2010-2011 STUDENT ACCIDENT AND SICKNESS INSURANCE PROGRAM

Designed For
Students of
GORDON-CONWELL Theological Seminary

Underwritten by:
NATIONWIDE LIFE INSURANCE COMPANY
Columbus, Ohio

Policy Number: 302-122-2008

Effective Dates: September 1, 2010 – September 1, 2011

IMPORTANT NOTICE

This brochure provides a brief description of the important features of the Policy. It is not a Policy. Terms and conditions of the Coverage are set forth in the Policy. We will notify Covered Persons of all material changes to the Policy. Please keep this material with your important papers.

NONDISCRIMINATORY

Health care services and any other benefits to which a Covered Person is entitled are provided on a nondiscriminatory basis, including benefits mandated by state and federal law.

This health plan satisfies **Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance. Please see page 4 for additional information.

Gordon-Conwell Theological Seminary
Student Accident and Sickness
Insurance Plan

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STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

This brochure is a brief description of the Student Accident and Sickness Insurance Plan made available to students through Gordon-Conwell Theological Seminary. Massachusetts Law requires that the student's insurance be equivalent to or better than the state's minimum standards in order to waive inclusion in the plan offered through the seminary. If You currently have coverage, it is Your responsibility to determine that it meets or exceeds the coverage available through Gordon-Conwell Theological Seminary's Student Accident and Sickness Insurance Plan.

Often a student covered by a Health Maintenance Organization (HMO) or a managed care policy at home has limited or no benefits while at College, other parts of the U.S. or in a foreign country. When reviewing Your current policy, check to ensure that it provides coverage to students who are over the age of nineteen (19), that it provides access to care in the Gordon-Conwell Theological Seminary area and provides comprehensive coverage, extending beyond emergency care to include Physician and Hospital services.

Students who do not want to participate in the Student Accident and Sickness Insurance Plan must submit a waiver form confirming participation in a comparable health insurance policy that will be in effect until September 1, 2011. Recognizing that Your current situation may change, each year You will be asked to provide proof of comparable coverage in order to waive participation in the Student Accident and Sickness Insurance Plan.

STUDENT ELIGIBILITY

Massachusetts Law mandates that all full-time and three quarter (¾) time students have health insurance coverage. To ensure compliance with the law, Gordon-Conwell Theological Seminary students enrolled at the South Hamilton Campus for at least six (6) credits are automatically enrolled in and billed for the Student Accident and Sickness Insurance Plan. Gordon-Conwell Theological Seminary students enrolled at the Boston Campus for at least nine (9) credits are automatically enrolled in and billed for the Student Accident and Sickness Insurance Plan.

If you are eligible for coverage and wish to enroll in the Program after the enrollment opportunities described in the brochure because of a qualifying event, You must make this request through Gordon-Conwell Theological Seminary. You must present documentation from Your former insurance company that is no longer providing You with personal accident and health insurance coverage to Gordon-Conwell Theological Seminary.

Your effective date under this Program will be the date Your former insurance expired, if You make the request for coverage within thirty-one (31) days after it expires. Your premium, which is not prorated, must accompany the request.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan satisfies **Minimum Creditable Coverage** standards that are effective during the term of coverage as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirements that you have health insurance meeting these standards.

THIS DOCUMENT IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2009. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

DEPENDENT ELIGIBILITY AND ENROLLMENT

Insured students who are enrolled in the Student Accident and Sickness Insurance Plan may also enroll their Dependents. An eligible Dependent is a spouse residing with the Insured student or an unmarried child who is under the age of twenty-six (26) and is not self-supporting.

Dependent eligibility expires concurrently with that of the Insured student. Your Dependents will be covered for the same benefits for which You are covered. To enroll a Dependent, the Insured student must select the appropriate level of coverage on the Online Enrollment Form. The applicable premium will be added to your student account. Coverage is not effective until the start date shown in the Plan Costs and Period of Coverage section. To enroll yourself and your Dependent(s), please visit www.universityhealthplans.com.

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

Coverage for newly born infants and adoptive children shall consist of Injury or Sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities or premature birth including the cost of a newborn hearing screening test to be performed before the newborn infant is discharged from the hospital or birthing center to the care of the parent or guardian or as provided by the regulations of the department of public health.

REFUND OF PREMIUM

Except for medical withdrawal due to a covered Injury or Sickness, any student withdrawing from school or becoming ineligible for inclusion in the policy based on a reduction in the number of courses taken 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. Students withdrawing after such thirty-one (31) days will remain covered under the Policy for the full period for which the premium has been paid and no refund will be allowed.

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. Refunds for any other reason are not available.

TERMINATION OF COVERAGE

Your coverage will terminate on the earliest of one (1) of the following: upon entry into the armed forces of any country; or the end of the coverage period for which premium was paid; or the date the Policy terminates. No benefits are payable after termination, except as stated in the Extension of Benefits provision.

