Student Health Insurance
Designed for the Students of

ST·OLAF COLLEGE

2014-2015

Underwritten by:
Nationwide Life Insurance Company
Columbus, OH
Policy Number: 302-101-2212

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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WHERE TO FIND HELP
For questions about claims status, eligibility, and benefits please contact:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
(413) 733-4540 or Toll Free (800) 633-7867
www.chpstudent.com

For questions about enrollment please contact:
USI Affinity Collegiate Insurance Resources
3070 Riverside Drive
Columbus, OH 43221
(800) 322-9901
www.cirstudenthealth.com/stolaf

AM I ELIGIBLE?
The St. Olaf College is making available a Student Health Insurance program (hereinafter called “plan”) underwritten by Nationwide Life Insurance Company and administered by Consolidated Health Plans. This brochure provides a general summary of the insurance coverage; the Schedule of Benefits is not all inclusive of eligible benefits payable under this plan. Keep this brochure as no individual policy will be issued. This summary is not a contract; however, the Master Policy will be available for review upon request. The Master Policy contains the contract provisions and shall prevail in the event of any conflict between this brochure and the Master Policy.
To be eligible for this Insurance Program, You must be enrolled in 6 or more credit hours. If You are eligible to be covered under this Program, You are automatically enrolled unless You can certify that You have comparable coverage. Home study, correspondence, Internet, and television (TV) courses do not fulfill the Eligibility requirements. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium, minus any claims paid.

HOW DO I WAIVE?
Students choosing to waive coverage for the 2014-2015 school year must complete the Student Health Insurance Form prior to September 17 2014. Failure to do so will result in your student account being billed a non-refundable insurance premium of $1,374 for the Student Health Plan through Consolidated Health Plans.

COVERAGE FOR DEPENDENTS
Insured Students who are enrolled in the Student Health Insurance Plan may also enroll their eligible Dependents. Eligible dependents under the plan include the Insured person’s spouse and dependent children. For information on how to enroll dependents please go to www.cirstudenthealth.com/stolaf.

Newborn Children: An Insured’s newborn child is automatically covered from the moment of birth and thereafter. Coverage for such child will be for Sickness and Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care.
Notification of Newborn, Step-Child, Foster and Adopted Children: Notification is not required, however, the Insured will be responsible to pay the required additional Premium, if any, and We will be entitled to all premiums that would have been collected had We been aware of the additional Dependent. We may withhold payment of any health Benefits for the new Dependent until We have been compensated with the applicable premium, which would have been owed if We had been informed of the additional Dependent immediately.

EFFECTIVE DATES AND COSTS
The St. Olaf College Student Health Insurance Plan provides coverage to students for a twelve (12) month period - from 12:01 a.m. August 15, 2014, through 11:59 p.m. August 14, 2015.

<table>
<thead>
<tr>
<th></th>
<th>Annual Cost*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$1,374</td>
</tr>
</tbody>
</table>

*Annual costs above include an admin fee.

TERMINATION
Coverage will terminate at 11:59 p.m. standard time at the Policyholder’s address on the earliest of:
- The Termination Date of the Policy;
- The last day of the term of Coverage for which Premium is paid;
- The date a Covered Person enters full time active military service. Upon written request, We will refund a pro-rata Premium with respect to such person; or
- The last date of the period for which Premium has been paid following the date a Dependent ceases to be a Dependent as defined.

PREMIUM REFUND POLICY
Any Insured Student withdrawing from the College during the first thirty-one (31) days of the period for which coverage is purchased shall not be covered under the Policy and a full refund of the premium will be made minus any claims paid. Students withdrawing after thirty-one (31) days will remain covered under the Policy for the full period for which premium has been paid and no refund will be made available. This is true for students on leave for medical or academic reasons, graduating students, and students electing to enroll in a separate comparable plan during the Policy Year. Premiums received by the Company are non-refundable except as specifically provided. Coverage for an Insured Student entering the armed forces of any country will terminate as of the date of such entry. Students withdrawing from the school to enter military service will be entitled to a pro-rata refund of premium upon written request.
The terms listed below, if used, have the meaning stated.

