

Student Accident and Sickness Insurance Program

Designed for the
Students of

CURRY COLLEGE

2011-2012

NATIONWIDE LIFE INSURANCE COMPANY
Columbus, Ohio

Policy Number: 302-539-2009


Effective August 18, 2011 to August 18, 2012

IMPORTANT NOTICE

This brochure provides a brief description of the important features of this Policy. It is not a Policy. Terms and conditions of the coverage are set forth in the Policy. We will notify Covered Persons of all material changes to the Policy. Please keep this material with your important papers.

NONDISCRIMINATORY

Health care services and any other benefits to which a Covered Person is entitled are provided on a nondiscriminatory basis, including benefits mandated by state and federal law.

 This health plan satisfies **Minimum Creditable Coverage standards** and will satisfy the individual mandate that you have health insurance. Please see page 3 for additional information.

PHCS PREFERRED PROVIDER NETWORK

By enrolling in this Insurance Program, you have PHCS Preferred Provider Network, except in the Western Massachusetts Counties of Hampden, Hampshire, Berkshire and Franklin where you have the CHP Preferred Provider Network, available to You and Your Dependents, if any, through Massachusetts, providing access to quality health care at discounted fees. A complete listing is available at www.phcs.com or www.consolidatedhealthplan.com.

A Preferred Provider may require a Covered Person to pay an annual fee for inclusion within the Preferred Providers panel of patients. Any services that are represented to be a part of the Preferred Provider's annual service agreement are part of that separate agreement and are not part of this Insurance Program.

THE PROGRAM DOES NOT REQUIRE YOU TO USE A PREFERRED PROVIDER. If a Preferred Provider is not available in a particular area or specialty, the Policy will cover at the Preferred Provider level until a provider has been added.

Coverage will be provided at the Preferred Provider level for a provider who is not a Preferred Provider for the first 30 days from the effective date of coverage if a Covered Person is undergoing an ongoing course of treatment or the provider is the Covered Person's primary care provider.

If the Covered Person is a female who is in her 2nd or 3rd trimester of pregnancy and whose provider in connection with her pregnancy is involuntarily disenrolled, other than disenrollment for quality-related reasons or fraud, treatment will be allowed with said provider, according to the terms of the Policy, for the period up to and including the Covered Persons first postpartum visit.

If a Covered Person is terminally ill and the provider in connection with said Sickness is involuntarily disenrolled, other than for quality related reasons or fraud, the Covered Person will be allowed to continue treatment with said provider, according to the terms of the Policy, until the death of the Covered Person.

Continued coverage is conditioned upon the provider agreeing to:

- Accept reimbursement at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the Covered Person in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled; and
- Adhere to the Policy's quality assurance standards and to provide necessary medical information related to the care provided; and
- Adhere to Our policies and procedures.

Physician profiling information may be available from the Board of Registration in Medicine for physicians licensed to practice in Massachusetts.

We will provide coverage for pediatric specialty care to Covered Persons requiring such services, including mental health services, by a person with recognized expertise in specialty pediatrics.

For a listing of Preferred Providers, please call PHCS at 1-866-559-7427 or Consolidated Health Plans at 1-413-733-4540 or 1-800-633-7867 for assistance.

You may also access this information on PHCS's website at: www.phcs.com or Consolidated Health Plan's website at: www.consolidatedhealthplans.com.

ELIGIBILITY AND EFFECTIVE DATE

To be eligible for this Insurance Program, You must be enrolled as a full-time student or carrying a course load equivalent to at least 3/4 full-time. **If You are eligible to be covered under this Program, You are automatically enrolled unless You can certify that You have comparable coverage.**

You may enroll in this Insurance Program only during the 31-day periods beginning with the start of the first and second semesters. If You are eligible for coverage and wish to enroll in the Program after these enrollment opportunities, You must present documentation from Your former insurance company that it is no longer providing You with personal accident and health insurance coverage. Your effective date under this Program will be the date Your former insurance expired, if You make the request for coverage within 31 days after it expires. Otherwise, the effective date will be the 1st of the month following our request. Your premium for this coverage must accompany the request.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan satisfies **Minimum Creditable Coverage** standards that are effective during the term of coverage as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirements that you have health insurance meeting these standards.