A Covered Person's coverage may be cancelled, or its renewal refused, only in the following circumstances: failure by the Covered Person or other responsible party to make payments under the Policy; misrepresentation or fraud on the part of the Covered Person; commission of acts of physical or verbal abuse by the Covered Person which pose a threat to providers or other Insureds and which are unrelated to the Covered Person's physical or mental condition; relocation of the Covered Person outside the Policy's service area; or non-renewal or cancellation of the Policy through which the Covered Person receives coverage or the Covered Person is no longer a student or Dependent.

No Covered Persons were involuntary disenrolled within the past two (2) years.

POLICY TERM AND PLAN COSTS

The insurance under Gordon-Conwell Theological Seminary's Student Accident and Sickness Insurance Plan for the annual policy is effective on September 1, 2010 at 12:01 am through September 1, 2011 at 12:01 am. The Spring term is effective on January 25, 2011 at 12:01 am through September 1, 2011 at 12:01 am. An eligible student's coverage becomes effective on that date. In the case of a qualifying event, the effective date will be the date the student's former insurance expired if documentation from the former insurance company and the full premium due are received by the college within thirty-one (31) days of the event.

PLAN COSTS

	Annual 9/1/10 – 9/1/11	Spring Term 1/25/11 - 9/1/11
Student Only	$1,875.00	$937.50
Student +1	$4,947.00	$2,473.50
Student + Family	$7,324.00	$3,662.00

Note: The rates above include an administrative fee.

ONLINE STUDENT WAIVER/ ENROLLMENT MANAGEMENT PROCESS

Students who do not want to enroll in the Student Accident and Sickness Insurance Plan can waive coverage if they can document proof of comparable coverage in another health insurance plan that will be in effect from September 1, 2010 for students beginning coverage in the fall semester and January 25, 2011 for students beginning coverage in the spring semester until September 1, 2011. Recognizing that health insurance situations may change, each year students will be asked to provide proof of comparable coverage in order to waive participation in the Student Accident and Sickness Insurance Plan. To document proof of comparable coverage, students must complete the Online Waiver Form.

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

Students who want to enroll in the Student Accident and Sickness Insurance Plan can complete the online Enrollment Form. The online form gives the option to elect coverage for the Student Only, Student and one (1) Dependent or Student and two (2) or more Dependents.

To complete the online process, go to www.universityhealthplans.com, choose Gordon-Conwell Theological Seminary from the list of schools, and then select the "Student Accident & Sickness Plan." Links to the "Waiver Form" and "Enrollment Form" appear on the left side. Please choose the link to the form You would like to complete.

Students who are electing to waive the plan will need to know the name, address and toll-free customer service telephone of the current insurance carrier, the name of the policyholder, the policy number and an expiration date (if applicable). Immediately upon submitting the Online Form, students will receive a confirmation number as documentation that the form has been submitted. The confirmation number should be printed as documentation that the online form was submitted. The Online Form is the only accepted process for making Your insurance selection. The deadline for completing the online process is midnight September 17, 2010 for students enrolling in the fall, and midnight February 4, 2011 for students who are newly enrolled for the spring semester.

PHCS / CONSOLIDATED HEALTH PLANS PREFERRED PROVIDER NETWORK

The Gordon-Conwell Theological Seminary Student Accident and Sickness Insurance Plan provides access to Hospitals and health care providers locally and throughout the country through the PHCS Network.

By enrolling in this Insurance Program, you have the PHCS Preferred Provider Network available to You and Your Dependents if any, throughout Massachusetts, providing access to quality health care at discounted fees. In the Western Massachusetts Counties of Hamden, Hampshire, Berkshire and Franklin, the CHP Preferred Provider Network is available. A complete listing of the PHCS Network is available at www.phcs.com, and a complete listing of the CHP network is available at www.chpstudent.com.

A Preferred Provider may require a Covered Person to pay an annual fee for inclusion within the Preferred Providers panel

of patients. Any services that are represented to be a part of the Preferred Provider's annual service agreement are part of that separate agreement and are not part of this Insurance Program.

THE PROGRAM DOES NOT REQUIRE YOU TO USE A PREFERRED PROVIDER, but if a Covered Medical Expense is incurred through a Preferred Provider, the Program will pay:

- For covered Doctor's office visits, including Licensed Mental Health Professionals, 100% of the fees after payment of a $15 Co-payment per visit.

If a Preferred Provider is not available in a particular area or specialty, the Policy will cover at the Preferred Provider level until a provider has been added.

Coverage will be provided at the Preferred Provider level for a provider who is not a Preferred Provider for the first thirty (30) days from the effective date of coverage if a Covered Person is undergoing an ongoing course of treatment or the provider is the Covered Person's primary care provider.

If the Covered Person is a female who is in her second (2nd) or third (3rd) trimester of pregnancy and whose provider in connection with her pregnancy is involuntarily disenrolled, other than disenrollment for quality-related reasons or fraud, treatment will be allowed with said provider, according to the terms of the Policy, for the period up to and including the Covered Person's first postpartum visit.

