Student Health Insurance

Designed for the Domestic Undergraduate and Graduate Students of

Marquette University

2014-2015

Underwritten by:
Nationwide Life Insurance Company
Columbus, OH

Policy Number: 302-001-4812
Effective: 8/1/2014 to 7/31/2015

Group Number: S210214

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.

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INTRODUCTION

Marquette University is making available a Student Health Insurance program (hereinafter called “plan”) underwritten by Nationwide Life Insurance Company and administered by Consolidated Health Plans. This brochure provides a general summary of the insurance coverage; the Schedule of Benefits is not all inclusive of eligible benefits payable under this plan. Keep this brochure as no individual policy will be issued. This summary is not a contract; however, the Master Policy will be available for review upon request. The Master Policy contains the contract provisions and shall prevail in the event of any conflict between this brochure and the Master Policy.

The insurance plan provides continuous protection, 24 hours a day, anywhere in the world during the period of coverage for which the proper premium has been paid. Coverage is not automatically renewed. Students must re-enroll when coverage terminates to maintain continuous coverage.

WHERE TO FIND HELP

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

<table>
<thead>
<tr>
<th>For Questions About:</th>
<th>Please Contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment</td>
<td>American Management Advisors</td>
</tr>
<tr>
<td>Dependent Enrollment</td>
<td>1-888-533-7654</td>
</tr>
<tr>
<td>Insurance Benefits</td>
<td>Consolidated Health Plans</td>
</tr>
<tr>
<td>Preferred Provider Listings</td>
<td>2077 Roosevelt Avenue</td>
</tr>
<tr>
<td>Claims Processing</td>
<td>Springfield, Massachusetts 01104</td>
</tr>
<tr>
<td></td>
<td>(800) 633-7867</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.chpstudent.com">www.chpstudent.com</a></td>
</tr>
<tr>
<td>Preferred Provider Listings</td>
<td>Cigna</td>
</tr>
<tr>
<td>Prescription Drug Benefit &amp; Providers</td>
<td>Cigna PBM</td>
</tr>
</tbody>
</table>

AM I ELIGIBLE?

All domestic undergraduate students taking 6 or more credit hours and all graduate students are eligible to enroll in the insurance plan.

Students must actively attend classes for at least the first thirty-one (31) days after the date for which coverage is purchased.

Home study, correspondence, Internet, and television (TV) courses do not fulfill the Eligibility requirements. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium, minus any claims paid.

COVERAGE FOR DEPENDENTS

Insured Students who are enrolled in the Student Health Insurance Plan may also enroll their eligible Dependents. Eligible dependents under the plan include the Insured person’s spouse, domestic 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 thirty-one (31) 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 thirty-one (31) days following the qualifying event will not be accepted. Coverage will be effective as of the date of the qualifying event.

Students who wish to enroll for dependent coverage may enroll as follows:

1. Complete the enrollment form or download and print an enrollment form on the website:
   http://www.marquette.edu/riskunit/riskmanagement/student_health_insurance.shtml

2. Print all information legibly and indicate the coverage and options desired.

3. Enclose a check or money order payable to American Management Advisors, Inc. or complete all credit card information.

4. Send the form and payment to:
   American Management Advisors, Inc.
   333 North Oxford Valley Rd., Suite 606
   Fairless Hills, PA 19030

ID CARDS

An ID card will be mailed to the student’s address on file approximately 2 weeks after the enrollment form and premium payment are received. Students do not need an ID card to be eligible to receive benefits under the Policy. For lost ID cards, request an ID card from the website:

http://www.marquette.edu/riskunit/riskmanagement/student_health_insurance.shtml
EFFECTIVE DATES AND COSTS

The Marquette University International Student Health Insurance Plan provides coverage to students for a twelve (12) month period - from 12:01 a.m. August 1, 2014, through July 31, 2015.

