Student Health Insurance Program

Designed for the Students
of

MGH Institute of Health Professions

2015-2016

NATIONWIDE LIFE INSURANCE COMPANY
COLUMBUS, OHIO

Policy Number: 302-530-2013
Group Number: S210109

Effective: May 1, 2015 to April 30, 2016

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.

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 4 for additional information.

PREFERRED PROVIDER NETWORK

By enrolling in this Insurance Program, you have the Cigna PPO Network. To find a complete listing of Cigna PPO Providers, go to www.cigna.com, or contact Consolidated Health Plans at (413) 733-4540, toll-free at (800) 633-7867, or www.chpstudent.com for assistance.

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 thirty (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 second (2nd) or third (3rd) trimester of pregnancy and whose provider in connection with her pregnancy is involuntary 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 (1st) 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.

ELIGIBILITY AND EFFECTIVE DATE

To be eligible for this Insurance Program, You must be enrolled as a degree-seeking student, a full-time student or a student 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 thirty-one (31) day periods beginning with the start of the applicable Coverage Period.

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 sixty (60) days after it expires. Otherwise, the effective date will be the 1st of the month following Your Request. Your premium for this coverage must accompany the request.

If You are eligible for Coverage but do not enroll in Coverage under this Policy when You first meet the definition of Eligible Person as a result of coverage under another Policy, You may be eligible to enroll in coverage under this Policy provided enrollment and Premium are received within sixty (60) days of Involuntary Loss of Other Coverage.

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 DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2009. BECAUSE THE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH 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.

PREMIUM

Premium for coverage must be received within the thirty-one (31) day periods beginning with the start of the applicable Coverage Period.

Rates* per Coverage Period			
	5/01/15-8/31/15	**9/01/15-12/31/15**	**1/01/16-4/30/16**
Student	$2,013	$2,013	$2,013
Student & Spouse	$4,026	$4,026	$4,026
Student & 1 Child	$4,026	$4,026	$4,026
Student & 2 Children	$6,039	$6,039	$6,039
Student & 3 or more Children	$8,052	$8,052	$8,052
Student, Spouse & 1 Child	$6,039	$6,039	$6,039
Student, Spouse & 2 Children	$8,052	$8,052	$8,052
Student, Spouse & 3 or more Children	$10,065	$10,065	$10,065

*The above rates include a service fee retained by the broker.

PREMIUM REFUND POLICY

In the case of medical withdrawal, any Insured withdrawing from school must submit documentation or certification of the medical withdrawal to Us at least thirty (30) days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable, or thirty (30) days after the start date of the medical leave of absence from school. Any Insured voluntarily withdrawing from school during the first thirty-one (31) days of the period for which Coverage is purchased, will not be covered under this Policy and a full refund of Premium will be made minus the cost of any claim Benefits made by Us. Insureds withdrawing after such thirty-one (31) days will remain covered under the Policy for the term purchased and no refund will be allowed except as otherwise specified herein or unless required in accordance with Massachusetts State Law.

DEPENDENT ELIGIBILITY AND ENROLLMENT

Students who are enrolled in the Student Health Insurance Plan may also enroll their Dependents. Dependent coverage, if any, begins and ends with Your coverage.

A Dependent newborn child will be automatically covered under the Policy from the moment of birth until the thirty-first (31st) day following birth. During the thirty-one (31) day period, We must receive written notice of the birth and the required premium must be paid. Coverage for such newborn children will consist of coverage for Injury or Sickness including the necessary care and treatment of medically diagnosed congenital defects, 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. To continue coverage beyond the thirty-one (31) day period or to obtain other Dependent coverage, the Insured must notify Us in writing within thirty-one (31) days of birth, marriage, adoption, or other qualifying event, and pay the required additional Premium.

TERMINATION

Coverage will terminate at 11:59 p.m. standard time at the Policyholder's address on the earliest of:

- The Termination Date of the Policy;
- The last day of the term of Coverage for which Premium is paid;
- The date a Covered Person enters full time active military service. Upon written request within ninety (90) days of leaving school, We will refund the unearned pro-rata Premium to such person.

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.

Termination is subject to the Extension of Benefits provision.

INVOLUNTARY DISENROLLMENT

The number of Covered Persons involuntarily disenrolled in the past two (2) years is zero (0).

COVERAGE FOR DEPENDENTS

If You are covered under the Policy, coverage may be purchased for Your eligible Dependents. Your Dependents will be covered for the same benefits for which You are covered. Dependent coverage, if any, begins and ends with Your coverage.

A Dependent newborn child will be automatically covered under the Policy from the moment of birth until the thirty-first (31st) day following birth. During the thirty-one (31) day period, We must receive written notice of the birth and the required premium must be paid.

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.

WAIVER/ ENROLLMENT PROCESS

Students who DO NOT WANT to enroll in the Student Accident and Sickness Insurance Program may waive coverage if they can document proof of comparable coverage in another health insurance plan that will be in effect from:

- May 1, 2015 through April 30, 2016, for students who become eligible in the first coverage period;
- September 1, 2015 through April 30, 2016, for students who become eligible in the second coverage period; or
- January 1, 2016 through April 30, 2016, for students who become eligible in the third coverage period.

Recognizing that health insurance situations may change, students will be required to provide proof of comparable coverage each academic year in order to waive participation in the Student Accident and Sickness Insurance Program.

Please note: The Company issuing the policy used to waive inclusion in the Student Accident and Sickness Insurance Program must be wholly based in the United States.

To document proof of comparable coverage, students must go to www.universityhealthplans.com, select MGH Institute for Health Professions, and follow the instructions on that page to submit the online Waiver Form.

