Student Health Insurance

Designed for the Students

of

2012-2013

Underwritten by:

Nationwide Life Insurance Company

Columbus, Ohio

Policy Number: 302-004-2010

Effective: August 15, 2012 to August 14, 2013

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.

NOTICE: Your student health insurance coverage, offered by Nationwide Life Insurance Company, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits for health insurance plans other than Student Health Insurance coverage for the 2012/2013 policy year. Minimum restrictions for policy year dollar limits for Student Health Insurance coverage are $100,000 for the 2012/2013 policy year. Your Student Health Insurance coverage has a policy year limit of: $100,000 per Policy Year. Be advised that you may be eligible for coverage under your parents' plan if you are under the age of 26. If you have any questions or concerns about this notice, contact Consolidated Health Plans.

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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MASSACHUSETTS REQUIREMENTS 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

WHERE TO FIND HELP

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

For Questions About:	**Please Contact:**
Enrollment Waiver	**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
Insurance Benefits Claims Processing ID Cards	**Consolidated Health Plans** 2077 Roosevelt Avenue Springfield, Massachusetts 01104 (800) 633-7867 www.chpstudent.com
Status of Pharmacy Claim Pharmacy Claim Forms Excluded Drugs and Pre-authorization	**Express Scripts** (800) 451-6245 www.express-scripts.com

AM I ELIGIBLE?

All full-time or ¾ full time students who are registered for 9 or more credits are automatically enrolled in the Student Health Insurance Plan. The premium for coverage is added to their Student Account unless proof of comparable coverage is furnished.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, Internet, and television (TV) courses do not fulfill the eligibility requirements that the student actively attend classes.

International students are enrolled on a mandatory basis and cannot waive the Student Health Insurance Plan.

HOW DO I WAIVE/ENROLL?

Eligible Students who DO NOT WANT to be enrolled in the Student Health Insurance Program must submit an online Waiver Form documenting proof of comparable coverage in another health insurance plan prior to the posted waiver deadline.

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

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

To document proof of comparable coverage OR confirm enrollment in the Student Health Insurance Program, students must go to www.universityhealthplans.com and select Pine Manor College. The Waiver and Enrollment Forms can be accessed by clicking the "Waiver Form" or "Enrollment Form" link on the left of the page and following the instructions. Immediately upon submitting the online Waiver Form, students will receive a confirmation number as verification that the form has been submitted. **The form HAS NOT been submitted until a confirmation page is provided.** The confirmation should be printed as this is the student's ONLY proof of submitting the request.

EFFECTIVE DATES AND COSTS

The Pine Manor College Student Health Insurance Plan provides coverage to students for a twelve (12) month period - from 12:01 a.m. August 15, 2012, through 11:59:59 p.m. August 14, 2013. Premium for the Student coverage under this Plan is due and payable as part of Your Pine Manor College billing and tuition fees.

	Annual 8/15/12-8/14/13	Spring (New Students Only) 1/6/13-8/14/13
Student	$998	$683

TERMINATION OF COVERAGE

Your coverage will terminate on the earliest to occur:

- The date the policy ceases to be in force.
- The end of the period for which premium has been paid.
- Upon entry into the Armed Forces of any country.

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 involuntarily disenrolled within the past 2 years.

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under the Policy ceases on the Termination Date. However, if a Covered Person is hospital confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed ninety (90) days after the Termination Date.

The total payments made in respect of the Covered Person for such condition both before and after the Termination Date will never exceed the Maximum Benefit. After this provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

PREMIUM REFUND POLICY

Except for medical withdrawal due to a covered Injury or Sickness, any student withdrawing from school during the first 31 days of the period for which coverage is purchased shall not be covered under the Policy and a full refund of the premium, minus any claims paid, will be made. Students withdrawing after such 31 days will remain covered under the Policy for the full period for which 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 90 days of withdrawal from school. Refunds for any other reason are not available.

DEFINITIONS

Accident means a sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while a Covered Person is insured under the policy.

Autism Spectrum Disorder means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

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.

CHP Preferred Provider means a provider in the Consolidated Health Plans network who contracts to provide services at a discounted rate.

Co-payment means a separate charge for certain Covered Medical Expenses which is paid by the Covered Person.

Covered Medical Expense means the Reasonable and Customary Charge for a service or supply, which is performed or given under the direction of a Doctor for the treatment of Injury or Sickness pursuant to the terms of the Policy.