THIS DOCUMENT IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2009. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

TERM OF COVERAGE

The insurance under Curry College's Student Accident and Sickness Insurance Plan for the Annual Policy is effective at 12:01 a.m. on August 18, 2011. An eligible student's coverage becomes effective on that date or the date the application and full premium are received by the Company or Servicing Agent, whichever is later. The Annual Policy terminates at 12:01 a.m. on August 18, 2012 or at the end of the period through which the premium was paid. For new students registered for the Second Semester, coverage is effective at 12:01 a.m. on January 21, 2012 or the date the application and full premium are received by the Company or Servicing Agent, whichever is later and terminates at 12:01 a.m. on August 18, 2012 or at the end of the period through which the premiums are paid.

The deadline for traditional students to waive this coverage is July 14, 2011 for annual coverage and February 1, 2012 for second semester coverage.

Students who have waived coverage can purchase coverage during a semester if they furnish proof that they lost their parent's coverage, or otherwise had a change in their personal insurance status. Coverage will start upon receipt of the premium, which must be paid for that semester and through the remainder of the policy year.

INSURANCE COST

Premium for coverage must be received within the 31-day periods beginning with the start of the first and second semesters.

	Annual	Spring
Student	\$1,322*	\$754*

* An Administrative fee has been included in the premium.

REFUND OF PREMIUM

Except for medical withdrawal due to a covered Injury or Sickness, any student withdrawing from school during the first 31 days of the period for which coverage is purchased shall not be covered under the Policy and a full refund of the premium will be made. Students withdrawing after such 31 days will remain covered under the Policy for the full period for which premium has been paid and no refund will be allowed.

Covered Persons entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made for such person upon written request received by the Company within 90 days of withdrawal from school. Refunds for any other reason are not available.

TERMINATION OF COVERAGE

Your coverage will terminate on the earliest of one of the following: upon entry into the armed forces of any country; or the end of the coverage period for which premium was paid; or the date the Policy terminates. No benefits are payable after termination, except as stated in the Extension of Benefits provision.

A Covered Person's coverage may be cancelled, or its renewal refused, only in the following circumstances: failure by the Covered Person or other responsible party to make payments under the Policy; misrepresentation or fraud on the part of the Covered Person; commission of acts of physical or verbal abuse by the Covered Person which pose a threat to providers or other insureds and which are unrelated to the Covered Person's physical or mental condition; relocation of the Covered Person outside the Policy's service area; or non-renewal or cancellation of the Policy through which the Covered Person receives coverage or the Covered Person is no longer a student or Dependent.

No Covered Persons were involuntarily disenrolled within the past 2 years.

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under the Policy ceases on the Termination Date. However, if a Covered Person is hospital confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 90 days after the Termination Date.

The total payments made in respect of the Covered Person for such condition both before and after the Termination Date will never exceed the Maximum Benefit. After this Extension of Benefits After Termination provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

DEFINITIONS

Accident means a sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while a Covered Person is insured under the policy.

Biologically-Based Mental Disorders means those disorders described in the most recent edition of the Diagnostic and

Statistical Manual of the American Psychiatric Association, referred to as "the DSM": schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, eating disorders, post traumatic stress disorder, substance abuse disorders, autism, and any biologically-based mental disorders appearing in the DSM that are scientifically recognized and approved by the commissioner of the department of mental health in consultation with the commissioner of the division of insurance.

CHP Preferred Provider means a provider in the Consolidated Health Plans network who contracts to provide services at a discounted rate.

Co-payment means separate charge for certain Covered Medical Expenses which is paid by the Covered Person.

Covered Medical Expense means the Reasonable and Customary Charge for a service or supply, which is performed or given under the direction of a Doctor for the treatment of Injury or Sickness pursuant to the terms of the Policy.

Covered Person means You as an insured under the Plan.

Creditable Coverage means any blanket or general policy of medical, surgical or health insurance, including the Policy; any policy of accident or sickness insurance that provides hospital or surgical expense coverage; any non-group medical, surgical or hospital insurance; any non-group or group hospital or medical service plan issued by a non-profit hospital or medical corporation; any non-group health maintenance contract issued by a health maintenance organization; any self-insured or self-funded employer group health plan; any health coverage provided to persons serving in the Armed Forces of the United States; or Medicare or Medicaid.

Doctor means a licensed practitioner of the healing arts acting within the scope of his or her license. The Doctor may not be a member of the Covered Person's immediate family. Doctor includes podiatrists, chiropractors, certified registered nurse anesthetist, nurse practitioner and certified nurse midwife.