Students who want to enroll in the Student Accident and Sickness Insurance Program must go to www.universityhealthplans.com to complete the online Enrollment Form. The online form gives the option to elect coverage for 1) Student Only; 2) Student and Spouse; 3) Student and Child; 4) Student and Children; or 5) Student, Spouse, and Child(ren).

To request enrollment into the plan OR to document proof of comparable coverage, students must go to www.universityhealthplans.com. The Waiver and Enrollment Forms can be accessed by following the instructions on that page.

Immediately upon submitting either the online Waiver or Enrollment Form, students will receive a confirmation number as verification that the form has been submitted.

The form HAS NOT been submitted until a confirmation page is provided. The confirmation should be printed as this is the student's ONLY proof of submitting the request.

EXTENSION OF BENEFITS

The Coverage provided under this Policy ceases on the Covered Person's Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury or Sickness for which Benefits were paid before the Termination Date, Covered Expenses for such Injury or Sickness will continue to be paid for a period of, ninety (90) days, or until date of discharge, whichever is earlier.

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 all benefits cease to exist, and under no circumstances will further payments be made.

GENERAL DEFINITIONS

The terms listed below, if used, have the meaning stated.

Accident: An event that is sudden, unexpected and unintended, and over which the Covered Person has no control.

Biologically Based Mental Illness: A mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the Illness. Such biologically based mental illnesses are defined as 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; and Autism.

Condition: Sickness, ailment, Injury or pregnancy of a Covered Person.

Copayment: A specified dollar amount a Covered Person must pay for specified Covered Charges.

Covered Charge(s) or Covered Expense: As used herein means those charges for any treatment, services or supplies:

- for Preferred Providers, not in excess of the Preferred Allowance;
- for Out-of-Network Providers not in excess of the Reasonable and Customary expense; and
- not in excess of the charges that would have been made in the absence of this insurance; and
- not otherwise excluded under this Policy; and
- incurred while this Policy is in force as to the Covered Person.

Covered Services: Means the services and supplies, procedures and treatment described herein, subject to the terms, conditions, limitations, and exclusions of the Policy.

Deductible: The amount of expenses for Covered Services and supplies which must be incurred by the Covered Person before specified Benefits become payable.

Dependent: A person who is the Insured's:

- Legally married spouse, who is not legally separated from the Insured and resides with the Insured.
- Child who is under the age of 26 or for 2 years after the end of the calendar year in which such persons last qualified as dependent under 26 U.S.C 106, whichever occurs first.

The term child refers to the Insured's:

- Natural child;
- Stepchild or foster child; A stepchild is a Dependent on the date the Insured marries the child's parent.
- Adopted child, including a child placed with the Insured for the purpose of adoption, from the moment of placement as certified by the agency making the placement.
- Foster child is a Dependent from the moment of placement with the Insured as certified by the agency making the placement.

Elective Treatment: Those services that do not fall under the definition of Essential Health Benefits. Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body

occurring after the Covered Person's Effective Date of Coverage. Elective Benefits is shown on the Schedule of Benefits, as applicable.

Emergency: An Illness, Sickness or Injury for which immediate medical treatment is sought at the nearest available facility. The Condition must be one which manifests itself by acute symptoms which are sufficiently severe that a reasonable person would seek care right away to avoid serious impairment to body function, or 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.

Essential Health Benefits: Has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services, and includes the following categories of Covered Services: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care in accordance with the applicable state or federal benchmark plan.

Experimental/Investigational: The service or supply has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication.

Health Care Facility: A Student Health Center, Hospital, Skilled Nursing Facility, Sub-Acute Facility, or other duly licensed, certified and approved health care institution which provides care and treatment for sick or injured persons.

Home Country: The Insured's country of regular domicile.

Injury: Bodily Injury due to a sudden, unforeseeable, external event which results independently of disease, bodily infirmity or any other causes. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

In-Network Benefit: The level of payment made by Us for Covered Services received by a Preferred Provider under the terms of the Policy. Payment is based on the Preferred Allowance unless otherwise indicated.

Insured: The Covered Person who is enrolled at and meets the eligibility requirements of the Policyholder's school.

Insured Percent: That part of the Covered Charge that is payable by the Company after the Deductible and/or Copayment has been paid, and subject to the Policy Year Maximum or Maximum Benefit, as applicable.

Maximum Benefit: The maximum payment We will make under the Policy for each Covered Person for Covered Services. This amount is shown on the Schedule of Benefits, as applicable.

Mental Condition(s): Nervous, emotional, and mental disease, Illness, syndrome or dysfunction classified in the most recent addition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) or its successor, as a Mental Condition on the date of medical care or treatment is rendered to a Covered Person.

Out-of-Network Benefit Level: The lowest level of payment made by Us for Covered Services under the terms of the Policy. Payment is based on Reasonable and Customary charges unless otherwise indicated.

Out-of-Network Provider: Physicians, Hospitals and other Providers who have not agreed to any pre-arranged fee schedules. See the definition of Out-of-Network Benefit Level.

Out-of-Pocket Maximum: The most You pay during a Policy Year before Your Coverage begins to pay 100% of the allowed amount. This limit will never include Premium, balance-billed charges or health care Your Policy does not cover. The out-of-pocket includes Copayments, Deductibles and Coinsurance.

Physician: A health care professional, including a Physician Assistant, practicing within the scope of his or her license and is duly licensed by the appropriate State

Regulatory Agency to perform a particular service which is covered under the Policy, and who is not:

1. the Insured Person;
2. a Family Member of the Insured Person; or
3. a person employed or retained by the Policyholder.

Preferred Providers: Physicians, Hospitals and other healthcare Providers who have contracted to provide specific medical care at negotiated prices. See the definition of In-Network Benefit.

Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal law and is:

1. approved for general use by the U.S. Food and Drug Administration (FDA); and
2. prescribed by a licensed Physician for the treatment of a Life-Threatening Condition, or prescribed by a licensed Physician for the treatment of a Chronic and Seriously Debilitating Condition, the drug is necessary to treat that Condition, and the drug is on the Formulary, if any; and
3. the drug has been recognized for treatment of that Condition by one of the Standard Medical Reference Compendia or in the Medical Literature as recommended by current American Medical Association (AMA) policies, even if the prescribed drug has not been approved by the FDA for the treatment of that specific Condition.

The Drugs must be dispensed by a licensed pharmacy Provider for out of Hospital use.

Preventive Care: Provides for periodic health evaluations, immunizations and laboratory services in connection with periodic health evaluations, as specified in the Schedule of Benefits. Well Baby and Child Care, and Well Adult Care benefits will be considered based on the following:

a) Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;

b) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
c) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
d) With respect to women, such additional preventive care and screenings, not described in paragraph (a) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Provider: A Physician, Nurse Practitioner, Health Care Facility, or Urgent Care Facility that is licensed or certified to provide medical services or supplies. Physician profiling information may be available from the Board of Registration in Medicine for physicians licensed to practice in Massachusetts.

Reasonable and Customary (R&C): The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred. The most common charge means the lesser of:

- The actual amount charged by the Provider;
- The negotiated rate, if any; or
- The fee often charged for in the geographical area where the service was performed.

The Reasonable Charge is determined by comparing charges for similar services to a national database adjusted to the geographical area where the services or procedures are performed, by reference to the 80th percentile of Fair Health Inc. schedules. The Insured Person may be responsible for the difference between the Reasonable Charge and the actual charge from the Provider.

Sickness (Sick) means illness, disease or condition, including pregnancy and complications of pregnancy that impairs a Covered Person's normal functioning of mind or body and which is not the direct result of an Injury or Accident. All related conditions and recurring symptoms of a Sickness will be considered one (1) Sickness.

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

You and Your: The Covered Person or Eligible Person as applicable.

STUDENT HEALTH INSURANCE

This brochure is a brief description of the Student Health Insurance Plan available for all students and Dependents who meet the eligibility requirement as shown above. The exact provisions governing this insurance are contained in the Master Policy underwritten by Nationwide Life Insurance Company, serviced by University Health Plans and administered by Consolidated Health Plans.

The Policy will pay for Covered Medical Expenses according to the Schedule of Benefits and any exclusions, limitations, or state mandated provisions.

STATE MANDATED BENEFITS

Benefits are subject to applicable deductible, coinsurance, and co-payments as outlined in the Schedule of Benefits.

Autism Spectrum Disorder: Benefits provided for the diagnosis and treatment of autism spectrum disorder (ASD) in individuals. ASD includes any of the pervasive developmental disorders, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

Treatment of autism spectrum disorders includes the following care prescribed, provided or ordered for an individual diagnosed with an ASD by a licensed Physician or a licensed psychologist:

- *Habilitative or Rehabilitative Care*: Professional, counseling and guidance services and treatment programs, including, but not limited to, applied behavioral analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the function of an individual. Applied behavior analysis includes the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produces socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.
- *Pharmacy Care*: Medications prescribed by a licensed Physician and health-related services deemed necessary to determine the need or

effectiveness of the medications, to the same extent that pharmacy care is provided for other medical conditions.
- *Psychiatric Care:* Direct or consultative services provided by a licensed psychiatrist
- *Psychological Care*: Direct or consultative services provided by a licensed psychologist
- *Therapeutic Care*: Services provided by licensed or certified speech therapists, occupational therapist, physical therapists or social workers.

Benefits are payable the same as any other physical Illness.

Biologically Based Mental Disorders: Coverage will be provided the same as any other physical Illness for the following Biologically Based Mental Disorders:

1. Schizophrenia;
2. Schizoaffective disorder;
3. Major depressive disorder;
4. Bipolar disorder;
5. Paranoia and other psychotic disorders;
6. Obsessive-Compulsive disorder;
7. Panic disorder;
8. Delirium and dementia;
9. Affective disorders;
10. Eating disorders;
11. Post traumatic stress disorder;
12. Substance abuse disorders; and
13. Autism.

Bone Marrow Transplants for Breast Cancer: Coverage is provided as any other physical illness for bone marrow transplants for persons who have been diagnosed with breast cancer that has progressed to metastatic breast disease.

Breast Reconstruction Incident to Mastectomy: Coverage is provided for construction in connection with such mastectomy, coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the Attending Physician and the patient.

Cardiac Rehabilitation Coverage: Coverage is provided for Cardiac rehabilitation expense if a Covered Person has documented cardiovascular disease. This benefit includes multidisciplinary treatment provided in either a Hospital or other setting. Treatment must meet standards promulgated by the Commissioner of Public Health. Cardiac rehabilitation must be initiated within 26 weeks after the diagnosis of the disease.

Coverage for Human Leukocyte Antigen Testing for Certain Individuals and Patients: Coverage is provided as any other physical Illness for Human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability. Coverage will 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.

Cytological screening and mammograms: Coverage is provided for cytological screening (pap smear) and mammograms, payable as any other physical illness, for Covered female persons:

- One cytological (pap smear) screening for ages 18 and over;
- A baseline mammogram for ages 35 through 39;
- A mammogram every year age 40 and over.

Diabetes Diagnosis and Treatment Expense: Coverage is provided for diabetes diagnosis and treatment expense for treatment of insulin dependent, insulin using, gestational and non-insulin dependent diabetes. This 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 Physician and prescribed by a podiatrist or other qualified Physician 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.

