MGH Institute of Health Professionals 2016-2017 Student Health Insurance Program Underwritten by National Guardian Life Insurance Co. as Policy Form No. NBH-280(2014)PPO MA National Guardian Life Insurance Company is not affiliated with Guardian Life Insurance Company of America aka The Guardian or Guardian Life Policy No. 2016I5B17	This health plan satisfies **Massachusetts Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance. Please see full brochure for additional information

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.

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.

IMPORTANT NOTICE

This flyer provides a brief description of the important features of the Policy and is intended only for a quick reference. It does not limit the coverage as described in the master policy which contains complete terms and provisions. A copy of the master policy is on file at the college.

PREMIUM

Premium coverage must be received within the 31-day periods beginning with the start of the applicable Coverage Period. MGH Institute of Health Professionals collects this money as part of your tuition bill and pays the insurer to ensure coverage.

Rates* per Coverage Period			
	05/01/16-08/31/16	**09/01/16-12/31/16**	**01/01/17-04/30/17**
Student Only	$1,975	$1,975	$1,975
Student and Spouse	$3,950	$3,950	$3,950
Student & 1 Child	$3,950	$3,950	$3,950
Student & 2 Children	$5,925	$5,925	$5,925
Student & 3 or more Children	$7,900	$7,900	$7,900
Student, Spouse & 1 Child	$5,925	$5,925	$5,925
Student, Spouse & 2 Children	$7,900	$7,900	$7,900
Student, Spouse & 3 or more Children	$9,875	$9,875	$9,875

Note: the rates include a service fee retained by the broker

SCHEDULE OF BENEFITS

This is a schedule of benefits available of the 2016-2017 MGH institute of Health Professionals Student Health Insurance Plan. **This summary should be used in conjunction with the full plan description, including plan provisions, limitations and exclusions. To obtain a copy of the full plan certificate, please go to www.chpstudent.com**. Questions regarding the benefits, limitations and exclusions of the Student Health Insurance Plan can be directed to Consolidated Health Plans at (800) 633-7867 or by email at customerservice@consolidatedhealthplan.com.

Payments made to providers will be paid as stated below. By enrolling in this Insurance Program, you have access to the Cigna Preferred Provider Network. A listing of participating providers can be found at www.cigna.com. Covered Medical Expenses are considered incurred while the Policy is in force as to the Insured Person except with respect for any expenses payable under the Extension of Benefits provision. The benefits payable are as defined in and subject to all provisions of this Policy and any endorsements thereto.

Covered Medical Expenses include:

SCHEDULE OF BENEFITS

Eligibility	Benefit Amount Payable	
Annual Maximum Benefit for Non-Essential Health Benefits	Student: Unlimited Dependent: Unlimited	
Preventive Services	The Deductible is not applicable to Preventive Services. Benefits for services provided by a Network Provider are paid at 100% of the PPO Allowance of Covered Medical Expenses. Benefits for services provided by a Non-Network Provider are provided at the Coinsurance Amount shown below	
Deductible	$100, Individual Coverage / $200, Family Coverage	$200, Individual Coverage/$400, Family Coverage
Out-of-Pocket Expense Limit: The most an Insured would be required to	**In-Network**	**Out of Network**

pay for covered expenses during a plan year before the coinsurance level would pay at 100%.	Individual $2,000 Family $4,000	Individual $4,000 Family $8,000
Coinsurance	100% of Preferred Provider Allowance (PA) for Covered Medical Expenses In-Network	80% of Usual and Reasonable (U&R) Covered Medical Expenses Out of Network
Inpatient Benefits	**In-Network**	**Out of Network**
BENEFITS FOR COVERED INJURY/SICKNESS	**BENEFIT AMOUNT PAYABLE**	
Hospital Room & Board Expenses	The Coinsurance Amount shown above	The Coinsurance amount shown above
Hospital Intensive Care Unit Expense - ***in lieu of normal Hospital Room & Board Expenses***	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Hospital Miscellaneous Expenses for services & supplies	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Preadmission Testing	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Physician's Visits while Confined:	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Inpatient Surgery: Surgeon Services Anesthetist Assistant Surgeon	 The Coinsurance Amount shown above The Coinsurance Amount shown above 30% of benefit for Surgeon Services	 The Coinsurance Amount shown above The Coinsurance Amount shown above 30% of benefit for Surgeon Services
Physical Therapy (inpatient)	Co-Pay: $30 then The Coinsurance Amount shown above; subject to a maximum number of visits of 60 per Policy Year	The Coinsurance Amount shown above
Outpatient Benefits	**In-Network**	**Out of Network**
BENEFITS FOR COVERED INJURY/SICKNESS	**BENEFIT AMOUNT PAYABLE**	
Outpatient Surgery: Surgeon Services Anesthetist Assistant Surgeon	 The Coinsurance Amount shown above The Coinsurance Amount shown above 30% of benefit for Surgeon Services	 The Coinsurance Amount shown above The Coinsurance Amount shown above 30% of benefit for Surgeon Services
Outpatient Surgery Miscellaneous (excluding not-scheduled surgery) – expenses for services & supplies, such as cost of operating room, therapeutic services, misc. supplies, oxygen, oxygen tent, and blood & plasma	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Outpatient Facility Fee	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Short Term Rehabilitation Therapy (outpatient)	Co-Pay: $30, then the Coinsurance Amount shown above; subject to a maximum number of visits of 60 per Policy Year for Physical Therapy	The Coinsurance Amount shown above
Emergency Services Expenses In-network out of pocket maximum applies to out of network emergency services benefits	Co-Pay: $50, then 100% of PA Co-pay waived if admitted	Co-Pay: $50, then 100% of PA Co-pay waived if admitted
Primary Care Visit to Treat an Injury or Illness (includes syringes and needles dispensed during a visit)	Co-Pay: $30, then the Coinsurance Amount shown above	The Coinsurance Amount shown above
Specialist Visit	Co-Pay: $30, then the Coinsurance Amount shown above	The Coinsurance Amount shown above

