2007-2008 STUDENT ACCIDENT AND SICKNESS INSURANCE PROGRAM

Designed For
Undergraduate Students of
Babson College

Underwritten by:
NATIONWIDE LIFE INSURANCE COMPANY
Columbus, Ohio

Policy Number: 302-036-2005

Effective August 18, 2007 to August 18, 2008

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.
We will notify Covered Persons of all material changes to this policy.

IMPORTANT NOTICE

This brochure provides a brief description of the important features of the 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.

Dear Students and Parents:

The Student Health Insurance Plan for Babson College students, underwritten by Nationwide Life Insurance Company, will be effective on August 18, 2007.

We believe that the Student Health Insurance Plan will provide reasonable protection against expensive illness and accidents at a cost low enough so as not to constitute an undue burden on anyone.
Participation in a Qualifying Student Health Insurance Plan is required of all students who are registered for nine or more credits each semester and all international students regardless of the number of credits for which they are registered. All students must annually submit a waiver form by logging onto:

1. http://Portal.Babson.edu
2. Click on "Student Financial Services" in the left hand tool bar
3. Click on "view bill" in the left hand tool bar

Babson College is mandated to enroll all students who do not show proof that they have a qualifying student health insurance and to bill them $966, which represents the cost of the insurance premium. The deadline for completing a waiver is August 1, 2007 for all returning and new Fall semester 2007 students; and February 1, 2008 for all new Spring semester 2008 students.

This brochure has been prepared to provide a description of the Babson College Qualifying Student Health Insurance Plan. It also describes some of the services available at Babson College Health Services for all full-time students.

You can obtain additional information about Babson College Health Services at www.babson.edu/health.
Additional information regarding University Health Plans may be found on the Health Services web page or at www.universityhealthplans.com.

Sincerely,

Sharon Yardley APRN-BC, FNP
Director of Health Services
Babson College

THE BABSON COLLEGE STUDENT HEALTH INSURANCE PLAN

The Babson Student Health Insurance Plan has been developed especially for Babson full-time students. The Plan provides coverage for illnesses and injuries that occur on and off campus, and includes special cost saving features to keep the coverage as affordable as possible. Babson is pleased to offer the Plan, as described in this Brochure, to students.

WHERE TO FIND HELP

For questions about:

- Insurance Benefits
- Claims Processing

Please contact:
Consolidated Health Plans
195 Stafford Street
Springfield, MA 01104-3503
(800) 633-7867
www.chpstudent.com

For a copy of the Company's privacy notice, go to:
www.chpstudent.com

For questions about:

- Enrollment
- Waiver/Enrollment Process

Please contact:
University Health Plans, Inc.
One Batterymarch Park
Quincy, MA 02169-7454
Phone: (800) 437-6448
Fax: (617) 472-6419
www.universityhealthplans.com
Email: info@univhealthplans.com

For questions about:

- Lost ID Cards

Please contact:
Consolidated Health Plans
(800) 633-7867 (x-146)

If you need medical attention before you receive your ID card, inform your healthcare provider that your insurance coverage is provided by Nationwide Life Insurance Company. Benefits will be payable according to the Policy. You do not need an ID card to be eligible to receive benefits. Once you have received your ID card, present it to the health care provider to facilitate prompt payment of your claims.

For questions about:
On-campus Health Services
Please contact:
Health Services
(781) 239-4257
www.babson.edu/health

For questions about:
- Status of Pharmacy Claim
- Pharmacy Claim Forms
- Excluded Drugs

Please contact:
Express Scripts
(800) 451-6245

For Provider Listings
A complete list of Providers can be found by logging on to www.universityhealthplans.com or www.firsthealth.com .

Worldwide Web Access:
Consolidated Health Plans
www.chpstudent.com
University Health Plans, Inc.
www.universityhealthplans.com

For a copy of the Company's privacy notice, go to:
www.chpstudent.com.