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

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.

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.

Elective Treatment means Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Covered Person's effective date of coverage. Elective treatment includes, but is not limited to, vasectomy, breast reduction, sexual reassignment surgery (except counseling as provided under the Mental Illness benefit), submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis, treatment for weight reduction (except counseling provided under Preventive Care Services), and temporomandibular joint (TMJ) dysfunction.

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: Services and Charges will not be considered experimental/investigative if successfully completed Stage III clinical trials 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 been 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 that has, on the premises or prearranged access to, medical and surgical facilities. It must operate as a Hospital pursuant to law for the care and treatment of Injured or Sick persons on an Inpatient basis, maintaining 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 on 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 to an Insured caused by an Accident that is the sole cause of the Loss. All Injuries due to the same or related causes are considered one (1) Injury.

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 Expense caused by Injury or Sickness and which is covered by the 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 Disorder 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 interferes with or substantially limits 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 ofsuch 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 a condition that manifested itself during the 6 months immediately preceding the Covered Person's effective date of coverage in such a manner as would have caused 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.

Diagnosis, care or treatment shall not include any prior diagnosis of or prior treatment for infertility.

Pediatric 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 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, newborn hearing testing, appropriate immunizations, lead screening and tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the Doctor.

Reasonable and Customary Charge (R&C) means the normal and customary charge of the provider, incurred by the Covered Person, in the absence of insurance for a service or supply, but not more than the prevailing charge in the area.

Sickness (Sick) means illness or disease which begins or for which expense is incurred while coverage is in force under the Policy. Sickness includes normal pregnancy and complications of pregnancy. All related conditions and recurring symptoms of a Sickness will be considered one (1) Sickness.

Sound and Natural Teeth means teeth that are organic and formed by the natural development of the body and that do not have significant decay or periodontal disease.

We, Us or Our means Nationwide Life Insurance Company.

You, Your or Yours means Covered Persons.

PRE-EXISTING CONDITIONS LIMITATION

Pre-existing Conditions are not covered for the first 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 6 consecutive months. Prior creditable coverage of less than 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 63 days of termination of his or her prior coverage. The Covered Person must provide us proof of prior Creditable Coverage. Pregnancy and Infertility shall not be considered Pre-existing conditions. Pre-existing does not apply to Covered Persons under age 19.

PREFERRED PROVIDER INFORMATION

By enrolling in this Insurance Program, you have First Health Preferred Provider Network available to You and Your Dependents, providing access to quality health care at discounted fees. A complete listing is available at www.firsthealth.com or www.consolidatedhealthplan.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.

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 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 2nd or 3rd trimester of pregnancy and whose provider in connection with her pregnancy is involuntary disenrolled, other than disenrollment for quality-related reasons or fraud, treatment will be allowed with said provider, according to the terms of the Policy, for the period up to and including the Covered Persons first 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.

Pine Manor College has directories listing First Health Preferred Providers or call First Health at (800) 226-5116 or Consolidated Health Plans at (413) 733-4540 or toll-free at (800) 633-7867 for assistance.

MEDICAL EVACUATION BENEFIT

If as the result of a Covered Injury or Sickness, a Covered Person was hospital confined for a minimum of five (5) days, and must be transported to their country of origin or another facility, the Policy will pay up to $25,000. Such evacuation will require prior approval of both the attending doctor and the Company. Upon evacuation for International Students, all coverage under the Policy shall terminate.

REPATRIATION OF REMAINS BENEFIT

If a Covered Person dies as the result of a Covered Injury or Covered Sickness, the Policy will pay up to $25,000 for the preparation and transportation of the body to the country of the Covered Person. This benefit does not pay for any person accompanying the body.

PRE-CERTIFICATION POLICY

This plan does not require pre-certification of benefits. Please refer to the schedule of benefits section of the policy for covered benefits.

Benefit Enhancements

New for the 2012-2013 School Year

- Increased Prescription Drug benefit;
- Inclusion of wellness and preventive care benefits; and
- Increased policy maximum benefit.