Emergency Medical Condition means a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of a Covered Person or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, serious jeopardy to the fetus.

A Covered Person has the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever a Covered Person is confronted with an Emergency Medical Condition which in the judgment of a prudent layperson would require pre-hospital emergency services. No Covered Person shall in any way be discouraged from using the local pre-hospital emergency medical services system, the 911 telephone number, or the local equivalent, or be denied coverage for medical and transportation expenses incurred as a result of such emergency medical condition.

Experimental/Investigative Services and Charges: Will not be considered experimental/investigative if successfully completed Stage III clinical trials of the United States Food and Drug Administration.

Home Health Care means part-time nursing care, by or supervised by, a registered graduate nurse; part-time home health aide service which consists mainly of caring for the patient; physical, occupational, respiratory or speech therapy; nutrition counseling; medical social services by a qualified social worker licensed by the jurisdiction where services are rendered; medical supplies, prosthetic and orthopedic appliances, rental or purchase of durable medical equipment, drugs and medicines obtainable by prescription only, including insulin, but only to the extent that such charges would have been considered covered expenses had the Covered Person required confinement in a hospital or in a skilled nursing facility.

Hospice Care means Doctor services; nursing care provided by or under the supervision of a registered professional nurse; social services; volunteer services; and counseling services provided by a professional or volunteer staff under professional supervision.

Injury means bodily harm caused by an Accident, which results in loss. All Injuries sustained in one Accident, including related conditions, will be considered one Injury.

Licensed Mental Health Professional means a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist.

Loss means medical expense caused by Injury and Sickness and covered by the Policy.

Mental Illness means either the Biologically-Based Mental Disorders; or rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to commit rape; or a Non-Biologically Based Mental, Behavioral or Emotional

Disorder of a Child or Adolescent Under the Age of 19; or all other mental disorders described in the most recent edition of the DSM.

Non-Biologically Based Mental, Behavioral or Emotional Disorders of a Child or Adolescent Under the Age of 19 means a disorder described in the most recent edition of the DSM which substantially interferes with or substantially limits the functioning and social interactions of such a child or adolescent; provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by the primary care Doctor, primary pediatrician, or a Licensed Mental Health Professional of such a child or adolescent or is evidenced by conduct, including, but not limited to: 1) an inability to attend school as a result of such a disorder, 2) the need to hospitalize the child or adolescent as a result of such disorder, or 3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others. The Policy shall continue to provide such coverage to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's 19th birthday until said course of treatment, as specified in said adolescent's treatment plan, is completed and while the benefit contract under which such benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect.

PHCS Preferred Provider means a provider in the PHCS network who contracts to provide services at a discounted rate.

Pre-existing Condition means a condition that manifested itself during the 6 months immediately preceding the Covered Person's effective date of coverage in such a manner as would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received.

Diagnosis, care or treatment shall not include any prior diagnosis of or prior treatment for infertility.

Preventive Care Services means services rendered to a Dependent child from the date of birth through the attainment of six (6) years of age and shall include physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals: six (6) times during the child's first year after birth, three (3) times during the next year, annually until age six (6). Such services shall also include hereditary and metabolic screening at birth, newborn test, appropriate immunizations, lead screening, and tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the Doctor. **This benefit is only available for the 31-day newborn coverage and ends after 31 days.**

Reasonable and Customary Charge (R&C) means usual amount charged by a Provider for a service or supply, regardless of insurance coverage, but not more than the amount charged by most providers in the same area for a similar service.

Sickness (Sick) means illness or disease which begins or for which expense is incurred while coverage is in force under the Policy. Sickness includes normal pregnancy and complications of pregnancy. All related conditions and recurring symptoms of a Sickness will be considered one Sickness.

We, Our, or Us means Nationwide Life Insurance Company.

You, Your, Yours means the insured student.

BASIC ACCIDENT AND SICKNESS EXPENSE BENEFITS

The Policy will pay 80%, except as specifically stated, of Covered Medical Expenses incurred by a Covered Person due to a covered Sickness or covered Injury, up to a maximum benefit of \$50,000 per Sickness or Injury. Payments made to non-preferred providers shall be a percentage of the provider's fees, up to the Reasonable and Customary charge, and not a percentage of the amount paid to Preferred Providers. Covered Medical Expenses are considered incurred on the date the treatment or service is rendered or the supply is furnished. Covered Medical Expenses are:

Hospital Room and Board and general nursing care while hospital confined, up to the semi-private room rate or intensive care unit rate, if applicable.