BABSON COLLEGE HEALTH SERVICES

Student health care needs can best be satisfied and cost contained with an organized system of health care providers at Babson College Health Services. If you are enrolled in the Student Health Insurance Plan, you should always attempt to use Babson College Health Services first to maximize all of your Student Health Benefits. Certain benefits may be reduced if you do not utilize Health Services. (See the Description of Benefits in this Brochure).

Located on the ground floor of the Hollister Building, Health Services is committed to maintaining and improving student health through preventative, diagnostic, and therapeutic care. The professional staff includes a team of nurse practitioners, a part-time physician, a health educator and a part-time nutritionist. When appropriate, referrals are made to independent health care providers and specialists. Health Services is open weekdays from 8:00 a.m. to 6:00 p.m. during the Fall and Spring Semesters. Limited care is provided during the Winter Session. During the Summer, Health Services is open only for administrative issues.

To provide comprehensive care, Health Services works closely with the Babson Counseling Program at Human Relations Services and other departments.

For more information, call the Health Services at (781) 239-4257. In the event of an emergency, call Public Safety at extension #5555 or (781) 237-2828.

- Inpatient care is available by contract with Wellesley College for a student whose illness necessitates rest, nursing care, and medical monitoring, but does not require the full services of a hospital.
- The physician is on site in Health Services during regularly scheduled hours. Visits with the physician are by appointment only. Routine physical examinations are not provided.
- Counseling services are available through the Babson counseling program at Human Relation Services (HRS) in Wellesley for those students who want help adjusting to the college experience or are having emotional problems. The telephone number for HRS is (781) 235-4950 or call the Health Services at (781) 239-4257.

  Diagnostic X-rays, laboratory services, and medical specialists can be arranged through the Health Services after being evaluated by the Health Services staff.
- There is no charge to Babson College students for the following services rendered by the Health Services during clinic hours: services performed by a physician or nurse practitioner, supplies, or non-prescription medications. A limited number of crutches, heating pads, etc., are available for loan without charge.
- Services are provided to full-time, matriculating Babson College students only.

IMPORTANT NUMBERS

Health Services
(781) 239-4257

Public Safety
Extension #5555 or (781) 237-2828

Human Relation Services
(Babson Counseling Program at HRS)
(781) 235-4950

POLICY PERIOD

1. Students: Coverage for all covered students enrolled for the Fall Semester will become effective at 12:01 a.m. on August 18, 2007, and will terminate at 12:01 a.m. on August 18, 2008.
2. New Spring Semester Students: Coverage for all covered students enrolled for the Spring Semester will become effective at 12:01 a.m. on January 15, 2008, and will terminate at 12:01 a.m. on August 18, 2008.

INSURANCE COST

Undergraduates		
	Annual	Spring Semester
Student	$966 *	$691 *

*An Administrative Cost is included in the Annual & Spring rates.

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

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 the premium has been paid and no refund will be allowed. This applies to students on leave for medical or academic reasons and graduating students.

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 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 canceled, or its renewal refused, only in the following:

- 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.
- Non-renewal or cancellation of the Policy through which the Covered Person receives coverage or the Covered Person is no longer a student.

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

STUDENT COVERAGE

Eligibility: All full-time and qualifying part-time undergraduate students enrolled for 9 or more credits are eligible for coverage.

WAIVER/ENROLLMENT PROCESS

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. Your premium for this coverage must accompany the request.

All eligible students must complete an enrollment/waiver form by logging onto http://Portal.Babson.edu by the specified deadline dates (see below). Eligible students will be automatically enrolled in the Plan unless the enrollment/waiver form has been submitted by the following deadline dates:

Category	Waiver Deadline Date
Returning Students	August 1, 2007
New Fall 07 Students	August 1, 2007
New Spring 08 Students	February 1, 2008

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.

For information or general questions on enrollment, contact University Health Plans, Inc. at (800) 437-6448.

To enroll please visit www.universityhealthplans.com .

PREFERRED PROVIDER NETWORK

Covered Persons have access to the First Health Preferred Provider Network. To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. A complete listing of preferred providers is available by logging on to www.universityhealthplans.com or www.firsthealth.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, but if a Covered Medical Expense is incurred through a Preferred Provider, the Program will pay: For covered Doctor's office visits, including Licensed Mental Health Professionals, 100% of the fees after payment of a $10 Co-payment per visit.