STUDENT HEALTH INSURANCE EXPENSE BENEFITS

The Policy will pay 80% of Covered Medical Expense incurred by an Insured Person up to a Maximum Benefit of $100,000 per Policy Year, except as specifically stated. Covered Expenses are considered incurred on the date the treatment or service is rendered or the supply is furnished. Covered Medical Expenses are:

INJURY & SICKNESS EXPENSE BENEFITS

Policy Year Aggregate Maximum Benefit	**$100,000**

Hospital Expense Benefit

Hospital Room and Board. Services include semi-private room, nursing services, special care unit.	80% of R&C
Hospital ICU Expense	80% of R&C
Hospital Miscellaneous Expense. Services include anesthesia (excluding professional administration fee), operating room, diagnostic x-ray, laboratory tests, oxygen tent, Licensed Nurse, prescribed drugs & medicine, dressings, physical therapy, pre-admission testing, and other required non-Room and Board Hospital Expenses.	80% of R&C
In-Hospital Physician Visits and Medical Expense. Limited to one visit per day. No payment for a Surgeon, Assistant Surgeon, Anesthesiologist or Second Surgical Opinion are payable under this provision.	80% of R&C

Surgical Expense Benefits (Inpatient or Outpatient)

Surgical Expense. Expenses incurred for a surgical procedure, necessary pre-operative treatment in connection with such procedure and usual post-operative treatment. When more than one (1) surgical procedure is performed through the same incision or in immediate succession, the additional surgery will be covered at 50%.	80% of R&C
Anesthesia Expense. Under the Surgery Expense benefit, if the Surgery requires the services of an anesthetist, who is a Physician neither employed nor retained by the Hospital in which the Surgical Procedure is performed.	80% of R&C
Assistant Surgeon Expense. Under the Surgery Expense benefit, if the Surgery requires the services of an Assistant Surgeon.	80% of R&C

Outpatient Expense Benefits

Includes services provided in a Doctor's office, Licensed Mental Health Professional's office, a community mental health center, home based services for Mental Illness, chiropractor visits, hospital or outpatient department or emergency room, clinical lab, radiological facility or similar facility licensed by the state.

Outpatient Miscellaneous Expense. Services include diagnostic x-rays, laboratory tests, prescription medications and temporary surgical appliances and equipment.	80% of R&C
Emergency Room Expense	80% of R&C, after $100 co-pay (reduced to $50 if admitted).
Physician's Treatment Expense. No payments for a surgeon, Assistant Surgeon, or Anesthesiologist.	100% of R&C after $15 per visit co-pay
Hospital Outpatient Visit	80% of R&C after a $25 co-pay

Mental Illness Expense (Refer to page 18 for more details)

Non-Biologically Based Mental Illness: **Confinement Benefits,** up to 60 days for mental illness in 12 month period **Outpatient Benefits,** up to 24 visits in a 12 month period	Paid the same as any other covered Sickness
Biologically Based Mental Illness. Including inpatient, outpatient, intermediate service and prescription drugs	Same as any other Covered Sickness. Any limitations for non-biologically based mental illness do not apply.
Rape Related Mental or Emotional Disorders	Same as any other Covered Sickness
Treatments for Children and Adolescents. Under the age of 19 for the diagnosis and treatment of non-biologically based mental, behavioral or emotional disorders	Paid the same as any other covered Sickness
Psychopharmacological Services	Paid the same as any other covered Sickness

Additional Benefits

Physical Treatment Expense. Physical Therapy services must be prescribed by a licensed Physician and include a prescription for a stated number of treatments. Limited to 30 visits per Policy Year.	80% of R&C
Ambulance Expense	80% of R&C after a $25 co-pay per trip
Wellness/Preventive and Immunizations	100% of R&C
Durable Medical Equipment	80% of R&C

High Cost Procedure Expense. Covered Medical Expenses for high cost procedures in excess of $200. Services include, but are not limited to C.A.T. Scans, MRI, and Laser Treatments.	80% of R&C
Prescription Drug Benefits. Services include 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 (1) of the standard reference compendia, in medical literature, or by the commissioner under the provisions of section forty-seven L. Prescription Drug coverage shall also include Medically Necessary services associated with the administration of the drug. Prescriptions must be filled at an "Express Scripts" Participating Pharmacy. Insured 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 at Massachusetts School of Law or by calling Express Scripts directly at (800) 451-6245 or by logging onto www.universityhealthplans.com.	Generic Contraceptive Drugs - $0 co-pay per 30-day supply Other Generic Drugs - $5 co-pay per 30-day supply All Brand Name Drugs - $15 co-pay per 30-day supply
Voluntary Termination of Pregnancy	80% of R&C to $1,000
Accidental Dental Expense	100% of R&C up to $500
Intercollegiate Sports Expense	80% of R&C up to $1,500 per Injury
Medical Evacuation	100% of R&C up to $25,000
Repatriation	100% of R&C up to $25,000

MANDATED BENEFITS

If You are enrolled in this Insurance Program, Policy coverage also includes the following benefits, all subject to the Policy Aggregate Limit of $100,000 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.)

