2014-2015
Student Health Insurance Plan

Designed for the Students of

Troy University

Troy, AL

Underwritten by:

Nationwide Life Insurance Company

Columbus, OH

Policy Number: 302-071-0112

Effective: August 15, 2014 to August 14, 2015

Group Number: S212414

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, enrollment 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

AM I ELIGIBLE?

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

All students enrolled for a minimum of twelve (12) credit hours are eligible to enroll in the Troy University Student Health Insurance Plan on a voluntary basis.

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

COVERAGE FOR DEPENDENTS

Insured Students who are enrolled in the Student Health Insurance Plan may also enroll their eligible Dependents. Eligible dependents under the plan include the Insured person's spouse and dependent children.

Students may also enroll their Dependents within thirty-one (31) days of an eligible qualifying event. Eligible qualifying events for a Dependent are defined as birth or marriage (to the Insured Student). Coverage will be effective as of the date of the qualifying event. Enrollment requests (including payments) received after the thirty-one (31) days following the qualifying event will not be accepted. Coverage will be effective as of the date of the qualifying event.

HOW DO I ENROLL?

If You are eligible for this insurance plan, You will need to enroll on a voluntary basis by September 15, 2014. To enroll through CHP's website please follow the instructions below:

1. Go to www.chpstudent.com;
2. Select Troy University from the drop down box;
3. Click on the Enroll tab; and
4. Complete all information as directed.

You may enroll in this Insurance Program prior to September 15, 2014.

If You are eligible for coverage and wish to enroll in this Insurance Program outside of these enrollment opportunities, You must present documentation from Your former insurance company that it is no longer providing You with personal Accident and Sickness insurance coverage.

Your effective date of coverage under this Insurance Program will be the date that Your former insurance expired, but only if You make the request for coverage within thirty-one (31) days from the date that Your previous plan expired. Otherwise, the Effective Date of coverage will be the first (1st) of the month following Our receipt of Your written request for coverage. The appropriate premium must accompany Your application for coverage.

EFFECTIVE DATES AND COSTS

The Troy University 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.

	Annual Cost*
Student	$1,631
Spouse**	$4,891
One Child**	$2,656
2 or more Children**	$3,987
Family**	$6,881

**Annual costs above include an administrative fee payable to the servicing agent.*
*** Dependent rates are in addition to the student rate.*

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 within 60 days of leaving school, We will refund any unearned pro-rata Premium with respect to such person.
- The last date of the period for which Premium has been paid following the date a Dependent ceases to be a Dependent as defined.

Termination is subject to the Extension of Benefits provision.

EXTENSION OF BENEFITS

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

The total payments made in respect of the Insured for such Condition both before and after the termination date will never exceed the Maximum Benefit. After this Extension of Benefits provision has been exhausted, all Benefits cease to exist and under no circumstances will further Benefits be made.

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. 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.

DEFINITIONS

The terms listed below, if used, have the meaning stated.

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

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

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

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

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

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

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

Copayment: A specified dollar amount a Covered Person must pay for specified Covered Charges.

Covered Charge(s) or Covered Expense: As used herein means those charges for any treatment, services or supplies:

- for Preferred Providers, not in excess of the Preferred Allowance;
- for Out-of-Network Providers not in excess of the Reasonable and Customary expense; and
- not in excess of the charges that would have been made in the absence of this insurance; and
- not otherwise excluded under this Policy; and
- incurred while this Policy is in force as to the Covered Person.

Covered Person: A person:

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

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

Dependent: A person who is the Insured's:

- Legally married spouse, who is not legally separated from the Insured and resides with the Insured.
- Child who is under the age of 26.

The term child refers to the Insured's:

- Natural child;
- Stepchild 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.

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

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

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

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

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

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

Covered Services are Medically Necessary if they are:

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

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

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

Mental Condition(s): Nervous, emotional, and mental disease, Illness, syndrome or dysfunction classified in the most recent addition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) or its successor, as a Mental Condition on the date of medical care or treatment is rendered to a Covered Person.

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

Physician: A health care professional practicing within the scope of his or her license and is duly licensed by the appropriate State Regulatory Agency to perform a particular service which is covered under the Policy, and who is not:

1. the Insured Person;
2. a Family Member of the Insured Person; or
3. a person employed or retained by the Policyholder.

Reasonable and Customary (R&C): The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred. The most common charge means the lesser of:

- The actual amount charged by the Provider;
- The negotiated rate, if any; or
- The fee often charged for in the geographical area where the service was performed.

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

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

Sickness: 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.

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

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.

PREFERRED PROVIDER INFORMATION

By enrolling in this Insurance Program, you have the PHCS PPO Network, providing access to quality health care at discounted fees. To find a complete listing of PHCS PPO Participating Providers, go to www.phcs.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, 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.