<table>
<thead>
<tr>
<th>Period</th>
<th>Annual* 8/1/14-7/31/15</th>
<th>Fall* 8/1/14-12/31/14</th>
<th>Spring/Summer* 1/1/15-7/31/15</th>
<th>Summer* 8/1/14-12/31/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$2,646</td>
<td>$1,105</td>
<td>$1,847</td>
<td>$663</td>
</tr>
<tr>
<td>Spouse</td>
<td>$5,535</td>
<td>$2,306</td>
<td>$3,229</td>
<td>$1,383</td>
</tr>
<tr>
<td>Child(ren)</td>
<td>$3,140</td>
<td>$1,308</td>
<td>$1,832</td>
<td>$786</td>
</tr>
</tbody>
</table>

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

PERIODS OF COVERAGE AND ENROLLMENT PERIOD DEADLINE DATES

*Spring and Summer may be purchased by a new student not previously eligible to enroll for annual or fall coverage or a student who purchased fall coverage and wishes to continue coverage.

<table>
<thead>
<tr>
<th>Period</th>
<th>Date Coverage Begins</th>
<th>Date Coverage Ends</th>
<th>Enrollment Period Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Annual</td>
<td>08/01/2014</td>
<td>07/31/2015</td>
<td>10/01/2014</td>
</tr>
<tr>
<td>*Fall</td>
<td>08/01/2014</td>
<td>12/31/2014</td>
<td>10/01/2014</td>
</tr>
<tr>
<td>*Spring/Summer</td>
<td>01/01/2015</td>
<td>07/31/2015</td>
<td>01/31/2015</td>
</tr>
<tr>
<td>*Summer</td>
<td>05/01/2015</td>
<td>07/31/2015</td>
<td>05/30/2015</td>
</tr>
</tbody>
</table>

PREMIUM REFUND POLICY

Except for medical leave or withdrawal due to a covered Injury or Sickness, any Insured Student withdrawing from the college 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. Students withdrawing after 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.

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

Non-immigrant foreign nationals who have permanently left the United States for their home country may request a pro-rated refund, minus any claims paid. Such request must be made in writing within ninety (90) days of leaving school.

Refunds for any other reason are not available. All premium refunds are subject to a $25 administrative fee.

EXTENSION OF BENEFITS

The Coverage provided under this Policy ceases on the termination date, shown on the face page. However, if a Covered Person is Hospital Confined on the Termination Date for an Injury or Sickness for which Benefits were paid under this Policy prior to the Termination Date, Covered Expenses for such Injury or Sickness will continue to be paid for a period of thirty (90) days or until date of discharge, whichever is earlier.

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 the Covered Person departs the Policyholder’s school for their Home Country. No Benefits will be payable for any medical treatment received in the Covered Person’s Home Country;
- The date a Covered Person enters full time active military service. Upon written request within 90 days of leaving school, We will refund the unearned pro-rata Premium to such person upon request; or
- 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.
SCHEDULE OF BENEFITS

Your Coverage provides for the utilization of Preferred Providers in a Preferred Provider Organization (PPO). The student health center is considered an In-Network provider. Certain Benefits are paid at different rates if the service is not provided by a Preferred Provider, Out-of-Network Provider, In-Network Benefit and Out-of-Network Benefits. The Preferred Provider Organization(s) for your Coverage is: CIGNA

<table>
<thead>
<tr>
<th>Policy Year Aggregate Maximum Benefit</th>
<th>In-Network Benefit</th>
<th>Out-of-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible per Policy Year (except as specified herein) Benefits are subject to Deductible unless otherwise indicated.</td>
<td>$200</td>
<td>$500</td>
</tr>
<tr>
<td>Out-of-pocket maximum (Includes Coinsurance, Deductible and Copayments; does not include non-covered medical expenses or elective treatment)</td>
<td>$6,350 (Insured) $12,700 (Family)</td>
<td>None</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>80% of the Preferred Allowance</td>
<td>60% of the Reasonable and Customary Charges</td>
</tr>
</tbody>
</table>

Treatment outside of the United States is payable 60% of R&C.