Early Intervention Services: services provided by certified early intervention specialist for children from birth until their third birthday. Reimbursement of costs for such services is not subject to co-payments, coinsurance or deductibles, however subject to other Policy provision limitations.

Hearing Aids for Children: Coverage is provided for hearing aids for children who are 21 years of age or younger when prescribed by a licensed audiologist or hearing instrument specialist. Coverage includes the initial hearing aid evaluation, fitting, adjustments, and supplies, including ear molds up to $2,000 per hearing aid per hearing impaired ear in each 36 month period.

Hormone Replacement Therapy and Contraceptive Services:

Benefits will be provided for hormone replacement therapy and contraceptive services.

- Coverage is provided for hormone replacement therapy services for peri and post menopausal women and outpatient contraceptive services under the same terms and conditions as for such other outpatient services. Outpatient contraceptive services mean consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of all contraceptive methods to prevent pregnancy that have been approved by the United States Food and Drug Administration.
- Provides benefits for outpatient Prescription Drugs and devices that provide benefits for hormone replacement therapy for peri and post menopausal women and for outpatient prescription contraceptive drugs or devices which have been approved by the United States Food and Drug Administration under the same terms and conditions as for such other prescription drugs or devices, provided that in covering all FDA approved prescription contraceptive methods.

Hospice for Terminally Ill (Hospice Care): Coverage is provided for licensed hospice services to terminally ill patients with a life expectancy of six months or less. These services shall include, but not be limited to, Physician's services, nursing care provided by or under

the supervision of a registered nurse, social services, volunteer services and counseling services provided by professional or volunteer staff under professional supervision.

Infertility Benefits: The diagnosis and treatment of Infertility is payable the same as any other pregnancy related procedures. Infertility-related drugs will not be treated different from those imposed on any other Prescription Drugs. This Benefit includes expense incurred for the following non-experimental infertility procedures:

- Artificial insemination and Intrauterine insemination;
- In vitro fertilization and embryo placement;
- Gamete Intra-Fallopian Transfer;
- Zygote intrafallopian transfer;
- Intracyloplasmic sperm injection for the treatment of male factor infertility
- Assisted hatching;
- Cryopreservation of eggs;
- Sperm, egg, and/or inseminated egg procurement and processing, and banking of sperm or inseminated egg, to the extent such costs are not covered by the donor's insurer, if any. Coverage is not limited to sperm provided by the insured's spouse.

No pre-existing condition exclusions or waiting periods apply.

"Infertility" means the Condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35. For purposes of meeting the criteria for infertility in this section, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1 year or 6 month period, as applicable.

Maternity expense: Includes expenses for prenatal care, childbirth and post-partum care (including well baby care) on the same basis as any other physical Illness. Expenses for childbirth include Hospital inpatient care for 48 hours following vaginal delivery and 96 hours following a cesarean section. Any decision to shorten maternity

stays will be made by the Attending Physician 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. Attending Physician includes the attending obstetrician, pediatrician, or certified nurse midwife attending the mother and newly born child.

Mental Health Benefits for Children and Adolescents under age 19: Coverage will be provided the same as any other physical Illness for children and adolescents under age 19 for the diagnosis and treatment of non-Biologically-Based Mental, behavioral or emotional disorders, as described in the most recent edition of the DSM. The following requirements must be met:

- The disorders substantially interfere with or substantially limit 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 Physician, primary pediatrician or a licensed mental health professional.
- The child or adolescent 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 a disorder, or
  (3) a pattern of conduct or behavior caused by such disorder which poses a serious danger to self or others.

Benefits will continue to be provided to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's nineteenth 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.

Newborn Hearing: Coverage is provided for the cost of a newborn hearing screening test 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 regulations of the department of public health.

Non-Prescription Enteral Formulas for Home Use: Coverage is provided for nonprescription enteral formulas for home use for which a Physician has issued a written order 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.

Nurse Midwife Coverage: Benefits provided for services of a certified nurse midwife; provided, however, that expenses for such services are reimbursed when such services are performed by any other duly licensed practitioner; and provided, further, that such services are within the lawful scope of practice for a certified nurse midwife.

Off-Label Use of Drugs for the treatment of Cancer and HIV/AIDS: Coverage is provided for the off-label use of drugs for the treatment of cancer and HIV/AIDS.

- Coverage provided for any such drug used for the treatment of cancer on the grounds that the off-label use of the drug has not been approved by the United States Food and Drug Administration for that indication; provided, however, that drug is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature, or by the commissioner.
- Coverage provided for any such drug for HIV/AIDS treatment on the grounds that the off-label use of the drug has not been approved by the federal Food and Drug Administration for that indication, if the drug is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature, or by the commissioner.

Oral Cancer Therapy: When coverage is provided for cancer chemotherapy treatment, coverage is provided at the same Benefit level for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells on a basis not less favorable than intravenously administered or injected cancer medications that are covered.

Other Mental Disorders: 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, including home-based services delivered in such offices or settings

rendered by a licensed mental health professional acting within the scope of his license, that permit active and noncustodial treatment to take place in the least restrictive clinically appropriate setting.

Inpatient Services may be provided in a general hospital licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental Hospital licensed by the Department of Mental Health, or in a substance abuse facility licensed by the Department of Public Health.

Intermediate Services means a range of non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the patient's needs. Intermediate Services, include, but are not limited to the following: acute and other residential treatment; clinically managed detoxification services; partial hospitalization; intensive outpatient programs; day treatment; crisis stabilization; in-home therapy services.

The duration of authorized intermediate care services will vary according to that person's individual needs.