Miscellaneous Hospital Charges incurred while hospital confined, including expenses for: anesthesia; operating room; laboratory tests; x-rays; oxygen tent; pre-admission tests; medicines or supplies; dressings; other non-room and board expenses; prescription drugs, excluding take-home drugs.

Services of a Doctor during Hospital Confinement limited to one visit per day. This benefit does not apply when related to surgery.

Licensed Nurse Expense services of a private duty Registered Nurse or Licensed Practical Nurse.

Ambulance Expense for an Emergency Medical Condition: 100% up to \$800 per Injury or Sickness.

Surgical Expense limited to \$5,000 per surgery, includes a surgical procedure, necessary pre-operative treatment in connection with such procedure and usual post-operative treatment. When more than one (1) surgical procedure is performed through the same incision or in immediate succession, the additional surgery will be covered at 50%.

Second Surgical Opinion by a board certified specialist in the medical field relating to the surgical procedure to be performed. Benefit includes x-rays and diagnostic tests when elective surgery

is recommended. This benefit shall not exceed 5% of the amount paid to the surgeon.

Anesthesia and Assistant Surgeon Services of an Anesthetist who is not employed or retained by the hospital in which the surgery is performed, and services of an Assistant Surgeon required by the hospital, or by the procedure, will be provided for Covered Medical Expenses up to 30% of the amount paid to the surgeon not to exceed \$1,500.

Outpatient Services provided in a Doctor's office, Licensed Mental Health Professional's office, a community mental health center, home based services for Mental Illness, chiropractor visits, consultant or specialist visits, hospital or outpatient department or emergency room, clinical lab, radiological facility or similar facility licensed by the state, unless specifically stated elsewhere, subject to the following per visit Copayments:

- **Emergency Room** not resulting in a hospital admission - will be paid at 100% after a \$50 per visit Deductible/Co-payment.
- **Doctor's office visits to a PHCS Preferred Provider or a CHP Preferred Provider** will be paid at 100% after a \$8 per visit Co-payment.
- **Doctor's office visits to a Non-PHCS Preferred Provider or a Non-CHP Preferred Provider** will be paid at 100% after a \$25 per visit Deductible.

Physiotherapy Treatments prescribed by a Doctor. The prescription must be for a stated number of treatments.

Wellness Expense Benefit expenses incurred for one (1) preventative care visit (not including mandated benefits) provided by a Doctor up to a maximum of \$100.

Termination of Pregnancy covered medical expense resulting from the termination of a pregnancy up to a maximum benefit of \$300. Inception must have occurred while covered under the plan. No other benefits are payable.

Pre-Admission Testing Expense charges while an outpatient before scheduled surgery.

Laboratory and X-Ray Expenses will be provided up to 100% for Covered Medical Expenses.

Durable Medical Equipment (DME) will be provided up to 100% for Covered Medical Expenses.

Dental Injury Expense include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition Natural teeth damaged, lost, or removed, or other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under this Plan and benefits will be subject to Deductible, Coinsurance, and Co-Payments. This benefit does not apply to fillings, crowns, bridges, etc.

Impacted Wisdom Teeth Expense for removal of one (1) or more impacted wisdom teeth will be provided up to 80% of Actual Charge.

Speech or Hearing Therapy Expense for Covered Medical Expenses incurred for the diagnosis or treatment by a Physician for acute speech, hearing, and language disorders including charges for: rehabilitative services rendered that are expected to restore or improve a person's ability to speak or hear; and diagnostic services rendered to find out if, and to what extent, the Insured's ability to speak or hear is lost or impaired.

OTHER BENEFITS

All Policy provisions, including benefit maximums, coinsurance amounts, limitations, exclusions and general Provisions apply unless specifically stated otherwise.

High Cost Procedure Expense covered Medical Expenses for high cost procedures in excess of \$200, such as, but not limited to, outpatient diagnostic C.A.T. Scans, Magnetic Resonance Imaging, and Laser treatments are payable at 80% of the negotiated charge (Preferred Provider) or 80% of reasonable & customary charge (Non-Preferred Provider) to a maximum of \$2,000 per Accident or Sickness.