Preventive Care (see Definitions for additional information)

| Preventive Services | 100% of PA (Deductible waived) | Not covered |
| Preventive Care (see Definitions for additional information) |

Outpatient Services (other than Surgery, Maternity, Mental Conditions/Drug or Alcohol)

| Office visits benefits are limited to one (1) visit per day and do not apply when related to surgery. | After a $40 copay per visit 80% of PA | After a $40 copay per visit 60% R&C |
| Consultants when requested by treating Physician | 80% of PA | 60% R&C |
| Diagnostic X-ray and Laboratory services | 80% of PA | 60% R&C |
| Diagnostic Imaging, including CT Scan, MRI, and/or PET Scans | 80% of PA | 60% R&C |

Inpatient Services (other than Surgery, Maternity, Mental Conditions/Drug or Alcohol)

| Miscellaneous Hospital Services | 80% of PA | 60% R&C |
| Room and Board expense, daily semi-private room rate and general nursing care provided by the hospital | 80% of PA | 60% R&C |

Intensive Care Room | 80% of PA | 60% R&C |
Physician visit (includes Specialists/Consultants) during Confinement in a Hospital, limited to one (1) visit per day and does not apply when related to surgery. | 80% of PA | 60% R&C |
Skilled Nursing Facility and Sub-Acute Care Facilities | 80% of PA | 60% R&C |
Surgical Services (Inpatient and 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 one or more incisions at the same operative session, We will pay an amount not to exceed the Benefit for the most expensive procedure being performed. The Benefit for the primary or most expensive procedure or less expensive procedure 50% of the Benefit otherwise payable for each subsequent procedure.

Surgeon’s Fee | 80% of PA | 60% R&C |
Assistant Surgeon | 25% of Surgeon’s payment | 25% of Surgeon’s payment |
Anesthetist Services | 25% of Surgeon’s payment | 25% of Surgeon’s payment |
Hospital Outpatient Miscellaneous – Includes supplies, drugs, facility fee, and miscellaneous items used in association with the outpatient surgical event. | After a $500 copay per visit 80% of PA | After a $500 copay per visit 60% 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.

Maternity care and pre-post natal services | Paid the same as any other Sickness |
Mental Conditions and Substance Abuse

Inpatient services | Paid the same as any other Sickness |
Outpatient Office Visits | Paid the same as any other Sickness |

Urgent Care and Emergency Services

<p>| Urgent Care Facility Services | 80% of PA | 60% R&amp;C |</p>
<table>
<thead>
<tr>
<th>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. (In-Network Deductible applies to Out-of-network services)</th>
<th>After a $100 copay (copay waived if admitted) 80% of PA</th>
<th>After a $100 copay (copay waived if admitted) 80% of R&amp;C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medical Transportation services</td>
<td>80% of PA</td>
<td>80% R&amp;C</td>
</tr>
<tr>
<td>Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Services (testing/injections/treatment)</td>
<td>80% of PA</td>
<td>60% R&amp;C</td>
</tr>
<tr>
<td>Physical Therapy,</td>
<td>80% of PA</td>
<td>60% R&amp;C</td>
</tr>
<tr>
<td>Chiropractic care</td>
<td>80% of PA</td>
<td>60% R&amp;C</td>
</tr>
<tr>
<td>Home Health Care services</td>
<td>80% of PA</td>
<td>60% R&amp;C</td>
</tr>
<tr>
<td>Hospice</td>
<td>80% of PA</td>
<td>60% R&amp;C</td>
</tr>
<tr>
<td>Diabetic treatment and education</td>
<td>80% of PA</td>
<td>60% R&amp;C</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME) - Includes Prosthetic and Orthotic Devices</td>
<td>80% of PA</td>
<td>60% R&amp;C</td>
</tr>
<tr>
<td>Routine Vision Exam for Covered Persons under age nineteen (19). One exam/fitting per Policy Year, including prescription eyeglasses (lenses and frames, limited to one per year) or contact lenses (in lieu of eyeglasses).</td>
<td>100% up to $150; 50% thereafter</td>
<td></td>
</tr>
<tr>
<td>Hearing aids over the age of 18 – limited to single purchase every three years (including repair and replacement) up to $2,500</td>
<td>80% of PA</td>
<td>60% R&amp;C</td>
</tr>
<tr>
<td>Hearing aids for under age 18 – 1 pair per ear every 3 years.</td>
<td>80% of PA</td>
<td>60% R&amp;C</td>
</tr>
<tr>
<td>TMJ – diagnosis and non-surgical treatment for the dysfunction of the temporomandibular joints, up to $1,250 per PY.</td>
<td>80% of PA</td>
<td>60% R&amp;C</td>
</tr>
<tr>
<td>Prescription Drug Expense</td>
<td>• $0 Co-pay for generic</td>
<td></td>
</tr>
</tbody>
</table>

