

Student Health Insurance

Designed for the Students of

The University of Vermont

2016-2017

Underwritten by:

Nationwide Life Insurance Company
Columbus, OH

Policy Number: 302-054-4414

Effective: August 1, 2016 to July 31, 2017

Group Number: S210510

IMPORTANT NOTICE

PLEASE KEEP THIS BROCHURE AS A GENERAL SUMMARY OF THE INSURANCE BENEFITS. The Master Policy on file at the University contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Brochure. If any discrepancy exists between the Brochure and the Master Policy, the Master Policy will govern and control the payment of benefits.

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.

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WHERE TO FIND HELP?

The University of Vermont Student Health Insurance Plan has been developed especially for The University of Vermont students. The Plan provides coverage for Sicknesses and Injuries that occur on and off campus and includes special cost-saving features to keep the coverage as affordable as possible. The University of Vermont is pleased to offer the Plan as described in this brochure.

For questions about claims status, eligibility, enrollment and benefits please contact:

For Questions About:	Please Contact:
Waiver Process Health Services	The University of Vermont Student Health Insurance Office Center for Health and Wellbeing (802) 656-0602 Email: StudentInsurance@uvm.edu
Enrollment Dependent Enrollment	University Health Plans, Inc. One Batterymarch Park Quincy, MA 02169-7454 Phone : (800) 437-6448 Fax : (617) 472-6419 www.universityhealthplans.com or Email: info@univhealthplans.com
Insurance Benefits Preferred Provider Listings Claims Processing	Consolidated Health Plans 2077 Roosevelt Avenue Springfield, Massachusetts 01104 (800) 633-7867 www.chpstudent.com
Preferred Provider Listings	Consolidated Health Plans or www.cigna.com
Prescription Drug Providers	Cigna Pharmacy Plan www.cigna.com

AM I ELIGIBLE?

All undergraduate students attending UVM taking nine (9) or more credit hours and graduate students taking nine (9) or more credit hours are automatically enrolled in the UVM insurance plan, subject to the waiver requirements.

Part-time undergraduate and continuing educational students taking at least six (6) credit hours, and graduate students taking at least five (5) credit hours, may enroll at their option. Part-time students opting to enroll must also pay the health fee.

All international students will be required to pay the semester Health Fee and purchase the University of Vermont Student Health Insurance Plan. International Students will automatically be billed for the insurance premium and are not eligible to waive participation in the Plan. If you have questions regarding this requirement, please contact the Student Insurance Office at (802) 656-0602.

Any student whose personal health insurance policy is cancelled during the academic year would have the option to purchase the University's Student Health Insurance Plan.

Students must be physically and actively attending classes on campus for at least the first thirty-one (31) days beginning with the first day for which coverage is purchased. Students who are enrolled exclusively in online courses and whose enrollment does not consist entirely of Short-Term Courses do not fulfill the Eligibility requirements. Home study, correspondence, online, and television (TV) courses do not fulfill the Eligibility requirements.

INVOLUNTARY LOSS OF OTHER COVERAGE

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 31 days of Involuntary Loss of Other Coverage.

For purposes of this section, Involuntary Loss of Other Coverage means that prior coverage is involuntarily terminated due to no fault of the Eligible Person, which includes coverage that terminates due to a loss of employment by the Eligible Person or the Eligible Person's spouse or parent. This definition does not include coverage that has a predetermined termination date, or expiration of COBRA eligibility, and does not apply to coverage that has been voluntarily terminated.

Coverage is effective upon enrollment and receipt of Premium by Us or Our authorized representative.

HOW DO I WAIVE/ENROLL?

Participation in this Student Health Insurance Plan can be waived if the student has comparable coverage currently in force. A Waiver/Decision Form can be accessed online at www.uvm.edu/health/insurance. Follow the links to complete the waiver/decision form. The student can either: (a) purchase the University of Vermont Student Health Insurance Plan, or (b) decline the insurance by identifying comparable coverage currently in force with another insurance company. The online waiver process will be available but will not accept a decision past the published deadlines.

Category	Open Enrollment Deadline Date
Students enrolling for the Fall Semester	September 15, 2016
Students enrolling for the Spring Semester	February 15, 2017

Please note: International Students are not able to waive this coverage. If you have questions regarding this requirement, please contact the Student Insurance Office at (802) 656-0602.

LATE ENROLLMENT/ APPEAL PROCESS

After the deadline, The University of Vermont Student Health Insurance Plan may not be waived/cancelled, except as provided by policy guidelines. Call the Center for Health and Wellbeing for more information.

COVERAGE FOR DEPENDENTS

Insured Students may also enroll their lawful spouse, domestic partner, or civil union partner and dependent children under age twenty-six (26). Dependent eligibility expires concurrently with that of the Insured student.

Students may also enroll their Dependents within sixty (60) days of an eligible qualifying event. Eligible qualifying events for a Dependent are defined in the Master Policy. Enrollment requests (including payments) received after the sixty (60) days following the qualifying event will not be accepted. Coverage will be effective as of the date of the qualifying event.

Your Dependents will be covered for the same benefits for which You are covered. Coverage is not effective until the start date shown in the Plan Costs and Period of Coverage section. To enroll your Dependent(s), please visit:

www.universityhealthplans.com.