For covered medical treatments other than Doctor's office visits, including Licensed Mental Health Professionals, 80% coverage (unless specifically stated) of the discounted fee, meaning that the 20% share of the fee is also discounted.

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 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 dis-enrolled, other than dis-enrollment 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 dis-enrolled, 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 death of the Covered Person.

Continued coverage is conditioned upon the provider agreeing to:

Accept reimbursement at the rates applicable prior to notice of dis-enrollment 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 dis-enrolled; 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 complete listing of Preferred Providers available Call First Health at 800-226-5116 or Consolidated Health Plans at (413) 733-4540 or toll free at (800) 633-7867 for assistance.

You may also find participating providers on First Health or Consolidated Health Plan's websites at:

www.firsthealth.com or www.chpstudent.com

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, 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.

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

Covered Medical Expense means the Reasonable and Customary Charge (or Negotiated Fee) 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, 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 Untied 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 physician assistants, 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.

First Health Preferred Provider means a provider in the First Health Preferred Provider Network.

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 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.

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

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.

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 Disorders 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.

Negotiated Fee means the fee the Participating Provider has agreed to for services or supplies under the plan.

Pre-existing Condition means (1) 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; (2) a pregnancy existing on the Covered Person's effective date of

coverage.

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 years of age and shall include physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals: six times during the child's first year after birth, three times during the next year, annually until age six. Such services shall also include hereditary and metabolic screening at birth, appropriate immunizations, 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 the normal and customary charge of the provider, incurred by the Covered Person, in the absence of insurance for a service or supply, but not more than the prevailing charge in the area.

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.

DESCRIPTION OF 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. Covered Medical Expenses for Pre-existing Conditions for an insured student are covered to an aggregate of $10,000, limited to $2,500 for outpatient treatment. Reimbursement is based on the Negotiated Fee for Preferred Providers or Reasonable and Customary based in accordance with data provided by Ingenix for out-of-network Providers. Payments made to out-of-network providers shall be a percentage of the provider's fees, up to Reasonable and Customary Charge, and not a percentage of the amount paid to Preferred Providers. Covered Medical Expenses are:

Hospital Room and Board: Hospital room and board and general nursing care while hospital confined up to the semi-private room rate or the intensive care unit charge, if applicable. Preferred Provider: 90% for the first 5 days then 80% thereafter per Sickness or Injury.

Out-of Network: 90% for the first 5 days then 80% thereafter per Sickness or Injury..

Miscellaneous Hospital Expense: 100% up to $1,000 then 80% thereafter for 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).

In-Hospital Doctor's Expense: Services of a Doctor during hospital confinement, limited to one visit per day. This benefit does not apply when related to surgery.

Ambulance Expense: 100% for use of an ambulance for an Emergency Medical Condition to or from the hospital up to a maximum of $250.

Surgical Expense: Doctor's fee for surgery based on the Negotiated Fee for Preferred Providers or Reasonable & Customary for out-of-network providers.

Anesthesia Expense: Services of an anesthetist who is not employed or retained by the hospital in which the surgery is performed, up to 80% of the amount paid the surgeon.

Assistant Surgeon's Expense: Service of an assistant surgeon required by the hospital, or by the procedure, up to 80% of the amount paid the surgeon.

Outpatient Miscellaneous Expense: 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, hospital or outpatient department or emergency room, clinical lab, radiological facility or similar facility licensed by the state, up to a maximum benefit of $2,500 for each Sickness or Injury, unless specifically stated elsewhere, subject to the following per visit Co-payments:

- Emergency Room, not resulting in a hospital admission – 80% of the Negotiated Charge (Preferred Provider) or 80% of Reasonable & Customary (out-of-network).
- Doctor's Office Visit Preferred Provider: 100% of the Negotiated Charge after a $10 co-payment per visit. Out-of-Network: 80% of the Reasonable and Customary Charge after a $20 co-payment per visit.