If a Covered Person is terminally ill and the provider in connection with said Sickness is involuntarily disenrolled, other than for quality related reasons or fraud, the Covered Person will be allowed to continue treatment with said provider, according to the terms of the Policy, until the death of the Covered Person.

Continued coverage is conditioned upon the provider agreeing to:

- Accept reimbursement at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the Covered Person in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled; and
- Adhere to the Policy's quality assurance standards and to provide necessary medical information related to the care provided; and
- Adhere to Our policies and procedures.

Physician profiling information may be available from the Board of Registration in Medicine for physicians licensed to practice in Massachusetts.

We will provide coverage for pediatric specialty care to Covered

Persons requiring such services, including mental health services, by a person with recognized expertise in specialty pediatrics.

For a listing of PHCS Preferred Providers and Consolidated Health Plans Preferred Providers, contact PHCS at (866) 559-7427, www.phcs.com or Consolidated Health Plans at (413) 733-4540, toll-free at (800) 633-7867, or www.chpstudent.com for assistance.

DEFINITIONS

Accident means a sudden, unexpected and unintended identifiable event caused solely by an external physical force resulting in Injury to an Insured Person. Accident does not include a Loss arising out of a health condition or health impairment.

Biologically Based Mental Disorders means those disorders described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, referred to as "the DSM": schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, eating disorders, post traumatic stress disorder, substance abuse disorders, autism and any biologically-based mental disorders appearing in the DSM that are scientifically recognized and approved by the commissioner of the department of mental health in consultation with the commissioner of the division of insurance.

Co-payment means that portion of eligible Expenses which is payable by the Insured. Co-payments do not apply toward the Deductible and coinsurance obligations.

Covered Person means You or a Dependent insured under the Plan.

Covered Medical Expense means Usual and Customary Expense for services, supplies, or treatment which are: 1) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 2) made for services and supplies included in the Schedule of Benefits; 3) in excess of the amount stated as a Deductible, Co-payments or coinsurance, if any.

Creditable Coverage means any blanket or general policy of medical, surgical or health insurance, including the Policy; any policy of accident or sickness insurance that provides hospital or surgical expense coverage; any non-group medical, surgical or hospital insurance; any non-group or group hospital or medical service plan issued by a non-profit hospital or medical corporation; any non-group health maintenance contract issued by a health maintenance organization; any self-insured

or self-funded employer group health plan; any health coverage provided to persons serving in the Armed Forces of the United States; or Medicare or Medicaid.

Deductible means the amount an Insured is required to pay as provided by the applicable coverage under this policy in the event of a Loss.

Dependent means a person who resides with You and is Your: legal spouse; unmarried child(ren) under age twenty-six (26) who are/is financially dependent on You. The term child includes a stepchild, a foster child, an adopted child and a child legally placed with You who is a prospective adoptive parent, even if the adoption has not been finalized; child, despite attaining age twenty-six (26), who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and dependent on You for financial support.

Doctor means a licensed practitioner of the healing arts acting within the scope of his or her license. The Doctor may not be a member of the Covered Person's immediate family. Doctor includes, but is not limited to, podiatrists, dentists, chiropractors, certified registered nurse anesthetist, nurse practitioner and certified nurse midwife.

Emergency Medical Condition means a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of a Covered Person or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, serious jeopardy to the fetus.

A Covered Person has the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever a Covered Person is confronted with an Emergency Medical Condition which in the judgment of a prudent layperson would require pre-hospital emergency services. No Covered Person shall in any way be discouraged from using the local pre-hospital emergency medical services system, the 911 telephone number, or the local equivalent, or be denied coverage for medical and transportation expenses incurred as a result of such emergency medical condition.

Experimental/Investigative will not be considered experimental/investigative if successfully completed Stage III clinical trails of the United States Food and Drug Administration.

Home Health Care means part-time nursing care, by or supervised by, a registered graduate nurse; part-time home health aide service which consists mainly of caring for the patient; physical, occupational, respiratory or speech therapy; nutrition counseling; medical social services by a qualified social worker licensed by the jurisdiction where services are rendered; medical supplies, prosthetic and orthopedic appliances, rental or purchase of durable medical equipment, drugs and medicines obtainable by prescription only, including insulin, but only to the extent that such charges would have considered covered expenses had the Covered Person required confinement in a hospital or in a skilled nursing facility.

Hospice Care means Doctor services; nursing care provided by or under the supervision of a registered professional nurse; social services; volunteer services; and counseling services provided by a professional or volunteer staff under professional supervision.

Hospital means a licensed institution including a tax supported institution of the state, which has on the premises, or prearranged access to, medical and surgical facilities. It must maintain permanent facilities for the care of overnight resident patients under the care of a Doctor. It must have a Registered Nurse (R.N.) always on duty or call. Confinement in the special wing of a Hospital used primarily as a nursing, rest, convalescent or extended care facility is not confinement in a Hospital, unless such confinement is because of a lack of space in the Hospital's full service wing.