NEWBORN INFANT COVERAGE

A child born to a Covered Person shall be covered for Accident, Sickness, and congenital defects for sixty (60) days from the date of birth. At the end of this sixty (60) day period, coverage will cease under The University of Vermont Student Health Insurance Plan. However, the Insured must notify Us in writing within sixty (60) days of such birth and pay the required additional premium, if any, in order to have coverage for the newborn child continue beyond such sixty (60) day period.

Coverage is provided for a child legally placed for adoption with a Covered Person for sixty (60) days from the moment of placement, provided the child lives in the household of the Covered Person and is dependent upon the Covered Person for support. However, the Insured must notify Us in writing within sixty (60) days of such adoption and pay the required additional premium, if any, in order to have coverage for the adopted child continue beyond such sixty (60) day period.

A dependent will not be considered a late enrollee if a court order requires the Covered Person to provide coverage for his or her eligible dependent. Such coverage will become effective on the date of the court order and will remain in effect for sixty (60) days. To extend coverage past the sixty (60) days, Covered Person must (1) enroll the child(ren) within sixty (60) days of the court order, and (2) pay any additional premium, if necessary, starting from the date of the court order.

EFFECTIVE DATES AND COSTS

- Students:** Coverage for all insured students enrolled for the Fall Semester will become effective at 12:01 a.m. on August 1, 2016, and will terminate at 11:59 p.m. on July 31, 2017.
- New Spring Semester Students:** Coverage for all insured students enrolled for the Spring Semester will become effective at 12:01 a. m. on January 1, 2017, and will terminate at 11:59 p.m. on July 31, 2017.
- Insured Dependents:** Coverage will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the completed application and premiums are sent, if later. Coverage for insured dependents terminates in accordance with the Termination provisions as described in the Master Policy. Examples include, but are not limited to, the date the Insured

student's coverage terminates and the date the dependent no longer meets the definition of a dependent.

	Annual 8/1/16-7/31/17	Fall 8/1/16-12/31/16	Spring 1/1/17-7/31/17
Student*	\$3,230**	\$1,346**	\$1,884**
Spouse/Civil Union Partner/Domestic Partner	\$3,093	\$1,297	\$1,796
Each Child	\$3,093	\$1,297	\$1,796

* **All costs above include a fee retained by the Servicing Agent.**

** **Cost listed includes a school administrative fee.**

TERMINATION

Coverage will terminate at 11:59 pm 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; or
- 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 (minus claims paid) to such person upon written request.
- The last date of the period for which Premium has been paid following the date a Dependent ceases to be a Dependent as defined.

Termination is subject to the Extension of Benefits provision.

Termination will be made without prejudice to any existing expense. Coverage for any Covered person who leaves The University of Vermont before the end of the semester will continue in force through the end of the period for which a premium was paid.

EXTENSION OF BENEFITS

The Coverage provided under this Policy ceases on the termination date, shown on the face page. 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; or
- Totally Disabled 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 twelve (12) months or until the date the disability ends, whichever is earlier.

Totally Disabled means, with respect to the Insured, the inability to attend classes at the location where he is enrolled. With respect to a Dependent, or the Insured if such classes are not in session, disability means the inability to engage in any of the usual activities of a person of like age and sex whose health is comparable to that of the Covered Person immediately prior to the Injury or Sickness.

The total payments made in respect of the Insured for such Condition both before and

after the termination date will never exceed the Maximum Benefit. After this Extension of Benefits provision has been exhausted, all Benefits cease to exist and under no circumstances will further Benefits be made.

This Extension of Benefits provision is applicable only to the extent the Covered Person will not be covered under this or any other similar health insurance policy in the ensuing term of Coverage.

Dependents that are newly acquired during the Insured's Extension of Benefits period are not eligible for Benefits under the provision.

PREMIUM REFUND POLICY

Any student withdrawing from school during the first thirty-one (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 minus any claims paid. Students withdrawing after such thirty-one (31) days will remain covered under the Policy for the full period for which premium has been paid and no refund will be made available. This is true for students on leave for medical or academic reasons, graduating students, and students electing to enroll in a separate comparable plan during the Policy Year. Premiums received by the Company are non-refundable except as specifically provided.

A Covered Person 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 ninety (90) days of withdrawal from school. Refunds for any other reason are not available.

STUDENT HEALTH CENTER REFERRAL

Dependents are not eligible to use the SHC, and therefore, are exempt from the SHC referral requirement.

The Covered Person must first seek services of the Center for Health and Wellbeing (CHWB). If the CHWB cannot provide the service needed, the Insured must obtain an initial referral that verifies that the services were not available at the CHWB. The Insured is then free to seek services without penalty with a Provider outside of the CHWB. **Any Deductible is waived if the Insured first utilizes and/or is referred by the CHWB.**

Expenses incurred for treatment rendered outside of the CHWB for which no prior referral is obtained will be subject to the per condition deductible as listed in the Schedule of Benefits.

A CHWB referral for outside care is required except under the following Conditions:

- Medical Emergency;
- When the CHWB is closed;
- Medical care received when the Insured is more than fifty (50) miles from the CHWB;
- Medical care obtained when the Insured is no longer able to use the CHWB due to change in eligibility status; or
- Pregnancy or Maternity care
- Routine care from an obstetrician/gynecologist.