**Accident:** An event that is sudden, unexpected, and unintended, and over which the Covered Person has no control.

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

**Biologically Based Mental Illness:** A mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorders, bulimia, and anorexia.

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

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

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

**Covered Charge(s) or Covered Expense:** As used herein means those charges for any treatment, services or supplies:
- for Preferred Providers, not in excess of the Preferred Allowance;
- for Out-of-Network Providers not in excess of the Reasonable and Customary expense; and
- not in excess of the charges that would have been made in the absence of this insurance; and
- not otherwise excluded under this Policy; and
- incurred while this Policy is in force as to the Covered Person.

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

**Deductible:** The amount of expenses for Covered Services and supplies which must be incurred by the Covered Person before specified Benefits become payable.

- **Dependent:** A person who is the Insured’s:
  - Legally married spouse, who is not legally separated from the Insured and resides with the Insured.
  - Child who is under the age of 26.

Coverage is provided for an adult child of the Insured as a Dependent if the child satisfies all the following criteria:
- The child is 26 through 30 years of age;
- Is not married;
- Has no dependents.

The term child refers to the Insured’s:
- Natural child;
- Stepchild or foster child; A stepchild is a Dependent on the date the Insured marries the child’s parent.
- Adopted child, including a child placed with the Insured for the purpose of adoption, from the moment of placement as certified by the agency making the placement.
- Foster child is a Dependent from the moment of placement with the Insured as certified by the agency making the placement.

**Elective Treatment:** Those services that do not fall under the definition of Essential Health Benefits. Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Covered Person’s Effective Date of Coverage. Elective Benefits is shown on the Schedule of Benefits, as applicable.

**Emergency:** An Illness, Sickness or Injury for which immediate medical treatment is sought at the nearest available facility. The Condition must be one which manifests itself by acute symptoms which are sufficiently severe that a reasonable person would seek care right away to avoid severe harm.

**Essential Health Benefits:** Has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services, and includes the following categories of Covered Services: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care (in accordance with the applicable state or federal benchmark plan).

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

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

**Insured:** The Covered Person who is enrolled at and meets the eligibility requirements of the Policyholder’s school.
Mental Condition(s): Nervous, emotional, and mental disease, Illness, syndrome or dysfunction classified in the most recent addition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) or its successor, as a Mental Condition on the date of medical care or treatment is rendered to a Covered Person.

Physician: A health care professional practicing within the scope of his or her license and is duly licensed by the appropriate State Regulatory Agency to perform a particular service which is covered under the Policy, and who is not:
1. the Insured Person;
2. a Family Member of the Insured Person; or
3. a person employed or retained by the Policyholder.

Reasonable and Customary (R&C): The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred. The most common charge means the lesser of:
- The actual amount charged by the Provider;
- The negotiated rate, if any; or
- The fee often charged for in the geographical area where the service was performed.

The Reasonable Charge is determined by comparing charges for similar services to a national database adjusted to the geographical area where the services or procedures are performed, by reference to the 80th percentile of Fair Health Inc. schedules. The Insured Person may be responsible for the difference between the Reasonable Charge and the actual charge from the Provider.

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

Sickness: Illness, disease or condition, including pregnancy and Complications of Pregnancy that impairs a Covered Person's normal functioning of mind or body and which is not the direct result of an Injury or Accident. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness.

We, Our and Us: Nationwide Life Insurance Company.

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

Male pronouns whenever used include female pronouns.

MEDICAL NECESSITY AND MEDICAL APPROPRIATENESS DETERMINATION

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

Covered Services are Medically Necessary if they are:

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

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

PREFERRED PROVIDER INFORMATION

By enrolling in this Insurance Program, you have the Cigna PPO Network of Participating Providers, providing access to quality health care at discounted fees. To find a complete listing of Cigna PPO Network of Participating Providers, go to www.Cigna.com, or contact Consolidated Health Plans at (413) 733-4540, toll-free at (800) 633-7867, or www.chpstudent.com for assistance.

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

If care is received within the Network from a Preferred Provider, all Covered Medical Expenses will be paid at the Preferred Provider level of benefits found on the Schedule of Benefits.