Injury means bodily harm caused by an Accident which occurs while this policy is in force and is the sole cause of the Loss.

Insured Person means an eligible student or an eligible student's Dependent (if covered by this Policy).

Licensed Mental Health Professional means a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist.

Loss means medical Expenses caused by Injury or Sickness and covered by this Policy.

Mental Illness means either the Biologically-Based Mental Disorders; or rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to commit rape; or a Non-Biologically Based Mental, Behavioral or Emotional Disorders of a Child or Adolescent Under the Age of 19; or all other mental disorders described in the most recent edition of the DSM.

Non-Biologically Based Mental, Behavioral or Emotional Disorders of a Child or Adolescent Under the Age of 19 means a disorder described in the most recent edition of the DSM which substantially interfere with or substantially limit the

functioning and social interactions of such a child or adolescent; provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by the primary care Doctor, primary pediatrician, or a Licensed Mental Health Professional of such a child or adolescent or is evidenced by conduct, including, but not limited to: 1) an inability to attend school as a result of such a disorder, 2) the need to hospitalize the child or adolescent as a result of such disorder, or 3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others. The Policy shall continue to provide such coverage to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's 19th birthday until said course of treatment, as specified in said adolescent's treatment plan, is completed and while the benefit contract under which such benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect.

Pre-existing Condition means conditions which had, during the six (6) months immediately preceding the effective date of coverage, manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received. Once an Insured is covered under this plan for six (6) months, Pre-existing Conditions will be treated as any other condition. Diagnosis, care or treatment shall not include any prior diagnosis of or prior treatment for infertility. Pregnancy shall not be considered a pre-existing condition.

Preferred Allowance means the amount a Preferred Provider will accept as payment for Covered Medical Expenses.

Preventive Care Services means services rendered to a Dependent child from the date of birth through the attainment of six (6) years of age and shall include physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals: six (6) times during the child's first (1st) year after birth, three (3) times during the next year, annually until age six (6). Such services shall also include hereditary and metabolic screening at birth, appropriate immunizations, and tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the Doctor.

Sickness means disease or illness, which causes a Loss while the Insured is covered by this Policy. Sickness includes normal pregnancy and complications of pregnancy.

Usual and Customary Expense means an Expense which: 1) is charged for treatment, supplies or medical services to treat

the Insured's condition; and 2) does not exceed the usual level of charges made for similar treatment, supplies, or medical services in the locality where the Expense is incurred.

We, Us, Our means Nationwide Life Insurance Company.

You, Your, Yours means the Insured.

PRE-EXISTING CONDITIONS LIMITATION

Pre-existing Conditions are not covered for the first six (6) months following the Covered Person's effective date of coverage under the Policy. This limitation will not apply if, during the period immediately preceding the Covered Person's effective date of coverage under the Policy, the Covered Person was covered under prior creditable coverage for six (6) consecutive months. Prior creditable coverage of less than six (6) months will be credited toward satisfying the Pre-existing Condition limitation. This waiver of Pre-existing Conditions will apply only if the Covered Person becomes eligible and applies for coverage within sixty-three (63) days of termination of his or her prior coverage. The Covered Person must provide us proof of prior Creditable Coverage. Pregnancy shall not be considered a pre-existing condition.

CONTINUOUS COVERAGE

In determining whether a Pre-existing Condition provision applies to an Insured Person, the Student Accident and Sickness Insurance Policy will credit the time the person was previously covered under a previous health insurance plan or policy or employer provided health benefit arrangement, if the previous coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of the new coverage. Any waiting period prior to that previous coverage becoming effective shall also be credited. Such credit shall apply to the extent that the previous coverage meets the Policy definition of Credible Coverage.

EXTENSION OF BENEFITS

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured Person is confined to a Hospital on the day his or her insurance terminates, expenses incurred after such termination date and during the continuance of that Hospital confinement shall be payable in accordance with this plan, but only while they are incurred during the ninety (90) day period following such termination of insurance. The total payments per Insured will not exceed the maximum under this plan. After this Extension of Benefits After Termination provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

BASIC ACCIDENT AND SICKNESS EXPENSE BENEFITS

Mental Illness Treatment for Biologically Based Mental Disorders; rape-related mental or emotional disorders; and Non-Biologically Based Mental, Behavioral or Emotional Disorders of Child and Adolescents Under the Age of 19 will be paid the same as any other Sickness, except the diagnosis and treatment of rape-related mental or emotional disorders will be paid only if the costs of such diagnosis and treatment exceed the maximum compensation awarded to such victims. Treatment will consist of inpatient, intermediate and outpatient services that permit active and noncustodial treatment to take place in the least restrictive clinically appropriate setting.

Mental Illness Treatment of all other Mental Disorders: which are described in the most recent edition of DMS, consisting of inpatient, intermediate and outpatient services that permit active and noncustodial treatment to take place in the least restrictive clinically appropriate setting. Treatment is limited during each twelve (12) month period for a minimum of sixty (60) days inpatient treatment and twenty-four (24) outpatient visits.