Mental Illness Treatment for Biologically Based Mental Disorders rape-related mental or emotional disorders; and Non-Biologically Based Mental, Behavioral or Emotional Disorders of Children and Adolescents Under the Age of 19 will be paid the same as any other Sickness, except the diagnosis and treatment of rape-related mental or emotional disorders will be paid only if the costs of such diagnosis and treatment exceed the maximum compensation awarded to such victims. Treatment will consist of inpatient, intermediate and outpatient services that permit active and noncustodial treatment to take place in the least restrictive clinically appropriate setting.

Mental Illness Treatment of all other Mental Disorders which are described in the most recent edition of the DMS, consisting of inpatient, intermediate and outpatient services that permit active and noncustodial treatment to take place in the least restrictive clinically appropriate setting. Treatment is limited during each 12-month period for a minimum of 60 days inpatient treatment and 24 outpatient visits.

Psychopharmacological Services and Neuropsychological Assessment Services Expense.

Cytological Screening And Mammogram benefits will be provided for: an annual cytological (pap smear) screening for ages 18 and over; a baseline mammogram for ages 35 through 39; and a mammogram every year for women age 40 and over.

Home Health Care services

Hospice Care Services of a licensed hospice care agency which are furnished to a Covered Person at home, on an outpatient basis or on a back-up in-patient basis, as defined by the Department of Public Health.

Cardiac Rehabilitation for a Covered Person who has a documented cardiovascular disease. Multidisciplinary outpatient treatment will be provided in either a hospital or other setting. Treatment must meet standards promulgated by the Commissioner of Public Health and be initiated within 26 weeks after the diagnosis of the disease.

Bone marrow transplant for treatment of metastatic breast cancer. If a bone marrow transplant is not available from a Preferred Provider, benefits will be paid at the Preferred Provider level for services rendered by a non-preferred provider.

Non-Prescription Enteral Formulas coverage for nonprescription enteral formulas ordered by a Doctor for home use for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. Coverage for inherited diseases of amino acids and organic acids shall include food products modified to be low protein in an amount not to exceed \$5,000 annually for any insured individual.

Diabetes Diagnosis and Treatment expense for treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes. Benefit includes expense for blood glucose monitors; blood glucose monitoring strips for home use; voice-synthesizers for blood glucose monitors for use by the legally blind; visual magnifying aids for use by the legally blind; urine glucose strips; ketone strips; lancets; prescribed oral diabetes medications that influence blood sugar levels (provided under outpatient prescription drug benefit if provided by the policy); laboratory tests, including glycosylated hemoglobin, or HbA1c tests; urinary/protein/microalbumin and lipid profiles; insulin pumps and insulin pump supplies; insulin pens (provided under outpatient prescription drug benefit if provided by the policy), so-called; therapeutic/molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating doctor and prescribed by a podiatrist or other qualified doctor and furnished by a podiatrist, orthotist, prosthetist or pedorthist; supplies and equipment approved by the FDA for the purposes for which they have been prescribed and diabetes outpatient self-management training and education, including medical nutrition therapy.

Diagnosis and Treatment of Infertility payable the same as any other Sickness. Infertility is a condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one (1) year. Benefit includes expense incurred for the following non-experimental infertility procedures: artificial insemination; in vitro fertilization and embryo placement; gamete intra-fallopian transfer; zygote intrafallopian transfer; Intra-cytoplasmic sperm injection for the treatment of male factor infertility; and sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any. Coverage is not limited to sperm provided by the Covered Person's spouse.

Scalp hair prosthesis expense for prosthesis worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia, payable up to \$350 per policy year.

Maternity Expense to include expenses for prenatal care, childbirth and post partum care (including well baby care) on the same basis as any other Sickness. Benefit includes hospital inpatient care for 48 hours following vaginal delivery and 96 hours following a cesarean section. Any decision to shorten maternity stays shall be made by the attending Doctor in consultation with the mother, in accordance with regulations promulgated by the Department of Public Health. The Covered Person is entitled to one (1) home visit should they elect to participate in an early discharge.

A newborn child born to an Insured student will be automatically covered under the Policy from the moment of birth until the 31st day following birth.

Coverage for newly born infants and adoptive children shall consist of Injury or Sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities or premature birth including the cost of a newborn hearing screening test to be performed before the newborn infant is discharged from the hospital or birthing center to the care of the parent or guardian or as provided by the regulations of the department of public health. **Coverage will terminate after 31 days.**

Preventive Care Services preventive and primary care services expense for Dependent children from the date of birth through the attainment of six (6) years of age. **Coverage will terminate after 31 days.**

Special medical formulas for treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia to protect the unborn fetuses of pregnant women with phenylketonuria.