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.

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.

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 26 weeks after the diagnosis of the disease.

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

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

Early Intervention - services delivered by certified early intervention specialists for children from birth until their 3rd birthday. **This benefit is only available during the 31-day newborn/adoptive coverage.**

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.

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.

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 reasonable & customary charge.

Home Health Care Services

Hormone Replacement Therapy - for peri- and post-menopausal women.

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.

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.

Diagnosis and Treatment of Infertility - payable the same as any other Sickness up to a maximum of $5,000 per Policy Year. 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.

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 48 hours following vaginal delivery and 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.

Mental Illness Treatment for Biologically Based Mental Disorders; rape-related mental or emotionally disorders; and non-biologically based mental, behavioral or emotional disorders of children 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 DSM, 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 12-month period for a minimum of 60 days inpatient treatment and 24 outpatient visits.

Diagnosis and treatment of Autism Spectrum Disorder (ASD) to residents of MA, including the following medically necessary care prescribed, provided or ordered for an individual diagnosed with ASD by a licensed physician or licensed psychologist: "Habilitative or rehabilitative care", professional, counseling and guidance services and treatment programs, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning or an individual.

- "Pharmacy Care", medications prescribed by a licensed physician and health-related services deemed medically necessary to determine the need or effectiveness of the medications, to the same extent that pharmacy care is provided by the policy for other medical conditions.
- "Psychiatric care", direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
- "Psychological care", direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
- "Therapeutic care", services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers.

Benefits for the diagnosis and treatment of Autism Spectrum Disorder may be subject to annual, lifetime dollar, or unit of service limitation but such limitations will not be less than those imposed for other comparable Sickness under this Policy.

Benefits that otherwise available to an individual under a health insurance policy will not be limited by us.

Coverage under this section shall not be subject to a limit on the number of visits a covered Person may make to an autism services provider.

Newborn/Adoptive Children Coverage Expense Newborn or adoptive children of an Insured are automatically covered at birth for 31 days for the same benefits as provided to the Insured. We will pay as a Sickness benefit, 80% of R&C Charges for special medical formulas which are: (a) approved by the Commissioner of the Department of Public Health, (b) prescribed by a Physician, and (c) required for the treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia in infants and children; or are required to protect unborn fetuses of pregnant women with phenylketonuria.

Benefit coverage includes screening for **lead poisoning** as required by regulations promulgated pursuant to Section 193 of Chapter 111 of the Massachusetts General Laws.

Non-Prescription Enteral Formulas Coverage for non-prescription enteral formulas 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.

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.

Psychopharmacological services and neuropsychological assessment services expense.

Pediatric Preventive Care Services expense for Dependent children from the date of birth through the attainment of six (6) years of age. **This benefit is only available during the 31-day newborn/adoptive coverage.**

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

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.

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.

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.

EXCESS COVERAGE

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.

SUBROGATION

If the Insured is Injured or becomes Sick as a result of another person's negligence, We have the right to seek reimbursement on the Insured's behalf against the negligent party for any claims paid under this Policy, unless prohibited by state law.

EXCLUSIONS

This Policy does not cover Loss nor provide benefits for:

1. Pre-Existing Conditions as defined in this Policy.
2. Treatment provided in a government Hospital unless the Insured is legally obligated to pay such charges.
3. Loss resulting from participation in an illegal occupation, riot, or committing, or attempting to commit, a felony.
4. Injury or Sickness resulting from any declared or undeclared war, or any act thereof.
5. An occupational loss covered by any occupational benefit plan, Workers' Compensation Act or similar law.
6. Injuries sustained as the result of a Motor Vehicle Accident to the extent that benefits are recovered or recoverable under mandatory no-fault benefits insurance, other valid collectible insurance through settlement or litigation.
7. Treatment, services or supplies normally provided without charge by the Policyholder's Health Services, School Infirmary or similar facility or Hospital, or by a person or health care provider employed or retained by the Policyholder.
8. Elective plastic or cosmetic surgery, this exclusion does not apply to cosmetic surgery made necessary by an Injury or a congenital disease or deformity of a newborn child who is a Dependent insured under the Policy.
9. Elective Treatment or elective surgery.
10. Charges in excess of the Reasonable and Customary Charge.
11. Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extractions of teeth, TMJ dysfunction or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia. This exclusion does not apply to the repairs to sound natural teeth caused by an Injury.
12. Loss resulting from air travel, except as a fare-paying passenger on a commercial.
13. Loss resulting from parachuting or bungee jumping; hang-gliding.

14. Surgery for the correction of refractive error and services in connection with eye examinations, eye glasses or contact lenses or hearing aids, except as required for a repair due to an Accident in which the Covered Person sustains an Injury or except when due to a disease process or except as provided herein.
15. Injury or Sickness while on active duty in the Armed Forces of any country (this does not include Reserve or National Guard active duty for training unless it extends beyond 31 days). Upon Our receipt of written notice of an Insured entering such Armed Forces, We will refund the unearned pro-rata premium.
16. With regard to Expenses incurred as an Inpatient, charges for telephones, radios or televisions, extra beds or cots, guest meals, take home and convenience items.
17. Treatment or services provided by a member of the Insured's Immediate Family or by anyone who lives with the Insured.
18. Services or supplies received in the Covered Person's Home Country. This exclusion applies to international students only.
19. Injury resulting from participation in intercollegiate or professional sports. Participation includes practice, conditioning, play and travel in excess of $1,500 per Injury.
20. Services and charges that are determined to be Experimental/Investigational in nature.
21. Topical acne treatments; legend vitamins; food supplements except as specifically stated; drugs to promote or stimulate hair growth; experimental drugs; drugs dispensed in a rest home.
22. Services, supplies and facilities that are provided mainly for rest cure, maintenance or custodial care.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it is issued or in which the Insured resides, is hereby amended to conform to minimum requirements of such statutes.

CLAIM PROCEDURES

1. Itemized bills must be submitted within ninety (90) days from the date of treatment. All bills should include the patient's name and insured student's name, address, member identification number and name of the college under which the student is insured.
2. A company claim form is not required, however, after review; Consolidated Health Plans may contact the student and ask them to complete a claim form or questionnaire to get further information about the claim.
3. Payment for Covered Medical Expenses will be made directly to the hospital or Physician concerned unless bill receipts and proof of payment are submitted.

4. Submit all claims to:

CONSOLIDATED HEALTH PLANS (CHP)
2077 Roosevelt Avenue
Springfield, MA 01104

Within 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 45 days after receipt of the properly documented claim at the rate of 1.5 percent per month, not to exceed 18 percent 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.

CLAIMS APPEAL PROCESS

To appeal a claim, send a letter stating the issues of the appeal to Consolidated Health Plan's Appeal Department at the about address. Include your name, phone number, address, school attended and email address, if available.

Claims will be reviewed and responded to within 60 days by Consolidated Health Plans.

You have the right to appeal to the Office of Patient Protection at 1-800-436-7757, fax: 1-617-624-5046 or visit www.state.ma.us/dph/opp.

Translation services are available to assist insured's, upon request, related to administrative services.

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

This plan is underwritten and offered by:
Nationwide Life Insurance Company
Columbus, Ohio

Policy Number: 302-004-2010

For a copy of the Company's privacy notice, go to:
www.consolidatedhealthplan.com/about/hipaa

VALUE ADDED SERVICES

VISION DISCOUNT PROGRAM

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

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

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.

English/English

Notice Regarding Translator and Interpretation Services

We provide, upon request, interpreter and translation services related to administrative procedures and claims processing. This service is available to you when you contact our Customer Service Department at 1-800-633-7867.

Spanish/Español

Aviso sobre servicios de interpretación y traducción

Nosotros podemos ofrecerle, si usted lo solicita, servicios de traducción relacionados con procedimientos administrativos y procesamiento de reclamos. Este servicio se encuentra disponible cuando usted habla con el departamento del servicio al consumidor al 1-800-633-7867 (1-800-MED-STOP).