Psychopharmacological Services and Neuropsychological Assessment Services Expense.

Cytological Screening and Mammogram: Benefits will be provided for: one (1) annual cytological (pap smear) screening for ages eighteen (18) and over; a baseline mammogram for ages thirty-five (35) through thirty-nine (39); and a mammogram every year for women age forty (40) and over.

Home Health Care Services (see definitions).

Hospice Care: services of a licensed hospice care agency which are furnished to a Covered Person at home, on an outpatient basis or on a back-up in-patient basis, as defined by the Department of Public Health.

Cardiac Rehabilitation: for a Covered Person who has a documented cardiovascular disease. Multidisciplinary outpatient treatment will be provided in either a hospital or other setting. Treatment must meet standards promulgated by the Commissioner of Public Health and be initiated within twenty-six (26) weeks after the diagnosis of the disease.

Bone Marrow Transplant: for treatment of metastatic breast cancer. If a bone marrow transplant is not available from a Preferred Provider, benefits will be paid at the Preferred Provider level for services rendered by a non-preferred provider.

Non-Prescription Enteral Formulas: Coverage for nonprescription enteral formulas ordered by a Doctor for home

use for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. Coverage for inherited diseases of amino acids and organic acids shall include food products modified to be low protein in an amount not to exceed $5,000 annually for any Insured individual.

Diabetes: diagnosis and treatment expense for treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes. Benefit includes expense for blood glucose monitors; blood glucose monitoring strips for home use; voice-synthesizers for blood glucose monitors for use by the legally blind; visual magnifying aids for use by the legally blind; urine glucose strips; ketone strips; lancets; insulin; insulin syringes; prescribed oral diabetes medications that influence blood sugar levels; laboratory tests, including glycosylated hemoglobin, or HbAlc tests; urinary/protein/microalbumin and lipid profiles; insulin pumps and insulin pump supplies; insulin pens, so-called therapeutic/molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating doctor and prescribed by a podiatrist or other qualified doctor and furnished by a podiatrist, orthotist, prosthetist or pedorthist; supplies and equipment approved by the FDA for the purposes for which they have been prescribed and diabetes outpatient self-management training and education, including medical nutrition therapy.

Diagnosis and Treatment of Infertility: payable the same as any other Sickness. Infertility is a condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one (1) year. Benefit includes expense incurred for the following non-experimental infertility procedures: artificial insemination; in vitro fertilization and embryo placement; gamete intra-fallopian transfer; zygote intrafallopian transfer; Intracytoplasmic sperm injection for the treatment of male factor infertility; and sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any. Coverage is not limited to sperm provided by the Covered Person's spouse.

Scalp Hair Prosthesis Expense: for prosthesis worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia, payable up to $350 per Policy Year.

Maternity Expense: to include expenses for prenatal care, childbirth and post partum care (including well baby care) on the same basis as any other Sickness. Benefit includes hospital inpatient care for forty-eight (48) hours following vaginal delivery and ninety-six (96) hours following a cesarean section. Any decision to shorten maternity stays shall be made by the attending Doctor in consultation with the mother, in accordance with regulations promulgated by the Department of Public Health. The Covered Person is entitled to one (1) home visit should they elect to participate in an early discharge.

Preventive and Primary Care Services: expense for Dependent children from the date of birth through the attainment of six (6) years of age.

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

Early Intervention Services: for early intervention services delivered by certified early intervention specialists for children from birth until their third (3rd) birthday.

Emergency Services: expense for health care items and services furnished in an emergency department and all ancillary services routinely available to an emergency department to the extent they are required for stabilization of an Emergency Medical Condition. If a Covered Person receives emergency services and cannot reasonably reach a Preferred Provider, payment for emergency services will be at the same level and in the same manner as if the person had received treatment by a preferred provider.

Human Leukocyte Antigen Testing or Histocompatibility Locus Antigen Testing: that is necessary to establish bone marrow transplant donor suitability. The coverage shall cover the costs of testing for A, B or DR antigens, or any combination thereof, consistent with rules, regulations and criteria established by the department of public health.

High Cost Procedure Expense: Covered Medical Expenses for high cost procedures in excess of $200, such as, but not limited to, outpatient diagnostic C.A.T. Scans, Magnetic Resonance Imaging, and Laser treatments are payable at 80% of the negotiated charge (in-network) or 80% of Usual and Customary charge (out-of-network) to a maximum of $2,000 per Accident or Sickness.

Speech, Hearing and Language Disorders: Diagnosis and treatment of speech, hearing and language disorders by individuals licensed as speech-language pathologists or audiologists under the provisions of chapter 112, if such services are rendered within the lawful scope of practice for such speech-language pathologists or audiologists regardless of whether the services are provided in a Hospital, clinic or private office, payable the same as any other Sickness. Coverage shall not extend to the diagnosis or treatment of speech, hearing and language disorders in a school-based setting.