A written referral from the CHWB is required for any follow-up care, with a Provider other than CHWB, after Emergency services

A CHWB referral does not constitute a guarantee of Benefits when treatment is provided outside the CHWB. We reserve the right to determine the Medical Necessity of treatment for services provided outside the CHWB.

SCHEDULE OF BENEFITS

The Policy provides benefits for expenses incurred by an Insured Person for loss due to a covered Injury or Sickness. Benefits will be paid up to the maximum benefit for each service as scheduled below. **The Insured Student will be subject to a \$200 Deductible per Condition without a referral from the Center for Health and Wellbeing.** Note: Medical Students are not subject to the deductible when participating in mandatory out-of-area rotations.

Your Coverage provides for the utilization of Preferred Providers in a Preferred Provider Organization (PPO). The Preferred Provider Organization(s) for your Coverage is: Cigna Go to www.cigna.com for a list of participating providers.

Covered Medical Expenses include:

Policy Year Maximum Benefit	
Insured	Unlimited
Dependent	Unlimited
Deductible * (except as specified herein) Per Condition per Covered Person	\$200

***Deductible:**

- Benefits are subject to Deductible unless otherwise indicated.
- The Deductible shall not apply:
 - To In-Network Preventive/wellness exams and immunizations
 - When referred by the Policyholder's Student Health Center
 - Expenses incurred to meet the Deductible are cross applied between In-Network and Out-of-Network
 - To Outpatient Prescription Drugs
- Copayments do not apply to Deductible

Insured Percent (except as specified herein)	80% of the Preferred Allowance (PA)	70% of the Reasonable and Customary Charges (R&C)

Medical Out-of-Pocket Maximum**

Covered Person	\$6,850	None
Dependent	\$13,700	None

**Out-of-Pocket Maximum:		
<ul style="list-style-type: none"> Includes the Prescription Drug Out-of-Pocket Maximum Includes Coinsurance, Copayments, and Deductibles; Excludes Out-of-Network; non-covered medical expenses and Elective treatment; Any Coinsurance paid by You is applied to the Out-of-Pocket Limit per Policy Year; Once the Out-of-Pocket Limit is reached by the Covered Person, the Insured Percent paid by the Company will increase to 100% In-Network up to the Maximum Benefit as specified herein. 		
Prescription Drug Out-of-Pocket Maximum (including Copayment, Coinsurance and Deductible) per Covered Person	\$1,300 single/ \$2,600 family	Not Applicable
Covered Charges- Essential Health Benefit	In-Network Benefit	Out-of-Network Benefit
Preventive Care (See Definition for additional information.)		
Wellness, Preventive and Immunization Services	100% of PA + waiver of Deductible	70% of R&C +waiver of Deductible
Office visits- performed and billed by a Physician's office, including Family or General Practice, Nurse, Physician Assistant, Pediatrician, Internal Medicine or OB/GYN when acting as a primary care Physician <ul style="list-style-type: none"> Limited to one (1) visit per day Does not apply when related to surgery or Physical Therapy Includes Telemedicine when Medically Necessary 	80% of PA after a \$25 Copayment per visit	70% of R&C after a \$25 Copayment per visit
Diagnostic Imaging – Includes x-ray services which are diagnostic or therapeutic	80% of PA	70% of R&C
Laboratory Services- Includes laboratory services which are diagnostic or therapeutic	80% of PA	70% of R&C
CT Scan, MRI, and/or PET Scans	80% of PA	70% of R&C
Infusions (done in an Outpatient Health Care Facility or Physician's office)	80% of PA	70% of R&C
Injections (done in an Outpatient Health Care Facility or Physician's office)	80% of PA	70% of R&C
Radiation	80% of PA	70% of R&C
Chemotherapy	80% of PA	70% of R&C

Dialysis (hemodialysis and peritoneal) and Filtration Procedures, for acute or chronic renal failure - Includes administration and supplies.	80% of PA	70% of R&C
Inpatient Services – (other than Surgery and Maternity)		
Miscellaneous Hospital Services – includes meals and prescribed diets, Diagnostic Imaging, Laboratory, pharmaceuticals administered while an Inpatient, use of operating room, anesthesia, therapeutic services, supplies, dressings, blood and blood plasma, oxygen, radiation therapy, chemotherapy, miscellaneous items used in association with a surgical event, Pre-Admission Testing and Inpatient Rehabilitation	80% of PA	70% of R&C
Room and Board expense, daily semi-private room rate and general nursing care provided by the Hospital	80% of PA	70% of R&C
Intensive Care Room	80% of PA	70% of R&C
Physician visit, during Confinement in a Hospital <ul style="list-style-type: none"> Limited to one (1) visit per day Does not apply when related to surgery 	80% of PA	70% of R&C
Consulting Physician, when requested and approved by the Attending Physician. <ul style="list-style-type: none"> Limited to one (1) visit per Consulting Physician per day 	80% of PA	70% of R&C
Skilled Nursing Facility and Sub-Acute Care Facility Includes semi-private room and board, general nursing services, meals and prescribed diets, supplies, Diagnostic Imaging, laboratory, Rehabilitation and Physician visits	80% of PA	70% of R&C
Inpatient Rehabilitation Facility Includes Physical Therapy, occupational therapy, Restorative Speech Therapy, cardiac therapy, and pulmonary therapy which is expected to result in significant return of function.	80% of PA	70% of R&C