If a Preferred Provider is not available in the Network Area, or an Insured is out of the Country, benefits will be paid at the level of benefits shown on the Schedule of Benefits as a Preferred Provider.

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

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

SCHEDULE OF BENEFITS

<table>
<thead>
<tr>
<th>Policy Year Aggregate Maximum Benefit</th>
<th>Preferred Provider Benefit Amount</th>
<th>Non-Preferred Provider Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible per covered person/maximum 2 per family</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Out-of-pocket Maximum (All deductibles, copayments apply towards maximum) Excludes non-covered medical expenses &amp; Elective services; Once the Out-of-Pocket Limit is reached by the Covered Person, the Insured Percent paid by the Company will increase to 100% In-Network.</td>
<td>$6,350 per Individual $12,700 per Family</td>
<td>N/A</td>
</tr>
<tr>
<td>Wellness/Preventive and Immunizations</td>
<td>100% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>--------------------------------------</td>
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</tr>
<tr>
<td>Treatment outside of the United States</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Services - (other than Surgery, Maternity, Mental Conditions/Drug or Alcohol)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits, includes Consulting Physician/Specialist.</td>
<td>$20 co-pay then 100% of PA (deductible does not apply)</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Diagnostic X-ray and Laboratory Services</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Diagnostic Imaging, including CT Scan, MRI, and/or PET Scans.</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td><strong>Inpatient Services</strong> (other than Surgery, Maternity, Mental Conditions/Drug or Alcohol, except as specified)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous Hospital Services (includes Pre-Admission testing and Inpatient Rehabilitation).</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Room &amp; Board Expenses, daily semi-private room rate and general nursing care provided by the Hospital and ICU</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Physician In-Hospital Visits (includes Specialists/Consultants), limited to one (1) visit per day and does not apply when related to surgery.</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Skilled Nursing Facility and Sub-Acute Care Facility (limited to 120 days per admission)</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td><strong>Surgical Services</strong> (Inpatient/Outpatient)</td>
<td></td>
<td></td>
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<tr>
<td>When injury or Sickness requires multiple Surgical Procedures through the same incision, we will pay an amount not less than that for the most expensive procedure being performed. Multiple Surgical Procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the Covered Percentage of the Covered Charge of the most expensive Surgical Procedure then being performed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Surgical Miscellaneous - Includes supplies, drugs, facility fee, anesthesia, Diagnostic Imaging, laboratory and miscellaneous items used in association with the surgical event.</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Maternity Care – Includes forty-eight (48) hours of Inpatient care following a normal delivery and ninety-six (96) hours of Inpatient care following a cesarean delivery, unless after conferring with the mother or a person responsible for the mother or newborn, the Attending Physician or a certified nurse-midwife who consults with a Physician, decides to discharge the mother or newborn child sooner. In the event of early discharge, Home Health Care visits will be provided.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pre- and Post-Natal Care</strong></td>
<td>Paid the same as any other Sickness</td>
<td></td>
</tr>
<tr>
<td>Hospital Services</td>
<td>Paid the same as any other Sickness</td>
<td></td>
</tr>
<tr>
<td>Diagnostic services performed and billed by a Physician’s office, including ultrasounds and amniocentesis.</td>
<td>Paid the same as any other Sickness</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Conditions and Alcoholism/Drug Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>Paid the same as any other Sickness</td>
<td></td>
</tr>
<tr>
<td>Outpatient Office Visits</td>
<td>Paid the same as any other Sickness</td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care and Emergency Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care Visit</strong></td>
<td>$20 co-pay per visit then 80% of PA</td>
<td>$20 co-pay per visit then 50% of R&amp;C</td>
</tr>
<tr>
<td><strong>Emergency services</strong> – visits to an Emergency room for stabilization or the initiation of treatment for an Emergency Condition. Includes Physician’s fees, Diagnostic Imaging, Laboratory, Injections, use of Emergency Room and supplies and facility charges. (Copayment is per visit &amp; waived if admitted to Hospital, In-network Deductible applies to Out-of-Network services).</td>
<td>$200 co-pay then 80% of PA</td>
<td>$200 co-pay then 80% of R&amp;C</td>
</tr>
<tr>
<td><strong>Emergency Medical Transportation services</strong></td>
<td>80% of PA</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Services (testing/injections/treatment)</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Habilitative &amp; Rehaabilitative therapies (Includes Physical, Speech and Occupational Therapy).</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Cardiac, Pulmonary and Respiratory Therapy</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Home Health, limited to 120 days per Policy Year.</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Hospice</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Diabetic Treatment and Education</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME) – includes Prosthetic and Orthotic Devices</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Routine Vision Exam for Covered Persons under age nineteen (19). Includes one (1) pair of glasses (lenses and frames per Policy Year.</td>
<td>100% up to $150, 50% thereafter</td>
<td></td>
</tr>
<tr>
<td>Hearing aids for Covered Persons up to age 19; limit 1 per every 3 years.</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>HIV Testing (outside your preventive screening)</td>
<td>80% of PA</td>
<td>50% of R&amp;C</td>
</tr>
</tbody>
</table>
### Prescription Drug Expense
Prescriptions must be filled at an “Express Scripts” Participating Pharmacy. A directory of participating pharmacies is available by logging onto www.expresscripts.com.