Breast Reconstruction Incident to Mastectomy: Reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending Doctor and patient.

Hormone Replacement Therapy: for pre- and post-menopausal women.

Outpatient Contraceptive Services: including consultations, examinations, procedures and medical services related to contraceptive methods to prevent pregnancy approved by the U.S. Food and Drug Administration under the same terms and conditions for other outpatient services.

Cancer Clinical Trials: for Qualified Cancer Clinical Trials as defined in MA Chapter 257 subject to all other terms and conditions of the Policy.

Prosthetic devices and repairs: payable the same as any other durable medical equipment as defined in M.G.L. c. 175 §47Z(a).

CONFORMITY WITH STATE STATUTES

Any provision of this plan, which on its effective date, is in conflict with the statutes of the state in which it is issued, is hereby amended to confirm to the minimum requirements of such statutes.

COORDINATION OF BENEFITS

This Policy coordinates with other plans under which an individual is covered so that the total benefits available will not exceed 100% of the allowable Expenses. When a claim is made, other valid and collective insurance pays its benefits without regard to this Policy. This Policy then adjusts benefits so that the total benefits available will not exceed the allowable Expenses. No plan pays more than it would without the coordination provision. In the absence of other valid and collectible insurance, it is Our intention that Expenses incurred in connection with any covered

Injury shall be fully payable subject to the terms, conditions and limitations of this Policy.

EXCESS BENEFITS

No benefits are provided by the Policy for expenses which are reimbursable by any other valid and collectible insurance plan, but such charges in excess thereof shall be covered as otherwise provided.

PRESCRIPTION DRUG BENEFIT

Prescription drugs to a maximum of $1,000 per Policy Year after a $10 co-pay per 30-day supply of a prescription or refill of a generic drug and a $20 co-pay per 30-day supply of a prescription or refill of a brand name drug, including hormone replacement therapy and contraceptive outpatient prescription drugs or devices approved by the U. S. Food and Drug Administration.

Coverage for a prescription drug will not be excluded for the treatment of cancer or HIV/AIDS on the grounds that the drug has not been approved by the U.S. Food and Drug Administration (FDA) for that indication, if such drug is recognized for treatment of such indication in one of the standard reference compendia, in medical literature, or by the commissioner under the provisions of section forty-seven L (47L) of the Massachusetts General Laws. Prescription drug coverage shall also include services associated with the administration of the drug. Prescriptions must be filled at an "Express Scripts" Participating Pharmacy. Covered Persons will be given an ID card to show the Pharmacy as proof of coverage. No claim forms need be completed once you receive this ID card. Until such card is received, You may fill prescriptions and be reimbursed by submitting a completed "Express Scripts" claim form. Claim forms can be obtained by calling Consolidated Health Plans at (800) 633-7867 or visiting their website at www.chpstudent.com. A directory of participating pharmacies is available by calling Express Scripts directly at (800) 451-6245 or by logging onto www.universityhealthplans.com.

NOTE: Not all medications are payable. Medications not covered by this benefit include, but are not limited to, allergy serum, drugs whose sole purpose is to promote or stimulate hair growth (Rogaine, Propecia, Renova), appetite suppressants and smoking deterrents. A complete list of exclusions may be obtained by calling Express Scripts directly at (800) 451-6245.

VOLUNTARY DELTACARE DENTAL PLAN

The DeltaCare Dental Plan may be purchased regardless of Your enrollment in or waiver of the Student Accident and Sickness Insurance Plan. The cost for this dental plan is not included with your Accident and Sickness Plan premium. The dental insurance premium must be paid directly to University Health Plans. Please follow these steps to obtain more information about this dental insurance plan and enrollment deadlines: go to www.universityhealthplans.com, click on "Gordon-Conwell Theological Seminary" and choose the "Voluntary DeltaCare Dental Plan." You may also contact University Health Plans at (800) 437-6448 for more information.

DISCOUNT VISION PROGRAM

For Vision Discount Benefits please go to:
www.consolidatedhealthplan.com/student_health.

EXCLUSIONS & LIMITATIONS

The plan does not cover nor provide benefits for:

1. Expenses incurred for dental treatment including Temporomandibular Joint Dysfunction (TMJ), except for treatment resulting from Injury to natural teeth; or as specifically provided by a Sickness Dental Expense Benefit, if included in the Policy;
2. Services normally provided without charge by the Policyholder's health service, infirmary, Hospital, or employees;
3. Routine eye exams and contacts; replacing eyeglasses or prescription thereof; routine examinations and service related to hearing examinations or hearing aids, or treatment for hearing defects not related to an Injury or Sickness;
4. Routine physical examinations, preventive care, except as specifically provided; elective surgery and elective treatment services solely to improve appearance, for personal hygiene; services specifically for dietary control custodial, or sanitaria or rest care;
5. Cosmetic Surgery. Cosmetic Surgery does not include reconstructive surgery which results from trauma, infection or other diseases of the involved part; reconstructive surgery because of congenital disease or deformity of a Dependent child. Cosmetic surgery due to congenital defects will be covered for newborn children;
6. Treatment or supplies for newborn infant except that required for the treatment of a covered Accident or Sickness;
7. Voluntary termination of pregnancy, except as specifically provided;
8. Skydiving; recreational parachuting; hang gliding; glider flying, parasailing, sail planning; bungee jumping; or flight in any kind of aircraft; except while riding as a passenger on a regularly scheduled flight of a commercial airline;
9. Injury or Sickness resulting from any declared or undeclared war;
10. Injury due to participation in a riot; commission of or attempt to commit a felony;
11. Injury or Sickness sustained while in the Armed Forces of any country. When an Insured enters such Armed Forces, We will refund a pro-rata premium to the Insured;
12. Injury or Sickness covered by any workers' compensation or occupational disease law;
13. Treatment provided in a governmental Hospital unless the Insured is legally obligated to pay such charges;
14. Pre-existing Conditions in excess of $500, as defined in "Definitions"; 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;
15. 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;
16. Expenses covered by any other valid and collectible medical, health or Accident insurance;
17. Injury sustained while (a) participating in any interscholastic club, intercollegiate or professional sport, contest, or competition; (b) traveling to or from such sport, contest or competition as a participant; (c) while participating in any practice or conditioning program for such sport, contest or competition;
18. Expenses incurred for the following are excluded under this plan: legend vitamins or food supplements; smoking deterrents; immunization agents; biological sera; blood plasma; drugs to promote or stimulate hair growth; experimental drugs; drugs dispensed in a hospital or rest home.

MEDICAL EVACUATION BENEFIT

When hospital confined for at least five (5) consecutive days, and recommended and approved by the attending Doctor, benefits will be paid up to $10,000 for Your evacuation to Your home country. This benefit is limited to the Maximum Benefits specified above.

REPATRIATION BENEFIT

If You die while insured under the Policy, benefits will be paid up to $10,000 for preparing and transporting Your remains to Your home country. This benefit is limited to the Maximum Benefit specified above. No additional benefits will be paid under Basic or Major Medical coverage for Repatriation.

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

MEDEX Assistance Corporation provides you with a comprehensive program with 24/7 emergency medical assistance including emergency evacuation and repatriation and other travel assistance services when you are 100 or more miles away from home. Your MEDEX identification card is your key to travel security.

For general inquiries regarding your international assistance coverage, please call Consolidated Health Plans at 800-633-7867.

If you have a medical or travel problem, simply call MEDEX for assistance and provide your name, school name, the group number shown on your ID card, and a description of your situation.

If you are in North America, call the Assistance Center toll-free at: 800-527-0218 or if you are in a foreign country, call collect at: 410-453-6330.

If the condition is an emergency, you should go immediately to the nearest Doctor or hospital without delay and then contact the 24-hour Assistance Center.

CLAIMS PROCEDURES

1. Itemized bills must be submitted within ninety (90) days from the date of treatment. The Covered Person's name and identification number need to be included.
2. Payment for Covered Medical Expenses will be made directly to the hospital or Physician concerned unless bill receipts and proof of payment are submitted.

Within forty-five (45) days following receipt of the appropriate documentation, We will either 1) make payment for the services provided, 2) notify the provider or claimant in writing of the reason or reasons for nonpayment, or 3) notify the provider or claimant in writing of what additional information or documentation is necessary to complete the claim filing. If We fail to comply, We are required to pay, in addition to any reimbursement for health care services provided, interest on the benefits beginning forty-five (45) days after receipt of the properly documented claim at the rate of one and one half

percent (1.5%) per month, not to exceed eighteen percent (18%) per year. These provisions do not apply to claims that a carrier is investigating because of suspected fraud.

There is no utilization review performed on this policy.

CLAIM APPEAL

To appeal a claim, send a letter stating the issues of the appeal to Consolidated Health Plan's Appeal Department at the address below. Include your name, phone number, address, school attended and email address, if available. Claims will be reviewed and responded to within sixty (60) days by Consolidated Health Plans.

Translation services are available to assist Insured(s), upon request, related to administrative services.

This Brochure is a brief description of the Plan Benefits. The exact provisions governing the insurance are contained in the Policy issued to Gordon-Conwell Theological Seminary located in Health Services.

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

The Plan is Underwritten By:
Nationwide Life Insurance Company
Policy Number: 302-122-2008

Claims Administrator:
Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
(800) 633-7867
www.chpstudent.com

Please visit our website to check claims status and eligibility.

WHERE TO FIND HELP

For questions about:
- Insurance Benefits
- Claims Processing

Please contact:
Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
(800) 633-7867
www.chpstudent.com

For questions about:
- Enrollment
- Waiver/Enrollment Process

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

For questions about:
- Lost ID Cards

Please contact:
Consolidated Health Plans
(800) 633-7867
www.chpstudent.com

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

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

Please contact:
Express Scripts
(800) 451-6245

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

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

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

SCHEDULE OF MEDICAL EXPENSE BENEFITS

This plan provides benefits for the Usual and Customary (U&C) Charges incurred by an Insured Person for Loss due to a covered Accident or Sickness up to a $50,000 maximum per Injury and Sickness.