Other Practitioner Office Visit	Co-Pay: $30, then the Coinsurance Amount shown above	The Coinsurance Amount shown above
Urgent Care	Co-Pay: $30, then the Coinsurance Amount shown above	The Coinsurance Amount shown above
Imaging Tests	Co-Pay: $50, then the Coinsurance Amount shown above	Co-Pay: $50, then the Coinsurance Amount shown above
Diagnostic X-ray Services	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Laboratory Procedures (Outpatient**)**	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Outpatient Prescription Drugs	Co-Pay: subject to Generic Copay $20.00, subject to Preferred Brand Copay $30.00,- subject to Brand Copay $30.00 then Coinsurance: 100%	No Benefit
Home Health Care Expenses	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Hospice Care Coverage	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Skilled Nursing Facility Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Podiatry Care Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
TMJ Disorder Treatment	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Dialysis Services Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Other Benefits	**In-Network**	**Out of Network**
Ambulance Service - Ground and/or Air and/or water Transportation	The Coinsurance Amount shown above	100% of U&R
Braces and Appliances	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Durable Medical Equipment	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Maternity Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Routine Newborn Care	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Consultant Physician Services – when requested by the attending physician	Co-Pay: $30, then The Coinsurance Amount shown above	The Coinsurance Amount shown above
Sickness Dental Expense	The Coinsurance Amount shown above up to $300 per tooth	The Coinsurance Amount shown above up to $300 per tooth
Abortion Expense	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Medical Evacuation Expense	100% of PA	100% of U&R
Repatriation Expense	100% of PA	100% of U&R
Mandated Benefits	**In-Network**	**Out of Network**
BENEFITS FOR COVERED INJURY/SICKNESS	**BENEFIT AMOUNT PAYABLE**	
Autism Spectrum Disorder Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Cancer Treatment Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Clinical Trials Benefit for Cancer or other Life Threatening Disease	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Cardiac Rehabilitation Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Chiropractic Care Benefit	Co-Pay: $30, then the Coinsurance Amount shown above	The Coinsurance Amount shown above
Cleft Palate and Cleft Lip Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Cytologic Screening (pap smear) and Mammographic Examination	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Diabetes Equipment, Supplies and Service Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Early Intervention Services	100% of PA	100% of U&R
Fitness Benefit	Up to 2 months of membership to a Fitness Facility, at least $150 per policy year	Up to 2 months of membership to a Fitness Facility, at least $150 per policy year

Hormone Replacement Therapy Services; Outpatient Contraceptive Services. Same as other prescription drugs or devices	Co-Pay: subject to Generic Copay $20.00, subject to Preferred Brand Copay $30.00, subject to Brand Copay $30.00, then Coinsurance of 100%	No coverage out of network
Human Leukocyte Testing	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Infertility Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Mastectomy Surgery and Rehabilitation Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Mental Illness Benefit (Paid same as any other Sickness)	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Morbid Obesity & Bariatric Surgery Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Non-Prescription Enteral Formula and Low Protein Food Formulas	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Organ Transplant Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Oxygen and Respiratory Therapy Benefit (for home use)	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Pediatric Dental Care Benefit	100% of PA for Preventive	The Coinsurance Amount shown above
Pediatric Vision Care Benefit	100% of PA for Preventive	The Coinsurance Amount shown above
Pediatric Specialty Care	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Prosthetic Devices	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Telemedicine Consultation Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Treatment of Speech, Hearing, and Language Disorders Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Hearing Aid for Children Benefit	Maximum $2,000 for each hearing aid every 36 months	Maximum $2,000 for each hearing aid every 36 months
Weight Loss Program Benefit	Up to 2 months of membership to a Fitness Facility	Up to 2 months of membership to a Fitness Facility

Refer to plan detail for additional benefits, State Mandated Benefits, limitations, exclusions, and definitions. The complete Plan brochure is available online at: www.chpstudent.com.