Surgical Services (Inpatient & Outpatient)		
When multiple surgeries are performed through the same incision at the same operative session, We will pay an amount not to exceed the Benefit for the most expensive procedure being performed. When multiple surgeries are performed through more than one (1) incision at the same operative session, We will pay an amount not to exceed the Benefit for the most expensive procedure being performed and 50% of the Benefit otherwise payable for each subsequent procedure.		
Surgeon	80% of PA	70% of R&C
Assistant Surgeon	80% of PA	70% of R&C
Anesthetist Services	80% of PA	70% of R&C
Surgical Miscellaneous- Includes supplies, drugs, facility fee, and miscellaneous items used in association with the surgical event.	80% of PA	70% of R&C
Other Surgical Services		
General Anesthesia for Dental services	80% of PA	70% of R&C
Reconstructive Surgery	80% of PA	70% of R&C
Organ Transplant Surgery Live Donor: Coverage is provided when using a live donor (includes surgical expenses, storage and transportation of the organ for each covered transplant procedure completed. Costs must be incurred within one hundred twenty (120) days from the date of the donor's surgery. Deceased Donor: Coverage is provided when using a deceased donor, per solid organ transplant for search, removal, storage, and transportation of the organ. Transplant Recipient: From thirty (30) days before the transplant to three hundred sixty-five (365) days after a bone marrow transplant OR from five (5) days before the transplant to three hundred sixty-five (365) days after the transplant. Coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid. Limited to one (1).	80% of PA	70% of R&C

Obesity Surgery Limited to one (1) bariatric procedure per Lifetime.	80% of PA	70% of R&C
TMJ - surgery of the jaw to correct or treat TMJ (the dysfunction of the temporomandibular joints).	80% of PA	70% of R&C
Reproductive Services		
Voluntary Sterilization Surgery Note: Sterilization procedures for women are covered under Preventive Care.	80% of PA	70% of R&C
Sterilization reversal Limited to one (1) procedure per lifetime	80% of PA	70% 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 (up to 40 visits Per Policy Year).		
Pre and Post-Natal Care, including diagnostic services performed and billed by a Physician's office, delivery and Inpatient Physician visits for mother and baby.	Paid the same as any other Sickness	
Hospital services Includes room and board, general nursing care, meals and prescribed diets, pharmaceuticals administered while an Inpatient, anesthesia, dressings, other miscellaneous items, rooming in for maternity care, delivery, routine newborn care, including circumcision, or sick newborn care.	Paid the same as any other Sickness	
Diagnostic services performed and billed by a Physician's office, including ultrasounds and amniocentesis.	Paid the same as any other Sickness	
Mental Conditions and Alcoholism/Drug Abuse		
Inpatient Services Includes Alcoholism/Drug detoxification and residential treatment programs.	Paid the same as any other Sickness	
Outpatient Office Visits – Includes detoxification in outpatient rehabilitation facility (including services for the Covered Person's family when necessary); Includes partial residential or day treatment	Paid the same as any other Sickness	

Testing and treatment for learning disabilities, Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, and all related charges	Paid the same as any other Sickness	
Urgent Care and Emergency Services		
Urgent Care Facility services	80% of PA after a \$50 Copayment per visit	70% of R&C after a \$50 Copayment per visit
Emergency services- visits to an Emergency room for stabilization or the initiation of treatment for an Emergency Condition. Includes Physician's fees, Diagnostic Imaging, Laboratory, Injections, use of emergency room and supplies, and facility charges. Note: The Copayment amount for this visit is waived if You are admitted to a Hospital for the same Condition within forty-eight (48) hours of the visit.	80% of PA, after \$100 copayment per visit + waiver of Policy Year Deductible	80% of R&C, after \$100 Copayment per visit + waiver of Policy Year Deductible
Emergency Medical Transportation services	80% of Actual Charges	
Other Services		
Allergy Testing	80% of PA	70% of R&C
Allergy Injections/treatment - Includes treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications and asthma not responding to usual treatments. Also includes the administration of allergy therapy, injections, allergy serum, and supplies used for allergy therapy.	80% of PA	70% of R&C
Habilitative Care – only when prescribed by the Attending Physician; Includes Outpatient Physical Therapy, occupational therapy and Speech Therapy for a function that did not previously exist, but would normally be expected to exist.	80% of PA after a \$25 Copayment per visit	70% of R&C after a \$25 Copayment per visit