BENEFITS	Preferred Provider	Non-Network Provider
Maximum Benefit per Injury or Sickness	$50,000 Per Condition Aggregate Maximum	
INPATIENT EXPENSE BENEFITS	**Preferred Provider**	**Non-Network Provider**
Hospital Room and Board Expense, Semi-private room, general nursing care, and intensive care unit.	100% of Preferred Allowance	80% of Usual and Customary (U&C) Charges
Hospital Miscellaneous Expense, Operating room, laboratory tests, x-ray examination, anesthesia, and physiotherapy services.	100% of Preferred Allowance	80% of U&C Charges
Surgeon Expense, No more than one (1) surgical procedure will be covered when multiple procedures are performed through the same incision or immediate succession. Reimbursement based on Ingenix.	100% of Preferred Allowance up to a combined maximum of $5,000	80% of U&C Charges up to a combined maximum of $5,000
Assistant Surgeon **Anesthetist Expense**	100% of Preferred Allowance up to $1,500	80% of U&C Charges up to $1,500
Doctor Visit, (non surgical visit) Limited to one (1) visit per day	100% of Preferred Allowance (after $15 co-pay)	80% of U&C Charges (after $15 co-pay)
Pre-Admission Testing Expense	Paid under Hospital Miscellaneous Expense	
OUTPATIENT EXPENSE BENEFITS	**Preferred Provider**	**Non-Network Provider**
Surgeon Expense, No more than one (1) surgical procedure will be covered when multiple procedures are performed through the same incision or immediate succession. Reimbursement based on Ingenix.	100% of Preferred Allowance up to a combined maximum of $5,000	80% of U&C Charges up to a combined maximum of $5,000
Assistant Surgeon and Anesthetist Expense	100% of Preferred Allowance up to $1,500	80% of U&C Charges up to $1,500
Outpatient Hospital Services for Surgery Expense, Services related to scheduled surgery performed in a hospital, operating room, laboratory test, x-ray, examinations, anesthesia, supplies, drugs, and medication.	100% of Preferred Allowance up to a maximum of $5,000	80% of U&C Charges up to a maximum of $5,000
Outpatient Miscellaneous Expense, includes Doctor/Consultant visits, chiropractic care, emergency room, laboratory tests, diagnostic x-rays, injections (when administered in the Doctor's office), radiation and chemotherapy.	100% of Preferred Allowance up to a maximum of $2,000 per Injury or Sickness after the following Co-payments: Doctor/Consultant Office: $15 Emergency Room Visit: $100 (waived if admitted)	80% of U&C Charges, up to a maximum of $2,000 per Injury or Sickness after the following Co-payments: Doctor/Consultant Office: $15 Emergency Room Visit: $100 (waived if admitted)
MENTAL HEALTH EXPENSE BENEFITS	**Preferred Provider**	**Non-Network Provider**
Inpatient Mental Illness Expense Benefit for non-biologically based mental health conditions.	Covered as any other Sickness up to 60 days per Policy Year	
Outpatient Mental Illness Expense Benefit for non-biologically based mental health conditions.	After $15 co-payment per office visit, 100% Preferred Allowance up to 24 visits	After $15 co-payment per office visit, 80% of U&C Charges up to 24 visits
Inpatient Mental Health Expense for biologically based mental disorders	Covered as any other Sickness	
Outpatient Mental Health Expense for biologically based mental disorders	Covered as any other Sickness, refer to Outpatient Miscellaneous Expense	
Inpatient and Outpatient Mental Health Expense for rape-related mental or emotional disorders	Covered as any other Sickness	
ADDITIONAL BENEFITS	**Preferred Provider**	**Non-Network Provider**
High Cost Procedure Expense, in excess of $200 up to $2,000, includes CT scan, MRI, and laser treatment	100% of Preferred Allowance up to a maximum of $2,000	80% of U&C Charges up to a maximum of $2,000
Prescription Drug Expense, including prescription contraceptive drugs and devices.	$10 for a 30-day supply of a generic drug or $20 for a 30-day supply of a brand name drug up to $1,000 per Policy Year	
Annual Physical Exam (limited to one (1) per Policy Year)	100% up to $100 Per Policy Year	80% U&C up to $100 Per Policy Year
Cytologic Screening Expense, including screening and examination	100% of Preferred Allowance	80% of U&C Charges
Mammography Examination Expense	Covered as any other Sickness	
Maternity Expense	Covered as any other Sickness	
Ambulance Expense	100% of U&C Charges up to a maximum of $125	
Dental Injury Expense	Paid under Outpatient Miscellaneous Expense	
Wisdom Teeth Expense, for bony impacted wisdom teeth	Paid under Outpatient Miscellaneous Expense	