician Services:** means 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.
Primary Care Physician ("PCP"): means 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: means 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 from another Participating Provider (usually from a PCP to a participating Specialist) in order to arrange for additional care for a Member.

Skilled Nursing Facility: means 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.

Student: means the person to whom the Certificate is issued.

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

Us, We, Our: means National Union Fire Insurance Company of Pittsburgh, Pa. and anyone to whom We legally delegate performance, on Our behalf, under the Policy.

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

D. Dental Services. We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in this brochure.

E. Experimental or Investigational Treatment. We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, or when Our denial of services is overturned by an external appeal agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the Certificate for non-investigational treatments. See the utilization review and external appeal sections of the Certificate for a further explanation of Your appeal rights.

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

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

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

I. Medically Necessary. In general, We will not Cover any health care service, procedure, treatment, test, device or prescription drug that We determine is not Medically Necessary. If an external appeal agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or prescription drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or prescription drug is otherwise Covered under the terms of the Certificate.
J. Medicare or Other Governmental Program. We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

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

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

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

N. Services Provided by a Family Member. We do not Cover services performed by a member of the covered person’s immediate family. “Immediate family” shall mean a child, spouse, mother, father, sister or brother of You or Your spouse.

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

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

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

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

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

CERTIFICATE OF CREDITABLE COVERAGE

Coverage under the Plan is creditable coverage under Federal Law. When coverage terminates, the Member can request a Certificate of Creditable Coverage, which is evidence of coverage under the Plan. In order to obtain a Certificate of Creditable Coverage, please visit our website at www.studentinsurance.com/Schools/ny/Oswego or contact Consolidated Health Plans at (877) 657-5030.

CLAIM FILING PROCEDURES

In the event of an accident or sickness, a Member should:

If at the University, You should report immediately to the SUNY Oswego Mary Walker Health Center so appropriate direction can be provided. If away from the University, You should consult a Physician and follow the Physician’s advice.

Claims can be accepted directly from Doctors and medical facilities if the claim includes the name of the Covered Person, Covered Student’s school name, date of services, diagnosis, treatment procedure and billed charges. 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. Claims can be submitted online at www.studentinsurance.com/Schools/ny/Oswego or fill in the necessary information and mail all itemized medical and Hospital bills to the following address:

Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104

Questions regarding benefits, specific claim information and periods of coverage should be directed to the above address or the following Consolidated Health Plans Customer Service phone number: (877) 657-5030

IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

Member Services Representatives are available Monday –Friday 8:30 a.m. to 5:00 p.m.

CLAIMS ADDRESS

Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104

CLAIMS QUESTIONS

Consolidated Health Plans
1-877-657-5030

COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS

Consolidated Health Plans
1-877-657-5030
MEMBER SERVICES

Consolidated Health Plans
1-877-657-5030

WEBSITE

www.studentinsurance.com/Schools/NY/Oswego

PLAN ADMINISTRATOR:

Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
1-877-657-5030

SCHOOL’S BROKER:

Austin & Company, Inc.
20 Corporate Woods Boulevard
Albany, NY 12211-2350
Phone: 518-465-3591

IMPORTANT INFORMATION

At AIG, we value the trust our customers have placed in us. That is why protecting the privacy of your personal information is of paramount importance to us. For more information, please go to our website at www.AIG.com.

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