Rehabilitative care – only when prescribed by the Attending Physician; Includes Outpatient Physical Therapy, occupational therapy, Restorative Speech Therapy, which is expected to result in significant return of function.	80% of PA after a \$25 Copayment per visit	70% of R&C after a \$25 Copayment per visit
Pulmonary Therapy • Maximum of thirty-six (36) visits • Limited to three (3) visits per week	80% of PA	70% of R&C
Cardiac Therapy • Maximum of thirty-six (36) visits for each new cardiac event • Limited to three (3) visits per week	80% of PA	70% of R&C
Respiratory Therapy	80% of PA	70% of R&C
Chiropractic care – Includes x-rays, office visits, laboratory services, manipulations and modalities (e.g. hot packs, cold packs and ultrasounds, etc.) regardless of Provider type.	80% of PA	70% of R&C
Dermatology - only when prescribed by the Attending Physician	80% of PA	70% of R&C
Podiatry - only when prescribed by the Attending Physician	80% of PA	70% of R&C
Home Health Care services	80% of PA	70% of R&C
Hospice- Includes up to six (6) family social services visits before the patient's death and up to two (2) bereavement visits following the patient's death.	80% of PA	70% of R&C
Diabetic treatment and education	80% of PA	70% of R&C
Nutritional Counseling Limited to three (3) outpatient visits per Policy Year (Visits for treatment of diabetes do not count toward this visit limit)	80% of PA	70% of R&C
Prosthetic and Orthotic Device - Includes replacement, repair, fitting and adjustment	80% of PA	70% of R&C
Durable Medical Equipment (DME) – includes replacement, repair, fitting and adjustment.	80% of PA	70% of R&C

Neuropsychological Testing – coverage is limited to 8 hours per Policy Year.	80% of PA	70% of R&C
Dental treatment due to Injury to a Sound Natural Tooth not including broken fillings or damage caused by biting or chewing- Treatment must begin within six (6) months of Injury	80% of charges	
Dental surgery to correct gross deformity resulting from major disease or surgery. Surgery must take place within six (6) months of the onset of the disease or within six (6) months of surgery.	80% of PA	70% of R&C
Dental Prosthetics for treatment of accidental Injury	80% of R&C	
Outpatient private duty nursing care	80% of PA	70% of R&C
First pair of eyeglasses or contact lenses after surgery when the lens was not replaced at the time of surgery	80% of PA	70% of R&C
Optometrist services when a disease condition is suspected and the optometrist refers you to a Physician.	80% of PA	70% of R&C
Preventive Dental & Vision for Covered Persons under age twenty-one (21)		
Preventive Dental – preventive & diagnostic services, for Covered Persons under age twenty-one (21). Limited to 2 exams / prophylaxis / topical fluoride treatments per Policy Year. Includes: <ul style="list-style-type: none"> x-rays – bitewing, full-mouth, and panoramic – 1 per 6 months sealants (as needed for permanent 1st and 2nd molars only, 1 per tooth every 60 months) space maintainers – 1 per 24 months full mouth debridement – 1 per 24 months; counts toward prophylaxis benefit when performed 	100% of R&C	

Pediatric Dental – basic restorative services, for Covered Persons under age twenty-one (21). Includes: <ul style="list-style-type: none"> emergency palliative treatment of pain fillings (amalgam, resin-based composite) – limited to 1 per tooth per year prefabricated stainless steel crown periodontal maintenance simple extractions & oral surgery denture repair – 1 per denture per 6 months endodontics – pulpal therapy (1 per tooth per lifetime), apicoectomies, retrograde fillings, and root canal therapy (permanent teeth only; 1 per tooth per lifetime) general anesthesia, IV sedation, and non-IV conscious sedation – in conjunction with other covered services, as Medically Necessary 			70% of R&C	
Pediatric Dental – major services, for Covered Persons under age twenty-one (21). Includes: <ul style="list-style-type: none"> prosthodontics- crowns, bridges, and dentures- 1 per tooth/arch every 60 months crown repair 			50% of R&C	
Pediatric Dental – Medically Necessary orthodontia services *, for Covered Persons under age twenty-one (21). *Requires pre-authorization			50% of R&C	
Routine Vision Exam for Covered Persons under age twenty-one (21). Includes prescription eyeglasses (lenses and frames), or one (1) year supply of contact lenses in lieu of eyeglasses, limited to once per Policy Year; Limited to 1 exam/fitting per Policy Year.			100% of R&C up to \$150, 50% thereafter	
Outpatient Prescription Drugs	In-Network Pharmacy Benefit	Out-of-Network Pharmacy Benefit		
Retail Prescription Drugs - per prescription or refill, subject to dispensing limits. The Pharmacy Benefits Manager (PBM) is: Cigna. Note: Retail Prescription Drugs will be considered an Essential Health Service unless prescribed drug is related to an Elective Treatment, subject to exclusions and other limitations of the Policy.				
4 Tier Plan				
1. Generic Drugs	100% after a \$20 Copayment	Not Covered		
2. Formulary Brand Drugs	100% after a \$40 Copayment	Not Covered		
3. Non-Formulary Brand Drugs	100% after a \$60 Copayment	Not Covered		