Preventive and Primary Care Services: Coverage is provided for the following services to the dependent child of an Insured from the date of birth through the attainment of six (6) years of age:

- 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.
- Such services also include hereditary and metabolic screening at birth, screening for lead poisoning, appropriate immunizations, and tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the Physician.

Coverage is provided for pediatric specialty care, including mental health care, by persons with recognized expertise in specialty pediatrics to Insureds requiring such services.

Prosthetic Coverage: Coverage provided for prosthetic devices and repairs under the same terms and conditions that apply to other Durable Medical Equipment covered

under the Policy, except as otherwise provided in this section. “Prosthetic device" means an artificial limb device to replace, in whole or in part, an arm or leg.

Psychopharmacological and Neuropsychological Assessment Service: Coverage is provided for Psychopharmacological services and neuropsychological assessment services expenses.

Qualified Clinical Trials: Coverage and reimbursement for patient care services provided pursuant to a qualified clinical trial to the same extent as they would be covered and reimbursed if the patient did not receive care in a qualified clinical trial.

Rape Related Mental or Emotional Disorders: Coverage will be provided for the diagnosis and treatment of rape-related or emotional disorders to victims of a rape or victims of assault with intent to commit rape, whenever the costs of such diagnosis and treatment exceed the maximum compensation awarded to such victims.

Scalp Hair Prosthesis for Cancer Patients: Coverage provided for scalp hair prosthesis expense for prosthesis worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia, for one (1) prosthesis per Policy Year.

"Prosthesis", an artificial appliance used to replace a lost natural structure; provided, however, that prosthesis shall include, but not be limited to, artificial arms, legs, breasts, scalp hair or glass eyes.

"Scalp hair prosthesis", an artificial substitute for scalp hair.

Special Medical Formulas: Coverage provided for newly born infants and adoptive children prescribed by a Physician for treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia in infants and children or to protect the unborn fetuses of pregnant women with phenylketonuria.

Speech, Hearing, and Language Disorders: Coverage is provided for the diagnosis and treatment of speech, hearing and language disorders by individuals licensed as speech¬ language pathologists or audiologists 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. Benefits are payable the same as any other Sickness. Coverage does not extend

to the diagnosis or treatment of speech, hearing and language disorders in a school based setting.

Telemedicine: Coverage is provided for the delivery of health care services by the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment. It does not include the use of audio-only telephone, facsimile machine, or email.

Treatment of Cleft Palate and Cleft Lip for Children: Coverage is provided for the treatment of cleft palate and cleft lip for children under the age of 18. Coverage includes medical, dental, oral and facial surgery, surgical management and follow-up care by oral and plastic surgeons, orthodontic treatment and management, preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment and prosthetic management therapy, speech therapy, audiology, and nutrition services when services are prescribed by the treating Physician or surgeon.

EMERGENCY MEDICAL EVACUATION BENEFIT

If the Insured cannot continue his academic program because he sustains an Accidental Injury or Emergency Sickness while Insured under the Policy or if a Covered Dependent sustains an Accidental Injury or Emergency Sickness and is more than a 100 mile radius from his current place of primary residence or outside of his Home Country, We will pay for the actual charge Incurred for an emergency medical evacuation of the Covered Person to or back to the Insured’s home state, country, or country of regular domicile subject to the Coinsurance, Deductible, Copayment, as stated in the Schedule of Benefits, and the Exclusions and Limitations provisions. No payment will be made under this provision unless the evacuation follows a Hospital Confinement of at least five (5) consecutive days. Before We make any payment, We require written certification by the Attending Physician that the evacuation is necessary. Any expense for medical evacuation requires Our prior approval and coordination. For international students, once evacuation is made outside the country, Coverage terminates. This Benefit does not include the transportation expense of anyone accompanying the Covered Person or visitation expenses.

REPATRIATION OF REMAINS BENEFIT

If the Covered Person dies while Insured under the Policy and is more than 100 miles from his permanent residence or outside of his Home Country, We will pay for the actual charge incurred for embalming, and/or cremation and returning the body to his place of permanent residence in his home state, country or country of regular domicile, up to the benefit amount shown in the Schedule of Benefits, subject to the Coinsurance, Deductible, Copayment, as stated in the Schedule of Benefits, the maximum Benefit limit shown above, and the Exclusions and Limitations provisions. Expenses for repatriation of remains require the Policyholder’s and Our prior approval. If You are a United States citizen, Your Home Country is the United States. This Benefit does not include the transportation expense of anyone accompanying the body, visitation or lodging expenses or funeral expenses.

EXCESS BENEFITS

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.

GENERAL EXCLUSIONS AND LIMITATIONS

Unless specifically included, no Benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; b) treatment, services, or supplies for, at, or related to:

1. Eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses. Repair or replacement of eye glasses or contact lens except when required as a direct result of an Injury or as provided herein.
2. Hearing Screenings (except as specifically provided in the Policy) or hearing examinations or hearing aids (except as provided herein).
3. Vaccines and immunizations (except as specifically provided in the Policy): a) required for travel; and b) required for employment.
4. Treatment (other than surgery) of chronic Conditions of the foot including weak feet, flat foot, foot strain, care of corns, calluses, toenails.
5. Cosmetic treatment, cosmetic surgery, plastic surgery or other services and supplies that We determine to be furnished primarily to improve

appearance rather than a physical function or control of organic disease. Improvements of physical function does not include improvement of self-esteem, personal concept of body image, or relief of social, emotional, or psychological distress. Procedures not covered include, but are not limited to: face lifts; sagging eyelids; deviated nasal septum, including submucous resection; prominent ears; skin scars, correction of breast size, asymmetry or shape by means of reduction, augmentation, or breast implant (except for correction or deformity resulting from mastectomies or lymph node dissections). This exclusion does not include Reconstructive Surgery when the service is incidental to or follows surgery resulting from trauma, Injury, infection or other diseases of the involved part.