- Only a thirty (30) day supply can be dispensed at any time
- Policy deductible does not apply
- One (1) copayment per thirty (30) day supply
- Copayments apply to the out-of-pocket
- Prescriptions must be filled at an “Cigna Pharmacy” participating pharmacy
- $15 Co-pay for other generic prescriptions; or
- $35 Co-pay for any brand name prescription; or
- $60 Co-pay for any non-preferred brand name drugs

<table>
<thead>
<tr>
<th>Elective Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Treatment coverage is limited to injuries to sound natural teeth; does not include biting or chewing injuries; Benefit is payable up to maximum of $200 per PY</td>
</tr>
<tr>
<td>Private Duty Nurse – when Medically Necessary for inpatient confinement and requested by a physician.</td>
</tr>
<tr>
<td>Intramural and Club Sports Benefits payable up to a maximum of $5,000 Per PY</td>
</tr>
</tbody>
</table>

**MARQUETTE UNIVERSITY MEDICAL CLINIC BENEFITS**

When non-emergency care is needed, students are strongly encouraged to use the Marquette University Medical Clinic (formerly the Student Health Services) first. If the clinic does not provide the care needed, they can provide the student with information to make informed health care decisions. The following benefits are available when a student receives covered services at the Marquette University Medical Clinic and Sports Rehab Center:

- The covered percentage for payment of covered services is 100% of charges incurred, including lab tests; prescription drugs dispensed; allergy injections; and physical therapy.
- The deductible and copay are waived.
- Benefits for preventive services are payable at 100% of charges incurred, includes routine exam, pap smear, and routine lab services; age appropriate immunizations; immunizations for travel and vaccinations for influenza and meningitis; counseling services provided by dietitian; and counseling services for nicotine addiction.
- Hearing examinations are covered if related to a sickness or symptom, benefits are payable at 100% of charges incurred.

**NOTE:** The Marquette University Medical Clinic is not available to dependents.
Mandated Benefits

If you are enrolled in this Insurance Program, policy coverage also includes the following benefits, all subject to the policy aggregate limit, unless provided otherwise, and is subject to policy deductibles, limitations and exclusions where applicable.

(Note: Wellness/preventive benefits under the Affordable Care Act (ACA) are required to meet federal regulations. Under ACA, states retain the ability to mandate benefits beyond those established by the federal mandate. Please see the schedule of benefits for coverage details.)

The policy pays benefits in accordance with any applicable Wisconsin law. State-mandated benefits are listed below. Description of the mandates can be found in the master policy on the website:

- Autism Spectrum Disorders
- Breast Reconstruction
- Facility Charges and Anesthesia for certain Dental Care
- Diabetes Self-Management, Equipment and Supplies
- Hearing Aids, Cochlear Implants, Related treatment for Infants and Children
- HIV Drugs
- Home Health Care
- Immunizations
- Kidney Disease
- Mammogram
- Skilled Nursing Facility
- Temporomandibular Disorder, up to $1,250 per policy year
- Lead Poisoning

Preferred Provider Information

By enrolling in this Insurance Program, you have the Cigna PPO Network of Participating Providers, providing access to quality health care at discounted fees. To find a complete listing of Cigna PPO Network of Participating 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 select 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. Insured's may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the insured's responsibility.