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. medical services rendered by provider employed for or contracted with the School, including team physicians or trainers, except as specifically provided in the Schedule of Benefits.
2. dental treatment including orthodontic braces and orthodontic appliances, except as specified for Insured Persons under age 19 or for accidental injury to the Insured Person's Sound, Natural Teeth.
3. professional services rendered by an immediate family member or any who lives with the Insured Person.
4. services or supplies not related to the medical care of the Insured Person's Injury or Sickness.
5. services or supplies in connection with eye examinations, eyeglasses or contact lenses, except those resulting from a covered accidental Injury or as specifically provided in the Schedule of Benefits.
6. weak, strained or flat feet, corns, calluses or ingrown toenails.
7. treatment of acne.
8. expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
9. any expenses in excess of Usual and Reasonable charges.
10. loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
11. loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority, unless indicated otherwise on the Schedule of Benefits.
12. loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate, intramural or club sports.
13. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport;
14. treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which the Insured Person is required to pay.

15. Injury sustained as the result of the Insured Person's operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.
16. Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.
17. Treatment or care for weight increase or weight loss, except as specifically provided in the Schedule of Benefits
18. expenses for hair growth or removal unless otherwise specifically covered under the Policy.
19. racing or speed contests, skin diving or sky diving, ultra light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles) or other hazardous sport or hobby.
20. expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical treatment within 24 hours of the Accident or results from Reconstructive Surgery.
    a. For the purposes of this provision, Reconstructive Surgery means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible.
    b. For the purposes of this provision, Plastic or Cosmetic Surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance).
21. treatment to the teeth, including surgical extractions of teeth Except as specifically provided in the Schedule of Benefits.
22. an Insured Person's:
    a. committing or attempting to commit a felony,
    b. being engaged in an illegal occupation, or
    c. participation in a riot.
23. custodial care service and supplies.
24. Specific non-life threatening surgeries including but not limited to: non-endocrine or pulmonary related Hysterectomy, Salpingo-oophorectomy, Vaginectomy, Metoidioplasty, Scrotoplasty, Urethroplasty, placement of testicular prostheses (except when related to injury or disease process), Phalloplasty, Orchiectomy, Penectomy, Vaginoplasty, Clitoroplasty, Labiaplasty unless determined to be medically necessary by a physician practicing within the scope of his or her license.
25. expenses that are not recommended and approved by a Physician.
26. Physician's charges for diagnosis and treatment of structural imbalance, distorting or subluxation in vertebral column or elsewhere in body by manual, mechanical means, through muscular-skeletal adjustments, manipulations, and related modalities. Except as specifically provided in the Schedule of Benefits.
27. Personal convenience items such as modifications to dwellings or property that may increase the value of the residents or automobile, regardless of therapeutic value.
28. Non-Prescription drugs or medicines such as legend vitamins, minerals, food supplements, herbs, herbal formulas, biological sera, except as specifically provided in the Schedule of Benefits.
29. Acupressure, aroma therapy, hypnosis, hyperhidrosis (excessive sweating), rolfing type services, reflexology, biofeedback, alternative health care except as specifically provided.
30. Vocational recreation: art, dance, poetry, music, or other similar-type therapies. ;and
31. Pregnancy that results under a surrogate parenting agreement.
32. Treatments and resulting complications the American Medical Association (AMA), consider to be unsafe, Experimental, or Investigational.

PRIVACY POLICY

The Student Health Insurance Plan is underwritten by National Guardian Life Insurance Company. Claims are paid by Consolidated Health Plans. We know that your privacy is important to you and we strive to protect the confidentially of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling (800) 633-7867 or by visiting www.chpstudent.com

WHERE TO FIND HELP

Enrollment & Waiver Process	Insurance Benefits, Claims Questions, ID Cards	Where to Send Claims
University Health Plans, Inc. One Batterymarch Park Quincy, MA 02169-7454 Phone: (800) 437-6448 - Fax: (617) 472-6419 www.universityhealthplans.com info@univhealthplans.com	**Consolidated Health Plans** 2077 Roosevelt Avenue Springfield, MA 01104 (800) 633-7867 www.chpstudent.com	**Cigna** PO Box 188061 Chattanooga, TN 37422-8061 Electronic Payor ID: 62308

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