6. Treatments which are considered to be unsafe, Experimental, or Investigational by the American Medical Association (AMA).
7. Dental care or treatment of the teeth, gums or structures directly supporting the teeth, (except as specified herein).
8. Temporomandibular Joint Dysfunction (TMJ);
9. Injury sustained while (a) participating in any intercollegiate, intramural, club or professional sport, contest, or competition; (b) traveling to or from such sport, contest, or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest, or competition.
10. Injury sustained by reason of a motor vehicle Accident to the extent that benefits are paid or payable by any other valid and collectible insurance whether or not claim is made for such benefits.
11. Injury resulting from participation in any hazardous activity, including: scuba diving, parachuting, hang gliding or bungee jumping.
12. Injury occurring in consequence of riding as a passenger or otherwise being in any vehicle or device of aerial navigation, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline.
13. Treatment in a government Hospital, unless there is a legal obligation for the Covered Person to pay for such treatment.

14. Any services of a Physician or Nurse who lives with You or Your Dependent(s) or who is related to You or Your Dependent(s) by blood or marriage.
15. Expense covered by any other medical insurance to the extent that Benefits are payable under any other medical insurance whether or not a claim is made for such Benefits.
16. Services received before the Covered Person's Effective Date or after the Covered Person's Coverage ends, except as specifically provided under the Extension of Benefits provision.
17. Under the Prescription Drug Benefit, any drug or medicine:
    - Obtainable Over the Counter (OTC);
    - for the treatment of alopecia (hair loss) or hirsutism (hair removal);
    - for the purpose of weight control;
    - anabolic steroids used for body building;
    - sexual enhancement drugs;
    - cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, or treatment of acne except as specifically provided in this Policy;
    - refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
    - for an amount that exceeds a 30 day supply;
    - drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
    - purchased after Coverage under the Policy terminates;
    - consumed or administered at the place where it is dispensed;
    - if the FDA determines that the drug is contraindicated for the treatment of the Condition for which the drug was prescribed; or Experimental for any reason.
18. Vitamins, minerals, or food supplement; except as specifically stated.
19. Services for the treatment of any Injury or Sickness incurred while committing or attempting to commit a felony; or while taking part in an insurrection or riot.

20. Injury or Sickness for which Benefits are paid or payable under any workers' compensation or occupation disease law or act, or similar legislation.
21. War or any act of war, declared or undeclared; or while in the armed forces of any country.
22. Treatment received outside of the United States of America, except when medically necessary for an Emergency Confinement in a Hospital or as specified herein.
23. Non-cystic acne.
24. Pregnancy that results under a Surrogate Parenting Agreement.
25. Nutrition counseling services (except as specifically provided in the Policy), including services by a Physician for general nutrition, weight increase or reduction services, except as specifically provided in the Policy; exercise machinery or equipment, including but not limited to treadmill, stair steps, trampolines, weights, sports equipment, support braces used primarily for use during any sport or in the course of employment, any equipment obtainable without a Physician's prescription.
26. Aroma therapy, hypnosis, rolfing, hyperhidrosis, psychosurgery, and biofeedback.
27. Elective surgery or treatment.
28. Custodial Care.
29. Modifications made to dwellings, property, or automobiles such as ramps, elevators, stair lifts, swimming pools, spas, air conditioners or air-filtering systems, equipment that may increase the value of the residence, or car hand controls, whether or not their installation is for purposes of providing therapy or easy access, or are portable to other locations.
30. Vocational recreation, art, dance, poetry, music, or other similar-type therapies, including regression therapy; personal enhancement or self-actualization therapy.

CLAIM PROCEDURE

In the event of Covered Injury 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.

SUBMIT ALL MEDICAL CLAIMS TO:
Cigna
PO Box 188061
Chattanooga, TN 37422 – 8061
Electronic Payor ID: 62308

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 No. 302-530-2013

Customer Service, verification of benefits, claim correspondence, and ID card requests should be directed to:

Claims Administrator:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
(413) 733-4540 or Toll Free (800) 633-7867
www.chpstudent.com

You can access up to date information about your plan, including amendments, privacy notice, and rights and responsibilities at www.chpstudent.com.
Within forty-five (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 forty-five (45) days after receipt

of the properly documented claim at the rate of one and one half percent (1.5%) per month, not to exceed eighteen percent (18%) 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 above address. Include your name, phone number, address, school attended and email address, if available.
Claims will be reviewed and responded to within sixty (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

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

NURSE HOTLINE FOR STUDENTS
For quick, sound medical advice from specially trained Nurses
24 hours a day, 365 days per year
Call toll free at 800-557-0309

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE
FrontierMEDEX ACCESS services is a comprehensive program providing You with 24/7 emergency medical and travel assistance services including emergency security or political evacuation, repatriation services and other travel assistance services when you are outside Your home country or 100 or more miles away from your permanent residence. FrontierMEDEX is your key to travel security.
For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at 1-800-633-7867.
If you have a medical, security, or travel problem, simply call FrontierMEDEX 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: 1-800-527-0218 *or* if you are in a foreign country, call collect at: 1-410-453-6330**.**
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. FrontierMEDEX will then take the appropriate action to assist You and monitor Your care until the situation is resolved.