Laboratory and X-Ray Expense: If referred by the College Health Services, Covered Medical Expenses are payable at 100% up to $250 per Sickness or Injury. Thereafter, benefits are payable at 80%. If not referred, Covered Medical Expenses will be paid at 80%.

Chiropractic/Physical Therapy Expense: Covered Medical Expenses will be paid as detailed under the Outpatient Miscellaneous Expense benefit of this Brochure.

Dental Expense: Treatment for Injury to sound natural teeth will be paid at 100% up to $500 per Accident.

Removal of impacted wisdom teeth is payable up to $100 per tooth.

Voluntary Termination of Pregnancy: Benefits will be paid the same as any other Sickness when a pregnancy had its inception during the term insured and is voluntarily terminated. These expenses must be incurred while the coverage is in force for the Covered Person.

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

PRESCRIPTION DRUG BENEFIT

Prescription drugs to a maximum of $750.00 per Policy year after a $10.00 co-pay per prescription or refill of a generic drug and a $25.00 co-pay per prescription or refill of a brand name drug, including hormone replacement therapy and contraceptive outpatient prescription drugs or devices approved by the U. S. Food and Drug Administration. Prescriptions must be filled at an "Express Scripts" Participating Pharmacy.

Coverage for a prescription drug will not be excluded for the treatment of cancer or HIV/AIDS on the grounds that the drug has not been approved by the U.S. Food and Drug Administration (FDA) for that indication, if such drug is recognized for treatment of such indication in one of the standard reference compendia, in medical literature, or by the commissioner under the provisions of section forty-seven L of the Massachusetts General Laws. Prescription Drug coverage shall also include Medically Necessary services associated with the administration of the drug.

Covered Persons will be given an ID card to show the Pharmacy as proof of coverage. No claim forms need be completed once you receive this ID card. Until such card is received, you may fill prescriptions and be reimbursed by submitting a completed "Express Scripts" claim form. Claim forms can be obtained by calling Consolidated Health Plans at (800) 633-7867 or visiting their website at www.chpstudent.com. A directory of participating pharmacies is available by calling Express Scripts directly at (800) 451-6245 or by logging onto www.universityhealthplans.com

NOTE: Not all medications are payable. Medications not covered by this benefit include, but are not limited to, allergy

serum, drugs whose sole purpose is to promote or stimulate hair growth (Rogaine, Propecia, Renova), appetite suppressants and smoking deterrents. A complete list of exclusions may be obtained by calling Express Scripts directly at (800) 451-6245.

Mental Illness treatment for Biologically-Based Mental Disorders; rape-related mental 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 non-custodial 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 DMS, consisting of inpatient, intermediate and outpatient services that permit active and non-custodial 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 and 24 outpatient visits.

Psychopharmacological services and neuropsychological assessment services expense.

Treatment of alcoholism and chemical dependency:

Inpatient: Confinement in a hospital or in any other public or private facility providing services especially for the detoxification or rehabilitation and which is licensed by the department of public health, or in a residential alcohol treatment program, up to 60 days in any calendar year.

- Outpatient: Outpatient services furnished by a hospital or by any public or private facility or portion thereof providing services especially for the rehabilitation of intoxicated persons or alcoholics, up to $2,500 per Policy Year.

The limitation on benefits for treatment of alcoholism and chemical dependency shall not apply when said treatment is rendered in conjunction with treatment of mental or nervous disorders.

Cytological Screening and Mammography Expense: Benefits will be provided for: One annual cytological (pap smear) screening for ages 18 and over including chlamydia screening; A baseline mammogram for ages 35 through 39; and A mammogram every year for women age 40 and over.

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 home visit should they elect to participate in an early discharge.

Preventive Care Services expense for Dependent children from the date of birth through the attainment of six years of age. This benefit is only available for the 31 day newborn coverage, and ends after 31 days.

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.

Early intervention services delivered by certified early intervention specialists for children from birth until their 3rd birthday, up to $5,200 per year and an aggregate benefit of $15,600 over the total enrollment period. This benefit is only available for the 31 day newborn coverage and ends after 31 days.

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.

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.