Excess Coverage

No benefits are provided by the policy for expenses which are paid or payable by any other valid and collectible hospital or insurance plan, or to the extent that benefits are provided and paid for by or through a managed care program. This provision does not apply to emergencies.

Coordination of Benefits

This section applies to all benefits except prescription drugs. 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, 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; except when due to a disease process; except eye refractions, performed by a physician or optometrist, when used as a diagnostic tool in conjunction with a chronic or acute medical condition. Repair or replacement of eye glasses or contact lens except when required as a direct result of an injury.
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 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 weak feet, fallen arches, flat foot, pronated foot, subluxations of the foot, foot strain, care of corns, calluses, toenails or bunions (except capsular or bone surgery), any type of massage procedure on or to the foot, corrective shoes, shoe inserts and Orthotic Device; except for treatment of Injury, infection or disease except as provided herein.

5. Cosmetic treatment cosmetic surgery, plastic surgery, resulting complications, consequences and after effects 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 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; warts, non-malignant moles and lesions; hair growth hair removal; correction of breast size, asymmetry or shape by means of reduction, augmentation, or breast implants including gynecomastia (except for correction or deformity resulting from mastectomies or lymph node dissections); lipectomy services and supplies related to surgical suction assisted lipectomy; rhinoplasty; nasal and sinus surgery; and deviated nasal septum, including submucous resection except when Medically Necessary 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.

6. Circumcision, except as provided herein;

7. Sexual reassignment surgery; or any treatment of gender identity disorders, including hormone replacement therapy except as provided herein. This exclusion does not include related mental health counseling;

8. 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 Student Health Center or by the person’s Attending Physician or dentist.

9. Treatments which are considered to be unsafe, Experimental, or Investigational by the American Medical Association (AMA), and resulting complications. Upon written request, claims denied under this provision may be reviewed by an independent medical review entity if You or Your Dependent has a Terminal Condition that, according to the Physician’s current diagnosis, has a high probability of causing death within 1, 2 years from the date of the request for medical review.

10. 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, or that provides twenty-four (24) hour non- medical residential care or day care (except as provided for Hospice care).

11. Dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth, (except as specified herein).

12. Injury sustained while (a) participating in any intramural, intercollegiate, professional, semi-professional or club 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.

13. 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 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.

14. Injury resulting from participation in any hazardous activity, including: travel in or upon a snowmobile, ATV (all terrain or similar type two or three wheeled vehicle and/or off-road four wheeled motorized vehicles motor vehicles not primarily designed and licensed for use on public streets or highways or personal watercraft, parachuting, hang gliding, skydiving, parasailing, scuba diving, skin diving, glider flying, sailplaning, racing or speed contests, mountaineering (where ropes or guides are customarily used), rock wall climbing, rodeo or bungee jumping; (except as specifically provided in this Policy). 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 or as a passenger in a Policyholder owned leased chartered or operated aircraft or as a passenger on an official flight of the Military Airlift Command of the United States or similar air transport services of other countries.