<table>
<thead>
<tr>
<th>Item</th>
<th>Payment Details</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Cost</td>
<td>$0 Co-pay for Generic contraceptives; $20 Co-pay for other generic drugs; $40 Co-pay for brand name drugs</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

| Note: | Policy Year deductible does not apply. |

### Intercollegiate and Club Sport, up to $1,000 per Injury
- 80% of PA
- 50% of R&C

### Emergency Medical Evacuation Benefit
- Unlimited

### Repatriation of Remains Benefit
- Unlimited

### STUDENT HEALTH SERVICES
Services rendered at the Student Health Service will be paid at 100% to $250 per year for Students only. Deductible waived at the Student Health Services.

### ACCIDENTAL DEATH AND DISMEMBERMENT
If the Eligible Person, within 365 days from the date of an Accident which occurs while Coverage is in force dies as the result of an Injury from such Accident, We will pay the Eligible Person’s beneficiary the amount for loss of life as shown in the Schedule of Benefits. If the Eligible Person, within 365 days from the date of an Accident, which occurs while Coverage is in force, suffers dismemberment as the result of Injury from such Accident, We will pay the Eligible Person the amount set opposite such loss, as shown on the Schedule of Benefits. If more than one (1) such loss is sustained as the result of one (1) Accident, We will pay only one (1) amount, the largest to which the Eligible Person or his or her beneficiary would be entitled.

The following table shows the amounts We will pay for loss of:

- Life: $1,000
- Two hands: $1,000
- Two feet: $1,000
- Sight of two eyes: $1,000
- One hand and one foot: $1,000
- One hand and sight of one eye: $1,000
- One foot and sight of one eye: $1,000
- One hand or one foot or one eye: $500

Loss of hand or foot means loss by severance at or above the wrist or ankle joint. Loss of sight must be entire and irrecoverable. Loss of a thumb and index fingers means loss by severance at or above the metacarpophalangeal joints, which are the joints between the fingers and the hand.

This Benefit is subject to all the terms, Conditions and exclusions of the Policy.

### MEDICAL EVACUATION BENEFIT
If the Insured cannot continue his academic program because he sustains an Accidental Injury or Emergency Sickness while Insured under the Policy or if a Covered Dependent sustains an Accidental Injury or Emergency Sickness and is more than 100 miles from his current place of primary residence or outside of his Home Country, We will pay for the actual charge incurred for an emergency medical evacuation of the Covered Person to or back to the Insured’s home state, country, or country of regular domicile subject to the Coinsurance, Deductible, Copayment, as stated in the Schedule of Benefits, and the Exclusions and Limitations provisions. No payment will be made under this provision unless the evacuation follows a Hospital Confinement of at least (5) consecutive days. Before We make any payment, We require written certification by the Attending Physician that the evacuation is necessary. Any expense for medical evacuation requires Our prior approval and coordination. For international students, once evacuation is made outside the country, Coverage terminates. This Benefit does not include the transportation expense of anyone accompanying the Covered Person or visitation expenses.