4. Specialty and Injectable Drugs	100% after a \$60 Copayment	Not Covered
<p>You will be notified of any changes in prescription coverage and can access the preferred drug list at www.chpstudent.com.</p> <ul style="list-style-type: none"> Only a thirty (30) day supply can be dispensed at any time (certain exceptions apply as specified by the retail pharmacy). One (1) Copayment per thirty (30) day supply; Includes prescription contraceptives which have been approved by the FDA; prescribed pre-natal vitamins and smoking deterrent prescription medications. Includes medications, equipment and supplies for the management and treatment of diabetes ADD and ADHD-related drugs are covered; The Deductible does not apply; The Covered Person will be charged for the difference between Brand and Generic the Tier 2, 3 Copayment for a Brand drug when there is a Generic equivalent available unless "Do Not Substitute" or "Dispense as Written" is indicated on the prescription. Infertility drugs are limited to a one hundred twenty (120) day supply per Policy Year. Attempt to conceive must be through natural means (not by artificial insemination, in vitro fertilization, embryo transplantation and gamete intrafallopian transfer, zygote intrafallopian transfer or any variations of these procedures). You must get Prior Approval for the fertility medications. 		
State Mandated Benefits		
Covered Charges		
Athletic Trainer	Paid the same as any other Physician	
Autism Spectrum Disorders (birth to age twenty-one (21))	See above in the Schedule of Benefits for cost sharing information	
Cancer Clinical Trial	Paid as any other Condition	
Chemotherapy Treatment	Paid as any other Condition	
Chiropractic coverage	See above in the Schedule of Benefits for cost sharing information	
Colorectal screening	Paid under Preventive Services	
General Anesthesia for Certain Dental Procedures	See above in the Schedule of Benefits for cost sharing information	
Home Health Services (maternity & childbirth)	See above in the Schedule of Benefits for cost sharing information	
Low Protein Modified Food Products	Paid as any other Condition	
Mammography	Paid under Preventive Services	

Maternity	See above in the Schedule of Benefits for cost sharing information	
Mental Health (including alcohol/drug abuse)	See above in the Schedule of Benefits for cost sharing information	
Midwife and Home Birth Coverage	Paid the same as any other Provider	
Naturopathic Physician	Paid the same as any other Physician	
Off-label drugs for cancer treatment	Paid as any other Prescription drug	
Organ Transplant surgery	See above in the Schedule of Benefits for cost sharing information	
Outpatient Diabetes treatment	Paid as any other Condition	
Pediatric vaccines	Paid under Preventive Services	
Prescriptions bought in Canada	Paid as any other Prescription drug	
Prostate screening	Paid as any other Condition	
Prosthetic devices	Paid as any other Condition	
Telemedicine	Paid as any other Provider	
Tobacco Cessation Program (Prescribed medication for tobacco cessation would be covered at 100%)	See above in the Schedule of Benefits for cost sharing information	
Treatment of Bones or Joints in the Face, Neck, or Head	Paid as any other Condition	
Elective Treatment (does not apply to the Out-of Pocket maximum)		
Acupuncture – up to a maximum Benefit: \$300 per Policy Year.	80% of PA	70% of R&C
Acupuncture in lieu of Anesthesia	80% of PA	70% of R&C
Treatment for an impacted wisdom tooth up to a maximum Benefit \$100 per tooth per Policy Year	80% of PA	70% of R&C
Routine Vision Exam for Covered Persons twenty-one (21) and older – limited to one (1) eye exam per Policy Year. Excludes eyeglasses and contact lens	80% of PA	70% of R&C
Elective termination of pregnancy – up to a maximum Benefit: \$360 per pregnancy	80% of PA	70% of R&C
Sleep studies	80% of PA	70% of R&C

Non-emergency coverage outside of the United States, if not covered by any other coverage	70% of charges
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PREFERRED PROVIDER INFORMATION

By enrolling in this Insurance Program, you have the Cigna PPO Network, providing access to quality health care at discounted fees. 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.

“Preferred Providers” are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices.

If care is received within the Network from a Preferred Provider, all Covered Medical Expenses will be paid at the Preferred Provider level of benefits found on the Schedule of Benefits. In the case of an Emergency, if an Out-of-Network Provider is used, the In-Network percentage in the Schedule of Benefits will be applied.

A Covered Person is not required to seek treatment from a Preferred Provider. Each Covered Person is free to elect the services of a Provider and Benefits payable will be made in accordance with the terms and Conditions of this benefit.

“Preferred Allowance” means the amount a Preferred Provider will accept as payment in full for covered medical expenses.

“Out of Network” providers have not agreed to any prearranged fee schedules. Insureds may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured’s responsibility.

COORDINATION OF BENEFITS

The Policy Year is the basis for consideration of claims. This provision will be used when the Benefits the Covered Person would receive under this Policy plus those received under all other Plans would exceed the total Allowable expense. If the Benefits provided under all Plans exceed the Allowable expense, We will reduce Our Benefits so that the total benefit received from all plans does not exceed 100% of Allowable expenses. When Benefits are reduced under the primary plan because the Covered Person did not comply with the plan provisions, the amount of such reduction will not be considered an Allowable expense.

SUBROGATION AND RECOVERY RIGHTS

If We pay Covered Expenses for an Accident or Injury You incur as a result of any act or omission of a third party, You are obligated to reimburse Us for the expenses paid. We may also take subrogation action directly against the third party. Our reimbursement rights are limited by the amount You recover. Our reimbursement and subrogation rights are subject to deduction for the pro-rata share of Your costs, disbursements and reasonable attorney fees. You must cooperate with and assist Us in exercising Our rights under this provision and do nothing to prejudice Our rights.