15. Reproductive/Infertility services, unless caused by Injury or Sickness, including but not limited to: family planning 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) sterilization reversal; vasectomy; vasectomy reversal 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.
17. 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.
18. Treatment in a government Hospital, unless there is a legal obligation for the Covered Person to pay for such treatment.
19. 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.
20. 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.
21. Services received before the Covered Person’s Effective Date or during an Inpatient stay that began before the Insured’s Effective Date; Services received after the Covered Person’s Coverage ends, except as specifically provided under the Extension of Benefits provision.
22. Services of an Outpatient private duty Nurse.
23. 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;
   - growth hormones;
   - for the treatment of infertility;
   - 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;
   - treatment of nail (toe or finger) fungus;
   - 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, 60, 90 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:
     o contraindicated for the treatment of the Condition for which the drug was prescribed;
     o or Experimental for any reason.
24. Vitamins, minerals, food supplements, herbs, herbal formulas, or home remedies; except as prescribed.
25. Addictions, such as, caffeine addiction and non-chemicals addictions such as gambling, sexual, spending, shopping, working and religious; codependency; except as specifically provided in the Policy.
26. Injuries sustained as a result of intentional/unintentional self-inflicted Injury or any attempt at intentional/unintentional self-inflicted Injury.
27. 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; or fighting, except in self-defense.
28. Injury or Sickness for which Benefits are paid or payable under any workers’ compensation or occupation disease law or act, or similar legislation.
29. War or any act of war, declared or undeclared; or while in the armed forces of any country.
30. Obesity treatment: Services and associated expenses for the treatment of obesity, except nutrition counseling specifically provided in the Policy, and any resulting complications, consequences and after effects of treatment that involves surgery and any other associated expenses, including, but not limited to:
   - Gastric or intestinal bypasses;
   - Gastric balloons;
   - Stomach stapling;
   - Wiring of the jaw;
   - Panniculectomy;
   - Appetite suppressants;
   - Surgery for removal of excess skin or fat.
31. 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.
32. Treatment received in the Covered Person’s Home Country, outside of the United States of American, except as specified herein.
33. Acupuncture and acupressure, aroma therapy, hypnotic therapy, rolfing, Hyperhidrosis, Psychosurgery biofeedback (except as specifically provided).
34. Diagnosis and treatment of sleep disorders including but not limited to apnea monitoring, sleep studies, and oral appliances used for snoring, except treatment and appliances for documented obstructive sleep apnea.
35. Elective surgery or treatment.

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

Anesthetist: A Physician duly licensed according to state law, who administers the anesthesia agent during a surgical procedure.

Assistant Surgeon: A Physician who assists the Surgeon who actually performs a surgical procedure.

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/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorders, bulimia, and anorexia.

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.

Company: Nationwide Life Insurance Company. Also hereinafter referred to as We, Our and Us.

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 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.
- Child who is under the age of 26.

The term child refers to the Insured’s:

- Natural child;
- Stepchild; 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.

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.

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).

Hospital: A facility which provides diagnosis, treatment, and care of persons who need acute Inpatient Hospital care under the supervision of Physicians. It must be licensed as a general acute care Hospital according to state and local laws.

Injury: Bodily Injury due to a sudden, unforeseeable, external event which results independently of disease, bodily infirmity or any other causes.

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

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
- Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorders, bulimia, and anorexia.

Psychological syndrome or pattern that substantially limits the functioning of the person with the Illness. Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorders, bulimia, and anorexia.
• 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.

**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-Pocket:** means the most You will pay during a Policy Year before your coverage pays at 100%. This includes deductibles, copayments (medical and prescription) and any coinsurance paid by You. This does not include non-covered medical expenses and elective services.

**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.

**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.

**You and 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 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.

**CLAIM PROCEDURES**

In the event of Injury or Sickness, students should:
1. Report to their Physician, Hospital or Student Health Center.
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 for filing a claim.
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.
4. Itemized medical bills should be mailed promptly to Cigna at the address listed.

**SUBMIT ALL CLAIMS TO:**
Cigna  
1000 Great West Drive  
Kennett, MO 63857-3749  
Electronic Payor ID: 62308

5. 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 Ave  
Springfield, MA 01104  
Local: (413) 733-4540 or Out of area: (800) 633-7867  
www.chpstudent.com  
Group Number: S210214

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

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**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:**
American Management Advisors, Inc.  
333 North Oxford Valley Rd, Suite 606  
Fairless Hills, PA 19030  
888-533-7654  
www.amastudentplans.com

This plan is underwritten by and offered by:  
NATIONWIDE LIFE INSURANCE COMPANY  
Columbus, OH  
Policy Number: 302-003-4812

For a copy of the privacy notice you may go to:  
[www.consolidatedhealthplan.com/about/hipaa](http://www.consolidatedhealthplan.com/about/hipaa)
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.