Early Intervention services delivered by certified early intervention specialists for children from birth until their 3rd birthday. **Coverage will terminate after 31 days.**

Emergency services expense for health care items and services furnished in an emergency department and all ancillary services routinely available to an emergency department to the extent they are required for stabilization of an emergency medical condition. If a Covered Person receives emergency services and cannot reasonably reach a Preferred Provider, payment for emergency services will be at the same level and in the same manner as if the person had received treatment by a preferred provider.

Human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability. The coverage shall cover the costs of testing for A, B or DR antigens, or any combination thereof, consistent with rules, regulations and criteria established by the department of public health.

Speech, Hearing and Language Disorders diagnosis and treatment of speech, hearing and language disorders by individuals licensed as speech-language pathologists or audiologists under the provisions of chapter 112, if such services are rendered within the lawful scope of practice for such speech-language pathologists or audiologists regardless of whether the services are provided in a Hospital, clinic or private office, payable the same as any other Sickness. Coverage shall not extend to the diagnosis or treatment of speech, hearing and language disorders in a school-based setting.

Breast Reconstruction Incident to Mastectomy reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending Doctor and patient.

Hormone Replacement Therapy for pre- and post-menopausal women.

Outpatient Contraceptive Services including consultations, examinations, procedures and medical services related to contraceptive methods to prevent pregnancy approved by the U.S. Food and Drug Administration under the same terms and conditions for other outpatient services.

Cancer Clinical Trials: for Qualified Cancer Clinical Trials as defined in MA Chapter 257 subject to all other terms and conditions of the policy.

Prosthetic devices and repairs payable the same as any other durable medical equipment as defined in M.G.L. c. 175 §47Z(a).

EXCESS COVERAGE

No benefits are provided by the Policy for expenses which are reimbursable by any other valid and collectible insurance plan, but such charges in excess thereof shall be covered as otherwise provided.

PRE-EXISTING CONDITIONS LIMITATION

Pre-existing Conditions are not covered for the first 6 months following the Covered Person's effective date of coverage under the Policy. This limitation will not apply if, during the period immediately preceding the Covered Person's effective date of coverage under the Policy, the Covered Person was covered under prior creditable coverage for 6 consecutive months. Prior creditable coverage of less than 6 months will be credited toward satisfying the Pre-existing Condition limitation. This waiver of Pre-existing Conditions will apply only if the Covered Person becomes eligible and applies for coverage within 63 days of termination of his or her prior coverage. The Covered Person must provide us proof of prior Creditable Coverage.

Covered Medical Expenses are payable on the same basis as any other condition for pre-existing Injury or Sickness. This limitation does not apply when the Covered Person has been continuously insured. This limitation is subject to all other policy limitations.

EXCLUSIONS

The policy does not cover Loss nor provide benefits for:

1. Smoking deterrents;
2. Biofeedback-services and supplies related to biofeedback;
3. Congenital conditions, except as specifically provided for Newborn or adopted Infants; circumcision;
4. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children; hirsutism; nonmalignant warts, moles and lesions;
5. Dental treatment, except as specifically provided;
6. Elective Surgery and Elective Treatment;
7. Hearing examinations or hearing aids; or other treatment for hearing defects and problems, except as specifically provided in the policy. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
8. Immunizations, services and supplies related to immunizations, preventative medicines or vaccines, except where required for treatment of a covered Injury or except where specifically provided in the policy;

9. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
10. Organ transplants;
11. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;
12. Prescription Drugs dispensed or purchased while not Hospital Confined;
13. Family planning, impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery, unless specifically stated;
14. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness, except as specifically provided in the Policy;
15. Services or supplies for foot care including care of corns, bunions (except capsular or bone surgery), calluses;
16. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
17. Services, supplies and/or treatment for acne; acupuncture; allergy, including allergy testing; alopecia;
18. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; nasal and sinus surgery; except surgery made necessary as the result of a covered Injury;
19. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planning, bungee jumping, or flight in any kind of aircraft except while riding as a passenger on a regularly scheduled flight of a commercial airline;
20. Sleep disorders, supplies, treatment, or testing relating to sleep disorders;
21. Supplies, except as specifically provided in the Policy;
22. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; other than as specifically provided in the Policy;
23. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
24. Vision services and supplies related to eye refractions or eye examinations, eyeglasses or contact lenses or prescriptions or fitting of eyeglasses, and radial keratotomy, keratomileusis or excimer laser photo refractive keratectomy or similar type procedures or service except when due to a disease process;
25. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered);
26. Weight management services and supplies related to weight reduction programs, weight management programs, related nutritional supplies, treatment for obesity, surgery for removal of excess skin or fat;
27. Services and charges that are determined to be Experimental/Investigational in nature;
28. Expense incurred for treatment of injuries resulting from any motor vehicle accident to the extent covered by other valid and collectible insurance, or third party action;
29. Expenses, which are reimbursable by any other valid and collectible hospital or insurance, plan, but such charges in excess thereof shall be covered as otherwise provided;
30. Expense incurred after coverage terminates, subject to the Extension of Benefits;
31. Injury resulting from participation in intercollegiate or professional sports, including practices and conditioning, play or travel or arising from scuba diving, hang gliding, parachuting or bungee jumping;
32. Treatment, services or supplies which:
 - Are not prescribed by a Doctor as necessary to treat an Injury or Sickness;
 - Are determined to be Experimental/Investigational in nature by Us;
 - Are received without charge or legal obligation to pay;
 - Would not routinely be paid in the absence of insurance;
 - Are received from any Family Member;
33. Services or supplies received in the Covered Person's Home Country. This exclusion applies to international students only; and
34. Expenses incurred for alternative; holistic medicine, and/or therapy; including but not limited to; yoga and hypnotherapy.

CLAIM PROCEDURE

In the event of Covered Accident or Sickness:

1. Itemized bills must be submitted within ninety (90) days from the date of treatment. The Covered Person's name and identification number need to be included.
2. Payment for Covered Medical Expenses will be made directly to the hospital or Physician concerned unless bill receipts and proof of payment are submitted.

All claim correspondence should be submitted to the Claims Administrator shown below:

**Claims Administrator:
CONSOLIDATED HEALTH PLANS**

2077 Roosevelt Avenue
Springfield, MA 01104
(413) 733-4540
Toll Free (800) 633-7867

Servicing Broker:

University Health Plans, Inc.
One Batterymarch Park
Quincy, MA 02169-7454
Local: (617) 472-5324
Out of area: (800) 437-6448
www.universityhealthplans.com

Please visit our website for frequently asked questions and answers regarding this plan, or email us at info@univhealthplans.com

The Plan is underwritten by:

**Nationwide Life Insurance Company
Policy Number: 302-539-2009**

Within 45 days following receipt of the appropriate documentation, we will either (1) make payment for the services provided, (2) notify the provider or claimant in writing of the reason or reasons for nonpayment, or (3) notify the provider or claimant in writing of what additional information or documentation is necessary to complete the claim filing. If we fail to comply, We are required to pay, in addition to any reimbursement for health care services provided, interest on the benefits beginning 45 days after receipt of the properly documented claim at the rate of 1.5 percent per month, not to exceed 18 percent per year. These provisions do not apply to claims that a carrier is investigating because of suspected fraud.

There is no utilization review performed on the Policy.

For a copy of the Company's privacy notice, go to:

www.consolidatedhealthplan.com/about/hipaa

CLAIM APPEAL

To appeal a claim, send a letter stating the issues of the appeal to Consolidated Health Plan's Appeal Department at the above address. Include your name, phone number, address, school attended and email address, if available.

Claims will be reviewed and responded to within 60 days by Consolidated Health Plans.

You have the right to appeal to the Office of Patient Protection at 1-800-436-7757, fax: 1-617-624-5046 or visit www.state.ma.us/dph/opp.

Translation services are available to assist insureds, upon request, related to administrative services.

VALUE ADDED SERVICES

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

MEDEX Assistance Corporation provides you with a comprehensive program with 24/7 emergency medical assistance including emergency evacuation and repatriation and other travel assistance services when you are 100 or more miles away from home. Your MEDEX identification card is your key to travel security.

For general inquiries regarding your international assistance coverage, please call Consolidated Health Plans at 800-633-7867.

If you have a medical or travel problem, simply call MEDEX for assistance and provide your name, school name, the group number shown on your ID card, and a description of your situation. If you are in North America, call the Assistance Center toll-free at: 800-527-0218 or if you are in a foreign country, call collect at: 410-453-6330.

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.

VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:

www.chpstudent.com