EXCLUSIONS

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, (except as specified herein), routine eye refractions, eye examinations except as in the case of Injury; prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery or Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision, except as provided herein or when due to a disease process or eye refractions, performed by a Physician or optometrist, when used as a diagnostic tool in conjunction with a chronic or acute medical Condition.
2. Hearing Screenings (except as specifically provided in the Policy) or hearing examinations or hearing aids and the fitting or repairing or replacement of hearing aids, except as specifically stated and except in the case of Accident or Injury.
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 care of corns, calluses, or symptomatic complaints of the feet.
5. Cosmetic treatment/cosmetic surgery or plastic surgery, resulting complications, consequences and after effects or other services and supplies furnished primarily to improve appearance rather than a physical function or control of organic disease, except as provided herein or for treatment of an Injury that is covered under the Policy. 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; prominent ears; skin scars; hair growth, hair removal; correction of breast size, asymmetry or shape by means of reduction, augmentation, or breast implants (except for correction or deformity resulting from mastectomies or lymph node dissections); deviated nasal septum, including submucous resection, except when Medically Necessary for treatment of acute purulent sinusitis. 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, or reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect.
6. Treatment, service, or supply which is not Medically Necessary for the diagnosis, care or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended or approved by the person’s Attending Physician or dentist.
7. Treatments which are considered to be unsafe, Experimental, or Investigational by the American Medical Association (AMA), and resulting complications, except to the extent required by law for routine costs for Covered Persons who participate in approved cancer clinical trials.
8. Custodial Care; care provided in a: rest home, home for the aged, halfway house, health resort, college infirmary or any similar facility for domiciliary or Custodial Care, (except as provided for Hospice care).

9. Dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth, (except as specified herein).
10. Injury sustained by reason of a motor vehicle Accident to the extent that Benefits are paid or payable by any motor vehicle no-fault law whether or not claim is made for such Benefits or if the Insured is not properly licensed to operate the motor vehicle within the jurisdiction in which the Accident takes place. This exclusion will not apply to passengers if they are insured under the Policy.
11. 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.
12. Reproductive/Infertility services, including but not limited to: treatment of infertility (male or female) including diagnosis, diagnostic tests, medication, surgery, supplies, and fertilization procedures rendered for the purpose or with the intent of inducing conception; premarital examination; impotence, organic or otherwise; sterilization (except as specifically provided in the Policy) and sterilization reversal (following first attempt), except as specifically provided in this Policy. Examples of fertilization procedures are ovulation induction procedures, in vitro fertilization, artificial insemination, embryo transfer or similar procedures that augment or enhance Your reproductive ability.
13. More than one (1) attempt at sterilization reversal (vasectomy reversal, vasovasostomy, vasovasorrhaphy, tubal ligation reversal, tubotubal anastomosis).
14. Hospital Confinement or any other services or treatment that are received without charge or legal obligation to pay.
15. Services provided normally without charge by the health service of the Policyholder or services covered or provided by a student health fee; Services rendered by employees or Physicians or other persons or retained by the University or for the use of the Universities facilities.
16. Treatment provided in a government Hospital, unless there is a legal obligation for the Covered Person to pay for such treatment.
17. Expenses that would be payable, or medical treatment that is available, under any governmental or national health plan for which the Covered Person could be eligible, except Medicaid.
18. Any services of a Physician or Nurse who lives with You or Your Dependent(s) and who is related to You or Your Dependent(s) by blood or marriage.
19. Services received after the Covered Person's Coverage ends, except as specifically provided under the Extension of Benefits provision.
20. Vitamins, minerals, food supplements, herbs, herbal formulas, or home remedies; except as prescribed.
21. Vocational recreation, art, dance, poetry, music, or other similar-type therapies, including regression therapy; personal enhancement or self-actualization therapy.
22. Services for the treatment of any Injury or Sickness incurred while the Covered Person was committing or attempting to commit a felony; or while taking part in an insurrection or riot.
23. Injury or Sickness for which Benefits are paid or payable under any state or federal; workers' compensation, employer's liability, or occupation disease law or act, or similar legislation.
24. War or any act of war, declared or undeclared; or any Injury or Sickness arising out of service in the armed forces or units auxiliary of any country.
25. 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.
26. 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; general fitness, exercise programs, health club memberships and weight management programs; 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.
27. Acupuncture and acupressure; aroma therapy; hypnosis; rolfing; Hyperhidrosis; Psychosurgery; and biofeedback, unless Medically Necessary and performed within the scope of a naturopathic Provider's license.
28. Elective surgery or treatment, except as provided in the Schedule of Benefits.
29. Long term care facility.

DEFINITIONS

Accidental Injury: A specific unforeseen event, which directly, and from no other cause, results in an Injury.

Coinsurance: The percentage of the expense for which the Covered Person is responsible for a Covered Service. The Coinsurance is separate and not a part of the Deductible and Copayment.

Copayment: A specified dollar amount a Covered Person must pay for specified Covered Charges. The Copayment is separate from and not a part of the Deductible or Coinsurance.

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 Person: A person:

- who is eligible for Coverage as the Insured or as a Dependent;
- who has been accepted for Coverage or has been automatically added;
- for whom the required Premium has been paid; and
- whose Coverage has become effective and has not terminated.

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.
- Domestic/Civil Union Partner who resides with the Insured.
- Child who is under the age of 26.

The term child refers to the Insured's:

- Natural child or child of Domestic/Civil Union Partner.
- 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 severe harm. Emergency does not include the recurring symptoms of a chronic Condition unless the onset of such symptoms could reasonably be expected to result in the above listed complications.

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).