In-Network Benefit: The level of payment made by Us for Covered Services received by a Preferred Provider under the terms of the Policy. Payment is based on the Preferred Allowance unless otherwise indicated**"**

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		
	In-Network	**Out-of-Network**
Policy Year Maximum Benefit (includes Medical Evacuation & Repatriation)	**Unlimited**	
Deductible, per Covered Person per Policy Year	$4,500	$6,500
Out-of-Pocket Maximum (includes Coinsurance and Copayments; does not include non-covered medical expenses or elective treatment) In- and Out-of-Network Maximums must be met separately and are not cross-applied.	$6,350 per Covered Person/ $12,700 Family Maximum	N/A
Coinsurance	80% of Preferred Allowance (PA) up to $2,500; then application of Deductible; then 100% of PA	60% of Reasonable and Customary (R&C) up to $2,500; then application of Deductible; then 80% of R&C
Treatment outside the United States	60% of R&C	
Preventive/Wellness & Immunization Services	100% of PA Deductible does not apply	The Coinsurance shown above
Outpatient Services (other than Surgery, Maternity, Mental Health/Drug or Alcohol)		
Office Visits (includes Specialists/Consultants), benefits are limited to one (1) visit per day and do not apply when related to surgery or physiotherapy.	The Coinsurance shown above	
Diagnostic Imaging, X-ray and Laboratory Services	The Coinsurance shown above	
Inpatient Services – (other than Surgery, Maternity, Mental Health/Drug or Alcohol, except as specified)		
Miscellaneous Hospital Services	The Coinsurance shown above	
Room and Board expense, at the semi-private room, general nursing care, and ICU	The Coinsurance shown above	
Physician visits (includes Specialists/Consultants), benefits are limited to one (1) visit per day and do not apply when related to surgery.	The Coinsurance shown above	

Skilled Nursing and Sub-Acute Care Facilities Up to 100 days per Policy Year	The Coinsurance shown above
Inpatient Rehabilitation Facility Up to 100 days per Policy Year	The Coinsurance shown above
Surgical Services (Inpatient & Outpatient) - 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, and with regard to the less expensive Surgical Procedure in an amount equal to 50% of the Covered Percentage of the Covered Charge for these procedures.	
• Surgeon's Fee • Assistant Surgeon, limited to 20% of Surgeon's Fees • Anesthetist Services, .limited to 25% of amount paid to surgeon. • Hospital Miscellaneous includes supplies, drugs, facility fee, and miscellaneous items used in association with the surgical event.	The Coinsurance shown above
Organ transplants	The Coinsurance shown above
Maternity Care – Includes forty-eight (48) hours of Inpatient care following a normal delivery and ninety-six (96) hours of Inpatient care following a cesarean delivery, unless after conferring with the mother or a person responsible for the mother or newborn, the Attending Physician or a certified nurse-midwife who consults with a Physician, decides to discharge the mother or newborn child sooner. In the event of early discharge, Home Health Care visits will be provided.	
Maternity care and pre-natal services	Paid the same as any other Sickness
Mental Conditions & Substance Abuse	
Inpatient Services	Paid the same as any other Sickness
Outpatient Office Visits	Paid the same as any other Sickness
Urgent Care and Emergency Services	
Urgent Care	The Coinsurance shown above
Emergency services. Use of the emergency room and supplies. Co-pay waived if admitted	The In-Network Coinsurance and In-Network Deductible shown above, after a $100 co-pay
Emergency Medical Transportation services	The Coinsurance shown above

Other Services		
Allergy Services (testing/injections/treatment)	The Coinsurance shown above	
Habilitative and Rehabilitative therapy – including Physical, Speech, and Occupational, up to 30 visits per Policy Year, combined	The Coinsurance shown above	
Chiropractic Care, up to 20 visits per Policy Year	The Coinsurance shown above	
Home Health Care	The Coinsurance shown above	
Hospice	The Coinsurance shown above	
Diabetic Treatment and Education	Paid the same as any other Sickness	
Durable Medical Equipment (DME) – includes Prosthetic and Orthotic Devices	The Coinsurance shown above	
Prescription Drug Expense • Deductible does not apply. • Only a thirty (30) day supply can be dispenses at any time. • One (1) co-payment per thirty (30) day supply. • Co-payments apply to the out-of-pocket. • Prescriptions must be filled at an "Express Scripts" participating pharmacy. Go to www.express-scripts.com for a list of participating pharmacies.	• $0 Co-pay for generic contraceptives and wellness prescriptions; or • $20 Co-pay for other generic prescriptions; or $30 Co-pay for any brand name prescription; or • $60 Co-pay for any non-preferred brand name drugs	Not covered
Routine Vision Exam for Covered Persons under nineteen (19) – limited to one (1) exam per Policy Year. Includes prescription eye glasses (lenses & frames), or contact lenses in lieu of eyeglasses, limited to once per Policy Year.	100% of R&C up to $150, 50% thereafter.	
Dental Expenses, Injury to sound, natural teeth only Limited to $500 per Policy Year	The Coinsurance shown above	
Medical Evacuation	The Coinsurance shown above	
Repatriation	The Coinsurance shown above	

MANDATED BENEFITS

If You are enrolled in this Insurance Program, Policy coverage also includes the following benefits, 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.)

Alcoholism; Colorectal Cancer Screening; Inpatient Care for Mothers and Newborn Children; Mammography; Prostate Cancer Early Detection.