Non-prescription Enteral Formulas Expense: We will pay up to $2,500.00 per Policy year for benefits for non-prescription enteral formulas (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.

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 year. Benefit includes expense incurred for the following non-experimental infertility procedure: artificial insemination; in vitro fertilization and embryo placement; gamete intra-fallopian transfer; zygote intra-fallopian transfer; Intracytoplasmic 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.

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; insulin; insulin syringes; prescribed oral diabetes medications that influence blood sugar levels; laboratory tests, including glycosylated hemoglobin, or HbAlc tests; urinary/protein/microalbumin and lipid profiles; insulin pumps and insulin pump supplies; insulin pens, 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, orthiostist, prosthetist; 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.

Please note: insulin, syringes, and diabetic testing supplies are Coved under the Prescription Drug portion of the Policy.

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 (in-network) or 80% of reasonable & customary charge (out-of-network) to a maximum of $2,000 per Accident or Sickness.

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.

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.

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.

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.

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.

Special Medical formulas: For treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic academia, or methylmalonic academia in infants and children or to protect the unborn fetuses of pregnant women with phenylketonuria.

All State mandated benefits will be paid according to Policy.

SUPPLEMENTAL MEDICAL COVERAGE

The Aggregate Maximum benefit under the Student Accident and Sickness Insurance is $50,000. If you have purchased the Basic Student Health Insurance Plan at Babson College, you are eligible to purchase this Supplemental Plan to extend the combined maximum to $250,000 for students .

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.

CONTINUOUSLY INSURED

Any Covered Person who has continuous coverage under this Plan and the prior plan shall be covered for conditions first manifesting themselves while continuously insured, except for benefits payable under prior policies in the absence of this Plan. Prior plan means the Student Health Insurance Policy issued to the Policyholder immediately before this Policy or any other Creditable Coverage, as defined.

SUBROGATION

If claims for an Injury or Sickness are incurred by an Insured Person, and it appears that the Injury or Sickness was due to the fault of someone else, the Plan will not pay for such claims until it has obtained documentation from the Insured Person establishing its reimbursement rights in accordance with the Plan.

LIMITATIONS

Excess Coverage

Benefits in excess of $250 are payable only on an excess basis over and above any coverage provided by any other group, blanket, franchise or pre-paid service policy or plan, regardless of any Coordination of Benefits, non-duplication of benefits, or any similar provisions contained in such policies or plans.

Pre-Existing Conditions Limitation

Benefits for Pre-existing Conditions are limited for insured students to an aggregate of $10,000; limited to $2,500 for outpatient treatment, 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.

You must contact the administrator of Your prior Creditable coverage and secure and submit to us a Certificate of Coverage in order for Consolidated Health Plans to allow the credit.

The time for which You are covered under this plan may be eligible for credit toward satisfaction in a Plan under which You subsequently become covered. When Your coverage terminates under this plan, Consolidated Health Plans will, at Your request, issue a Certificate of Coverage to You for that purpose.

EXCLUSIONS

The policy does not cover Loss nor provide benefits for:

1. Expenses for daily hospital room and board higher than the usual semi-private room charge or higher than the usual charge for the Intensive Care Unit, if applicable.
2. Expenses incurred for medical services, treatments and supplies for which no charge would have been normally made in the absence of insurance.
3. Services normally provided without charge by your Health Services, Infirmary or Hospital or any employees thereof.