### REPATRIATION OF REMAINS BENEFIT
If the Covered Person dies while Insured under the Policy and is more than 100 miles from his permanent residence or outside of his Home Country, We will pay for the actual charge incurred for embalming, and/or cremation and returning the body to his place of permanent residence in his home state, country or country of regular domicile, up to the benefit amount shown in the Schedule of Benefits, subject to the Coinsurance, Deductible, Copayment, as stated in the Schedule of Benefits, the maximum Benefit limit shown above, and the Exclusions and Limitations provisions. Expenses for repatriation of remains require the Policyholder’s and Our prior approval. If You are a United States citizen, Your Home Country is the United States. This Benefit does not include the transportation expense of anyone accompanying the body, visitation or lodging expenses or funeral expenses.

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

### EXCLUSIONS
Unless specifically included, no Benefits will be paid for: a) Loss or expense caused by, contributed to, or resulting from; b) treatment, services, or supplies for, at, or related to:

- Services provided normally without charge by the health service of the Policyholder; Services covered or provided by a student health fee; Services...
rendered by employees or Physicians or other persons or retained by the University or for the use of the Universities facilities.

2. War or any act of war, declared or undeclared; or while in the armed forces of any country.

3. Injury sustained by reason of a motor vehicle Accident to the extent that Benefits are paid or payable by any other valid and collectible insurance whether or not claim is made for such Benefits.

4. Cosmetic surgery, plastic surgery, or other services and supplies that We determine to be furnished primarily to improve appearance rather than a physical function or control of organic disease or for treatment of an Injury that is covered under the Policy. Improvements of physical function does not include improvement of self-esteem, personal concept of body image, or relief of social, emotional, or psychological distress. Procedures not covered include, but are not limited to: face lifts; sagging eyelids; prominent ears; skin scars; warts, non-malignant moles and lesions; hair growth hair removal; correction of breast size, asymmetry or shape by means of reduction, augmentation, or breast implants including gynecomastia (except for correction or deformity resulting from mastectomies or lymph node dissections); lpectomy services and supplies related to surgical suction assisted lpectomy; rhinoplasty; nasal and sinus surgery; and deviated nasal septum, including submucous resection except when Medically Necessary treatment of acute purulent sinusitis. This exclusion does not include Reconstructive Surgery when the service is incidental to or follows surgery resulting from trauma, Injury, infection or other diseases of the involved part.

5. Injury resulting from participation in any hazardous activity, including: parachuting, hang gliding, skydiving, parasailing, ski diving, glider flying, sailplaning, racing or speed contests, or bungee jumping; (except as specifically provided in this Policy).

6. Injury occurring in consequence of riding or otherwise being in any vehicle or device of aerial navigation, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline.

7. Injury or Sickness for which Benefits are paid or payable under any workers' compensation or occupation disease law or act, or similar legislation.

8. Services for the treatment of any Injury or Sickness incurred while committing or attempting to commit a felony; or while taking part in an insurrection or riot; or fighting, except in self-defense.

9. Treatment of chronic Conditions of the foot including weak feet, flat foot, subluxations of the foot, foot strain, care of corns, calluses, toenails or bunions, except for treatment of Injury, infection or disease.

10. Reproductive/Infertility services, including but not limited to: family planning, treatment of infertility (male or female) including diagnosis, diagnostic tests, medication, surgery, supplies, and fertilization procedures rendered for the purpose or with the intent of inducing conception, impotence, organic or otherwise; vasectomy. Examples of fertilization procedures are ovulation induction procedures, in vitro fertilization, artificial insemination, embryo transfer or similar procedures that augment or enhance Your reproductive ability.

11. Eyeglasses, contact lenses, routine eye refractions, eye examinations except as in the case of injury, or as provided; prescriptions or fitting of eyeglasses or contact lenses vision correction surgery or Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision, except as provided herein.

12. Treatment in a government Hospital, unless there is a legal obligation for the Covered Person to pay for such treatment.