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 (1) Accident, including all related conditions and recurrent symptoms of these injuries, and are considered a single injury.

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.

Medically Necessary/Medical Necessity: We reserve the right to review claims and establish standards and criteria to determine if a Covered Service is Medically Necessary and/or Medically Appropriate. Benefits will be denied by Us for Covered Services that are not Medically Necessary and/or Medically Appropriate. In the event of such a denial, You will be liable for the entire amount billed by that Provider. You do have the right to appeal any adverse decision as outlined in the Appeals and Complaint Section of this Policy.

Covered Services are Medically Necessary if they are:

- Required to meet the health care needs of the Covered Person; and
- Consistent (in scope, duration, intensity and frequency of treatment) with current scientifically based guidelines of national medical or research organizations or governmental agencies; and
- Consistent with the diagnosis of the Condition; and
- Required for reasons other than the comfort or convenience of the Covered Person or Provider; and
- Of demonstrated medical value and medical effectiveness.

A Covered Service is Medically Appropriate if it is rendered in the most cost-effective manner and type of setting appropriate for the care and treatment of the Condition.

When specifically applied to Hospital Confinement, it means that the diagnosis or treatment of symptoms or a Condition cannot be safely provided on an Outpatient basis.

Out-of-Pocket Maximum: The most You pay during a Policy Year before Your Coverage begins to pay at 100% of the allowed amount This limit will never include Premium, balanced billed charges or health care Your Policy does not cover. Your Out-of-Network payments or other expenses and Elective treatment do not count toward this limit.

Physician: A health care professional 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.

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. Evidence-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.

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.

For a Provider who has a reimbursement agreement, the Reasonable Charge is equal to the Preferred Allowance under any reimbursement agreement with Us, either directly or indirectly through a third party, as described in the Preferred Provider Benefit provision. If a Provider accepts as full payment an amount less than the rate negotiated under the reimbursement agreement, the lesser amount will be the maximum Reasonable Charge.

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 recurrent symptoms of the same or a similar condition will be considered the same Sickness.

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

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

Male pronouns whenever used include female pronouns.

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 outside of his home state or home country, We will pay for the actual charges Incurred for an emergency medical evacuation of the Covered Person to or back to the Covered Person’s home state, country or country of regular domicile, the maximum Benefit limit shown above, and the Exclusions and Limitations provisions. Before We make any payment, We require written certification by the Attending Physician that the evacuation is Medically 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, except as provided herein.

The Physician ordering the Emergency Evacuation must certify that the severity of the Insured’s Injury or Emergency Sickness warrants his Emergency Evacuation. All transportation arrangements made must be by the most direct and economical conveyance and route possible.

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, 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.

CLAIM PROCEDURES

In the event of Injury or Sickness, students should:

1. Report to their Physician, Hospital or Center for Health and Wellbeing.
2. Mail to the address below all medical and hospital bills along with the patient’s name and insured student’s name, address, Social Security number or student ID number and name of the University under which the student is insured. A Company claim form is not required
3. File claim within ninety (90) days of Injury or first treatment for a Sickness. Bills should be received by the Company within ninety (90) days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

Itemized medical bills should be mailed promptly to Cigna at the address listed.

SUBMIT ALL CLAIMS TO:

Cigna
PO Box 188061

Chattanooga, TN 37422-8061
Electronic Payor ID: 62308

Direct all questions regarding benefits available under the Plan, claim procedures, status of a submitted claim or payment of a claim to Consolidated Health Plans.

Claims Administrator:

CONSOLIDATED HEALTH PLANS

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

www.chpstudent.com

Group Number: S210510

CLAIMS APPEAL PROCESS

Once a claim is processed and upon receipt of an Explanation of Benefits (EOB), an Insured Person who disagrees with how a claim was processed may appeal that decision. The Insured Person must request an appeal in writing within 180 days of the date appearing on the EOB. The appeal request must include any additional information to support the request for appeal, e.g. medical records, physician records, etc. Please submit all requests to the Claims Administrator at the address below.

Claims Administrator:

CONSOLIDATED HEALTH PLANS

2077 Roosevelt Avenue
Springfield, MA 01104

www.chpstudent.com

(413) 733-4540

Servicing Agent:

UNIVERSITY HEALTH PLANS, INC.

One Batterymarch Park
Quincy, MA 02169-7454
Telephone (800) 437-6448

Email info@univhealthplans.com

www.universityhealthplans.com

This plan is underwritten by and offered by:
NATIONWIDE LIFE INSURANCE COMPANY

Columbus, OH
Policy Number: 302-054-4414

For a copy of the privacy notice you may go to:

www.consolidatedhealthplan.com/about/hipaa

VALUE ADDED SERVICES

VISION DISCOUNT PROGRAM

For Vision Discount Benefits, please go to:

www.chpstudent.com

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

Consolidated Health Plans provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at 1-800-633-7867. **If you are traveling and need assistance in North America, call the Assistance Center toll-free at: 877.305.1966 or if you are in a foreign country, call collect at: 715.295.9311.** When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. 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.



Your out-of-pocket costs may be lower when you utilize the Cigna PPO Providers. For a listing of Cigna PPO Providers, go to www.cigna.com or contact Consolidated Health Plans at (413) 773-4540, toll-free at (800) 633-7867, or www.chpstudent.com for assistance.