4. Surgery for the correction of refractive error and services in connection with eye examinations, eye glasses or contact lenses or hearing aids, except as required for a repair due to an Accident in which the Covered Person sustains an Injury.
5. Loss resulting from participation in an illegal occupation, riot, civil commotion or act of terrorism; or committing, or attempting to commit, a felony.
6. Elective plastic or cosmetic surgery, unless resulting directly from an Injury which necessitated medical treatment within 24 hours of the Accident.
7. Loss resulting from air travel, except as a fare-paying passenger on a commercial airline.
8. Injury sustained or Sickness contracted while in the armed forces of any country.
9. An occupational loss covered by any occupational benefit plan, Workers' Compensation Act or similar law.
10. Treatment, services or supplies received in a governmental hospital unless the Covered Person is legally obligated to pay such charges in the absence of insurance.
11. 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.
12. Expenses, which are reimbursable by any other valid and collectible hospital or insurance, plan in excess of $250, but such charges in excess thereof shall be covered as otherwise provided.
    Expenses for Prescription Drugs, except as specifically provided in this Insurance Program.
13. Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extractions of teeth, TMJ dysfunction or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia. This exclusion does not apply to the repairs to sound natural teeth caused by an Injury. This exclusion does not apply to the removal of impacted wisdom teeth.
14. Expense incurred after coverage terminates except as may be specifically provided in the Extension of Benefits Provision.
16. Elective treatment or elective surgery, except as specifically provided.
17. Routine physicals, preventive medicines, serums, or vaccines.
18. Injury resulting from the play or practice of intercollegiate sports, including intercollegiate club and intramural sports in excess of $1,500.
19. Services and charges that are determined to be Experimental/Investigational in nature.

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.

CLAIMS PROCEDURES

1. Bills must be submitted within 90 days from the date of treatment.
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.
3. If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to Consolidated Health Plans.

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 this policy.

CLAIM APPEAL

To appeal a claim, send a letter stating the issues of the appeal to Consolidated Health Plan's Appeal Department at the below 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.

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

This Brochure is a brief description of the Plan Benefits. The exact provisions governing the insurance are contained in the Policy issued to Babson College located in Health Services.

Any provision of the Policy or this brochure which is in conflict with the statutes of the state in which the Policy is issued, will be administered to conform with the mandates of the state.

The Plan is Underwritten By:
Nationwide Life Insurance Company
Policy Number: 302-036-2005

Claims Administrator:
Consolidated Health Plans
195 Stafford Street
Springfield, MA 01104-3503
(800) 633-7867
www.chpstudent.com
Please visit our website to check claims status and eligibility

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

15. The Plan is underwritten by Nationwide Life Insurance Company. The exact provisions governing the insurance are contained in the Master Policy issued to the College, and may be viewed at the College's Health Services during normal business hours. Any discrepancy between this brochure and the Master Policy will be governed by the Master Policy. The plan is managed by University Health Plans, Inc., One Batterymarch Park, Quincy, MA 02169-7454

VISION BENEFITS

The Vision One discount program is available to participants in the Student Health Insurance Plan through Cole Vision® at no additional cost. This program may help you save on many eye care products, including eyeglasses and contact lenses, nonprescription sunglasses, contact lens solutions and accessories.

The Vision One program is available at many optical centers nationwide – such as Sears, JCPenney, Target, most Pearle Vision Centers and others – as well as through selected independent optometrist and ophthalmologist offices.

When you visit a Vision One location, show your Student Health Insurance card, and any applicable services or merchandise you receive will be discounted right at the point of purchase. There are no claim forms to complete and no waiting for reimbursement.
Here is an example of some of the discounts you are eligible for:

Frames	Vision One Cost	Typical Savings
Up to $60 retail	$25	58%
$60 to $80 retail	$35	56%
$80 to $100 retail	$45	55%
Over $100 retail		35% off retail
Exams – Spectacle		$5 discount
Lenses		
Single Vision	$30	46%
Bifocal	$50	42%
Trifocal	$60	45%
Lens Options	Additional	
Standard Progressive (no-line bifocal)	$50	33%
Polycarbonate	$30	40%
Scratch Resistant Coating	$12	40%
Ultraviolet Coating	$12	40%
Anti-Reflective Coating	$35	30%
Photochromic	$30	25%
Solid or Gradient Tint	$ 8	33%
Contact Lenses		
Non-Disposable Contacts		20%
Disposable Contacts		10%
Exams – Contacts		$10 discount

To find the nearest Vision One location log on to the Cole Managed Vision website at www.cmvc.com or call 1-800-424-1155, weekdays from 9 a.m. to 9 p.m. ET and Saturdays from 9 a.m. to 5 p.m. ET to peak to a representative. Cole Managed Vision Plan #47034