15. Sexual/gender reassignment surgery, this exclusion does not include related mental health counseling.


17. Circumcision, except as provided herein.

18. Diagnosis and treatment of sleep disorders including but not limited to apnea monitoring, sleep studies.

19. Hearing Screenings (except as specifically provided in the Policy) or hearing examinations or hearing aids and the fitting or repairing or replacement of hearing aids, except in the case of Accident or Injury.

20. Custodial Care; Care provided in a: rest home, home for the aged, or any similar facility for domiciliary or Custodial Care, or that provides twenty-four (24) hour non-medical residential care or day care (except as provided for Hospice care).

21. Any services of a Physician or Nurse who lives with You or Your Dependent(s) or who is related to You or Your Dependent(s) by blood or marriage.

22. Expense incurred for any service, treatment or supply for the diagnosis or treatment of sexual dysfunction (including erectile dysfunction). This includes, but is not limited to, drugs, laboratory and x-ray tests, counseling, transsexual procedures or penile prostheses necessary due to any medical condition or organic disease. A penile prosthesis will be eligible for payment only after prostate surgery.

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

24. Services of a private duty Nurse.

25. Obesity treatment: Services and associated expenses for the treatment of obesity, except nutrition counseling specifically provided in the Policy, and any resulting complications, consequences and after effects of treatment that involves surgery and any other associated expenses, including, but not limited to:

- Gastric or intestinal bypasses;
- Gastric balloons;
• Stomach stapling;
• Wiring of the jaw;
• Panniculectomy;
• Appetite suppressants;
• Surgery for removal of excess skin or fat.

26. Nutrition counseling services (except as specifically provided in the Policy), including services by a Physician for general nutrition, weight increase or reduction services, except as specifically provided in the Policy; general fitness, exercise programs, health club memberships and weight management programs; exercise machinery or equipment, including but not limited to treadmill, stair steps, trampolines, weights, sports equipment, support braces used primarily for use during any sport or in the course of employment, any equipment obtainable without a Physician’s prescription.

27. Acupuncture and acupressure, aroma therapy, hypnosis, rolling, Hyperhidrosis, Psychosurgery, biofeedback.

CLAIM PROCEDURES

In the event of Injury or Sickness, students should:

1. Report to their Physician or Hospital.
2. Mail all medical and hospital bills along with the patient’s name, insured student’s name, address, Social Security number or student ID number and name of the University under which the student is insured to Cigna at the address listed below. A Company claim form is not required for filing a claim.
3. File claim within sixty (60) days of Injury or first treatment for a Sickness. Bills should be received by the Company within ninety (90) days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

There is no utilization review performed on this Policy.

SUBMIT ALL MEDICAL CLAIMS TO:

Cigna
1000 Great West Drive
Kennett, MO 63857-3749
Electronic Payor ID: 62308

Customer Service, verification of benefits, claim correspondence, and ID card requests should be directed to the Claims Administrator listed below:

Claims Administrator:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
www.chpstudent.com

Servicing Agent:
USI Affinity Collegiate Insurance Resources
3070 Riverside Drive

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

Claims Administrator:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104

This plan is underwritten by and offered by:
NATIONWIDE LIFE INSURANCE COMPANY
Columbus, OH
Policy Number: 302-101-2212
Group Number: S210813

For a copy of the privacy notice you may go to:
www.consolidatedhealthplan.com/about/hipaa
VALUE ADDED SERVICES

NURSE HOTLINE FOR STUDENTS
For quick, sound medical advice from specially trained Nurses
24 hours a day, 365 days per year
Call toll free at 800-557-0309

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE
FrontierMEDEX ACCESS services is a comprehensive program providing You with 24/7 emergency medical and travel assistance services including emergency security or political evacuation, repatriation services and other travel assistance services when you are outside Your home country or 100 or more miles away from your permanent residence. FrontierMEDEX is your key to travel security.

For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at 1-800-633-7867.

If you have a medical, security, or travel problem, simply call FrontierMEDEX for assistance and provide your name, school name, the group number shown on your ID card, and a description of your situation. If you are in North America, call the Assistance Center toll-free at: 1-800-527-0218 or if you are in a foreign country, call collect at: 1-410-453-6330.

If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center. FrontierMEDEX will then take the appropriate action to assist You and monitor Your care until the situation is resolved.