MGH Institute of Health Professions - 2015-2016 SCHEDULE OF BENEFITS		
	In-Network Benefit	**Out-of-Network Benefit**
Policy Year Maximum Benefit (including medical evacuation and repatriation)	**Unlimited**	
Policy Year Deductible - per Individual or Family (applies unless otherwise stated, additional deductibles and co-pays may apply)	$100 per Individual $200 per Family	$200 per Individual $400 per Family
Out-of-Pocket Maximum (includes Coinsurance, Deductible and Copayment; does not include non-covered medical expenses or elective treatment)	$1,000 per Individual $2,000 per family	$2,000 per Individual $4,000 per Family
Preventive/Wellness & Immunization Services	100% of Preferred Allowance (PA) (No Deductible)	Not covered
Outpatient Services (other than Surgery, Maternity, Mental Health/Drug or Alcohol)		
Physician visits, including Specialists and Consultants	100% of PA after $30 per visit co-pay	80% of R&C
Diagnostic X-ray and Laboratory Services; including pre-admission testing	100% of PA	80% of R&C
Diagnostic Imaging, including CT Scan, MRI, and/or PET Scans	100% of PA after a $50 per condition co-pay	80% of R&C after a $50 per condition co-pay
Inpatient Services – (other than Surgery, Maternity, Mental Health/Drug or Alcohol, except as specified)		
Miscellaneous Hospital Services	100% of PA	80% of R&C
Room and Board expense, at the semi-private room, general nursing care, and ICU	100% of PA	80% of R&C
Physician Visits (includes Specialists/Consultants)	100% of PA	80% of R&C
Skilled Nursing and Sub-Acute Care Facilities	100% of PA	80% of R&C
Surgical Services (Inpatient & Outpatient) When more than one (1) surgical procedure is performed in the same operative session, the additional surgery will be covered at 50%.		
Surgeon's Fee	100% of PA	80% of R&C
Assistant Surgeon / Anesthetist Services	30% of the Surgical Allowance, Payable at 100%	30% of the Surgical Allowance, Payable at 80%
Second Surgical Opinion	5% of the Surgical Allowance, Payable at 100%	5% of the Surgical Allowance, Payable at 80%
Hospital Miscellaneous, services related to a scheduled surgery performed in a hospital or ambulatory surgery center, includes operating room, laboratory tests, x-rays, examinations, anesthesia, supplies, drugs and medications.	100% of PA	80% of R&C
Maternity Care – Includes forty-eight (48) hours of Inpatient care following a normal delivery and ninety-six (96) hours of Inpatient care following a cesarean delivery, unless after conferring with the mother or a person responsible for the mother or newborn, the Attending Physician or a certified nurse-midwife who consults with a Physician, decides to discharge the mother or newborn child sooner. In the event of early discharge, Home Health Care visits will be provided.		
Pre- and Post-Natal Care	Paid the same as any other Sickness	Paid the same as any other Sickness
Hospital services	Paid the same as any other Sickness	Paid the same as any other Sickness
Biologically-Based and Non-Biologically Based Mental Conditions, including Alcoholism/Drug Abuse		
Inpatient services	100% of PA	80% of R&C
Outpatient Office Visits	100% of PA after $30 per visit co-pay	80% of R&C
Urgent Care and Emergency Services		
Urgent Care Facility (non Emergency) services	100% of PA after $30 per visit co-pay	80% of R&C
Emergency services - **(Note**: The In-Network deductible applies to Out-of-Network Emergency services)	100% of PA after $50 co-pay (Co-pay waived if admitted)	100% of R&C after $50 co-pay (Co-pay waived if admitted)
Emergency Medical Transportation services **(Note**: The In-Network deductible applies to both in and out-of-network)	100% of PA	100% of R&C
Other Services		
Allergy Testing & Treatment (limited to one (1) series of tests per Policy Year)	100% of PA after $30 per visit co-pay	80% of R&C
Habilitative care–including Physical and occupational therapy up to sixty (60) visits per Policy Year; No limit applied to autism treatment, home health care and speech/hearing disorders.	100% of PA after $30 per visit co-pay	80% of R&C
Rehabilitative Physical and Occupational Therapy (Outpatient) – maximum of 60 visits per Policy Year. No limit applied to autism treatment, home health care and speech/hearing disorders.	100% of PA after $30 per visit co-pay	80% of R&C
Rehabilitative & Habilitative Speech therapy	100% of PA after $30 per visit co-pay	80% of R&C
Cardiac Rehabilitation	100% of PA after $30 per visit co-pay	80% of R&C
Chiropractic	100% of PA after $30 per visit co-pay	80% of R&C
Home Health Care	100% of PA	80% of R&C
Hospice	100% of PA	80% of R&C
Diabetic treatment and Education	Paid the same as any other Sickness	
Durable Medical Equipment (DME) – includes Prosthetic and Orthotic Devices	100% of PA	80% of R&C
Prescription Drug Expense (Policy year deductible does not apply) (per 30-day supply) Prescriptions must be filled at a "Cigna" participating pharmacy.	• $0 Co-pay for generic contraceptives and wellness prescriptions; or • $20 Co-pay for other generic prescriptions; or • $30 Co-pay for any brand name prescription	Not Covered
Pediatric Dental for Covered Persons under nineteen (19)	Preventive: 100% of R&C Basic Restorative: 70% of R&C Major Services: 50% of R&C Medically Necessary Orthodontia: 50% of R&C	
Routine Vision Exam for Covered Persons under nineteen (19) – one exam every two (2) years. Eye glasses/contact lenses not covered.	100% of R&C up to $150, 50% thereafter	
Weight Loss programs – up to $150 per Policy Year.	100% of Reimbursable Charge	
Elective Treatment		
Acupuncture	100% of PA after $30 per visit co-pay	80% of R&C
Voluntary Termination of Pregnancy	100% of PA	80% of R&C
Private Duty Nursing	100% of PA	80% of R&C
Routine Hearing Exams (newborn screening is covered under Preventive Services with no cost sharing)	100% of PA after $30 per visit co-pay	Not Covered
Hearing aids for children (21 or younger)	100% of R&C up to $2,000 per ear every 36 months	
Hearing aids and hearing aid batteries (over age 21)	100% of R&C, up to $1,000 per Policy Year (No Deductible)	
Sickness Dental Expense – up to $350 per tooth for removal of impacted or infected wisdom teeth.	100% of PA	80% of R&C