French/Français

Avis sur les services de translation et d'interprétation

Nous fournissons, sur demande, des services d'interprétation et de translation relatifs aux procédures administratives et au traitement des réclamations. Ce service est à votre disposition quand vous contactez notre service après-vente (Customer Service Department) à 1-800-633-7867 (1-800-MED-STOP).

Greek/Ελληνικά

Ειδοποίηση σχετικά με τις υπηρεσίες μετάφρασης και διερμηνείας

Παρέχουμε, κατ' απαίτηση, υπηρεσίες μετάφρασης και διερμηνείας σχετικά με τις διοικητικές διαδικασίες και τις διεργασίες αιτήσεων. Η υπηρεσία αυτή είναι διαθέσιμη σε εσάς όταν εσείς επικοινωνείτε με το τμήμα εξυπηρέτησης πελατών στο τηλεφωνικό αριθμό 1-800-633-7867 (1-800-MED-STOP).

Haitian Creole/Kreyòl

Avi sou sèvis tradiksyon ak entèpretasyon

Nou bay, lè ou mande li, sèvis tradiksyon ak entèpretasyon pou keksyon administratif ak reklamasyon. Pou jwen sèvis sa, rele Depatman Kliyan sou nimewo 1-800-633-7867 (1-800-MED-STOP).

Italian/Italiano

Avviso Riguardante Servizi di Traduzione ed Interpretazione.

Forniamo, su richiesta, servizi di interpretazione e traduzione relativi a procedure amministrative e procedimenti per reclami. Questo servizio è disponibile contattando il Servizio Assistenza Clienti al 1-800-633-7867 (1-800 MED-STOP).

Portuguese/Português

Informação sobre serviços de Tradução e Interpretação

Nós fornecemos, mediante solicitação, serviços de tradução e interpretação relacionados a procedimentos administrativos e processamento de reclamações. Este serviço encontra-se à sua disposição quando Você contatar o nosso Departamento de Atendimento ao Consumidor: 1-800-633-7867 (1-800-MED-STOP).

Russian/Русский

Объявление: услуги устных и письменных переводчиков

По требованию клиентов мы предоставляем услуги устных и письменных переводчиков для оказания помощи в вопросах, связанных с административными процедурами и обработкой заявлений. Для того, чтобы воспользоваться услугами переводчика, обратитесь в Отдел обслуживания клиентов по телефону 1-800-633-7867 (1-800-MED-STOP).

Arabic

Arabic/عربي

إشعار بشأن خدمات الترجمة والترجمة الفورية

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

Cambodian

Cambodian(Khmer)/ ភាសាខ្មែរ

ការប្រកាស ស្តីពីការបំរើផ្នែកបកប្រែភាសាផ្ទាល់មាត់ និងភាសាសរសេរ

យើងផ្តល់ជូន ការបំរើផ្នែកបកប្រែភាសាផ្ទាល់មាត់ និងភាសាសរសេរ ប្រសិនបើអ្នកត្រូវការ
នៅក្នុងទំរង់ការ ផ្នែកចាត់ចែង និងទំរង់ការធ្វើបណ្តឹង។ បើអ្នកត្រូវការ សូមទាក់ទងតាមទូរស័ព្ទ មកការិយាល័យ
បំរើអតិថិជនយើង តាមលេខ ១៨០០-៦៣៣-៧៨៦៧។

Chinese (Mandarin)

Chinese(Mandarin)/國語

翻譯及傳譯服務通知

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

Laotian

Laotian/ ລາວ

ປະກາດກ່ຽວກັບການບໍລິການແປພາສາແບບປາກເປົ່າແລະແບບຂີດຂຽນ

ຕາມຄໍາຂໍ, ພວກເຮົາຈະໃຫ້ການບໍລິການດ້ານການແປພາສາແບບປາກເປົ່າ ແລະແບບ ຂີດຂຽນ ທີ່ກ່ຽວກັບການປະຕິບັດດ້ານການບໍລິຫານ ແລະການດໍາເນີນການທວງຖາມ ການຊ່ວຍເຫຼືອຕ່າງໆ. ການບໍລິການນີ້ ຈະມີໃຫ້ເມື່ອທ່ານຕິດຕໍ່ ໄປຫາຝ່າຍປະຊາສໍາພັນ ລູກຄ້າຂອງພວກເຮົາ ທີ່ເບີໂທ 1-800-MED-STOP (633-7867).