Arabic/عربي

إشعار بشأن خدمات الترجمة والترجمة الفورية

إننا نقدم، تلبية لطلب الراغبين، خدمات الترجمة والترجمة الفورية المتعلقة بالإجراءات الإدارية وتسيير المطالبات. ويمكنك الحصول على هذه الخدمة عن طريق الاتصال بقسم خدمة الزبائن Customer Service Department على الرقم: 1-800-633-7867

Cambodian(Khmer)/ *ភាសាខ្មែរ*

ការប្រកាស ស្តីពីការបំពីរផ្នែកបកប្រែភាសាផ្ទាល់មាត់ និងភាសាសរសេរ

យើងផ្តល់ជូន ការបំពីរផ្នែកបកប្រែភាសាផ្ទាល់មាត់ និងភាសាសរសេរ ប្រសិនបើអ្នកត្រូវការ
នៅក្នុងទំរង់ការ ផ្តែកចាត់ចែង និងទំរង់ការធ្វើបណ្តឹង។ បើអ្នកត្រូវការ សូមទាក់ទងតាមទូរស័ព្ទ មកការិយាល័យ
បំពីអតិថិជនយើង តាមលេខ ១៨០០-៦៣៣-៧៨៦៧។

Chinese(Mandarin)/國語

翻譯及傳譯服務通知

如果您提出要求，我們可以爲您提供與行政手續和索賠申請有關的翻譯及傳譯服務。請與我們的客戶服務部聯絡，電話是1-800-633-7867（1-800-MED-STOP ）。

English/English

Notice Regarding Translator and Interpretation Services

We provide, upon request, interpreter and translation services related to administrative procedures and claims processing. This service is available to you when you contact our Customer Service Department at 1-800-MED-STOP.

French/Français

Avis sur les services de translation et d'interprétation

Nous fournissons, sur demande, des services d'interprétation et de translation relatifs aux procédures administratives et au traitement des réclamations. Ce service est à votre disposition quand vous contactez notre service après-vente (Customer Service Department) à 1-800-MED-STOP.

Greek/Ελληνικά

Ειδοποίηση σχετικά με τις υπηρεσίες μετάφρασης και διερμηνείας

Παρέχουμε, κατ' απαίτηση, υπηρεσίες μετάφρασης και διερμηνείας σχετικά με τις διοικητικές διαδικασίες και τις διεργασίες αιτήσεων. Η υπηρεσία αυτή είναι διαθέσιμη σε εσάς όταν εσείς επικοινωνείτε με το τμήμα εξυπηρέτησης πελατών στο τηλεφωνικό αριθμό 1-800-MED-STOP.

Haitian Creole/Kreyòl

Avi sou sèvis tradiksyon ak entèpretasyon

Nou bay, lè ou mande li, sèvis tradiksyon ak entèpretasyon pou keksyon administratif ak reklamasyon. Pou jwen sèvis sa, rele Depatman Kliyan sou nimewo 1-800-MED-STOP.

Italian/Italiano

Avviso Riguardante Servizi di Traduzione ed Interpretazione.

Forniamo, su richiesta, servizi di interpretazione e traduzione relativi a procedure amministrative e procedimenti per reclami. Questo servizio è disponibile contattando il Servizio Assistenza Clienti al 1-800 MED-STOP.

Laotian/ *ລາວ*

ປະກາດກ່ຽວກັບການບໍຣິການແປພາສາແບບປາກເປົ່າ ແລະແບບຂຽນ

ຕາມຄຳຂໍ, ພວກເຮົາຈະໃຫ້ການບໍຣິການດ້ານການແປພາສາແບບປາກເປົ່າ ແລະແບບຂຽນ ຊຶ່ງກ່ຽວກັບການປະຕິ ບັດດ້ານການບໍຣິຫານ ແລະການດຳເນີນການທວງຄືນ ການຊ່ວຍເຫຼືອຕ່າງໆ. ການບໍຣິການນີ້ ຈະມີໃຫ້ເມື່ອທ່ານຕິດຕໍ່ ໄປຫາຝ່າຍປະຊາສຳພັນ ຂອງພວກເຮົາ ທີ່ເບີໂທ 1-800-MED-STOP (633-7867).

Portuguese/Português

Informação sobre serviços de Tradução e Interpretação

Nós fornecemos, mediante solicitação, serviços de tradução e interpretação relacionados a procedimentos administrativos e processamento de reclamações. Este serviço encontra-se à sua disposição quando Você contatar o nosso Departamento de Atendimento ao Consumidor: 1-800-MED-STOP.

Russian/Русский

Объявление: услуги устных и письменных переводчиков

По требованию клиентов мы предоставляем услуги устных и письменных переводчиков для оказания помощи в вопросах, связанных с административными процедурами и обработкой заявлений. Для того, чтобы воспользоваться услугами переводчика, обратитесь в Отдел обслуживания клиентов по телефону 1-800-MED-STOP.

Spanish/Español

Aviso sobre servicios de interpretación y traducción

Nosotros podemos ofrecerle, si usted lo solicita, servicios de traducción relacionados con procedimientos administrativos y procesamiento de reclamos. Este servicio se encuentra disponible cuando usted habla con el departamento del servicio al consumidor al 1-800-MED-STOP.