MEDICAL EVACUATION BENEFIT

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

REPATRIATION OF REMAINS BENEFIT

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

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:

1. Eyeglasses, contact lenses, including but not limited to routine eye refractions, eye exams except as in the case of Injury or as specifically provided. Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision, except as provided herein;
2. Hearing Screenings (except as provided herein) or hearing examinations or hearing aids and the fitting or repairing of hearing aids; except as eligible for this service under Part H of the Individuals with Disabilities Education Act or except in the case of Accident or Injury;
3. Treatment of chronic Conditions of the foot including weak feet, flat foot, pronated foot, subluxations of the foot, care of corns, calluses, toenails or bunions (except capsular or bone surgery), except for treatment of Injury, infection or disease, except as provided herein;
4. Cosmetic surgery, Plastic surgery, resulting complications, consequences and after effects or other services and supplies that We determine to be furnished primarily to improve appearance rather than a physical function or control of organic disease except as provided herein or for treatment of an Injury that is covered under the Policy. Improvements of physical function does not include improvement of self-esteem, personal concept of body image, or relief of social, emotional, or psychological distress. Procedures not covered include, but are not limited to: face lifts, rhinoplasty, sagging eyelids, prominent ears, skin scars, baldness, and correction of breast size, asymmetry or shape by means of reduction, augmentation, or breast implants (except for correction or deformity resulting from mastectomies or lymph node dissections);
5. Sexual/gender reassignment surgery, including, but not limited to, Hysterectomy, Salpingo-oophorectomy, Vaginectomy, Metoidioplasty, Scrotoplasty, Urethroplasty, placement of testicular prostheses, Phalloplasty, Orchiectomy, Penectomy, Vaginoplasty Clitoroplasty, Labiaplasty or any treatment of gender identity disorders, including hormone replacement therapy except as provided herein. This exclusion does not include related mental health counseling;
6. Treatment, service, or supply which is not Medically Necessary for the diagnosis, care or treatment of the Sickness or Injury involved;
7. Treatments which are considered to be unsafe, Experimental, or Investigational by the American Medical Association (AMA), and resulting complication;
8. Custodial Care, Care provided in a: rest home, home for the aged, or any similar facility for domiciliary or Custodial Care, (except as provided for Hospice care);

9. Dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth, (except as specified herein);
10. Temporomandibular Joint Dysfunction (TMJ);
11. Injury sustained while (a) participating in any intramural, intercollegiate, professional, semi-professional or club sport, contest, or competition; (b) traveling to or from such sport, contest, or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest, or competition.
12. 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;
13. Injury resulting from participation in any hazardous activity, including: travel in or upon a snowmobile, ATV (all terrain or similar type two or three wheeled vehicle and/or off-road four wheeled motorized vehicles motor vehicles not primarily designed and licensed for use on public streets or highways or personal watercraft, parachuting, hang gliding, skydiving, parasailing, scuba diving, skin diving, glider flying, sailplaning, racing or speed contests, mountaineering (where ropes or guides are customarily used), rock wall climbing, rodeo or bungee jumping, (except as specifically provided in this Policy).
14. 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;
15. Reproductive/Infertility services including but not limited to: treatment of infertility (male or female) including medication, surgery, supplies, and fertilization procedures rendered for the purpose or with the intent of inducing conception, premarital examination; impotence, organic or otherwise; sterilization (except as specifically provided in the Policy), sterilization reversal; vasectomy, vasectomy reversal, except as specifically provided in this Policy;
16. Elective termination of pregnancy.
17. Charges for which an Insured Person has no legal obligation to pay in absence of this or like coverage.
18. Hospital Confinement or any other services or treatment that are received without charge or legal obligation to pay; Inpatient Room & Board charges in connection with a Hospital stay primarily for environmental change; Inpatient room & board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an Outpatient basis.
19. Services provided normally without charge by the health service of the Policyholder, or services covered or provided by a Student health fee;
20. Treatment in a government Hospital, unless there is a legal obligation for the Covered Person to pay for such treatment;
21. Expenses that would be payable or medical treatment that is available, under any governmental or national health plan for which the Covered Person could be eligible;
22. 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;

23. Expense covered by any other medical insurance to the extent that Benefits are payable under any other medical insurance whether or not a claim is made for such Benefits.
24. Services received before the Covered Person's Effective Date; Services received after the Covered Person's Coverage ends, except as specifically provided under the Extension of Benefits provision.
25. Services of a private duty nurse;
26. Under the Prescription Drug Benefit, when included, any drug or medicine:
    a) Obtainable Over the Counter (OTC);
    b) For the treatment of alopecia (hair Loss) or hirsutism (hair removal);
    c) For the purpose of weight control;
    d) For the treatment of infertility;
    e) Sexual enhancement Drugs;
    f) Cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, or treatment of acne except as specifically provided in this Policy;
    g) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
    h) For an amount that exceeds a 30 day supply;
    i) Drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
    j) Purchased after Coverage under the Policy terminates;
    k) Consumed or administered at the place where it is dispensed;
    l) If the FDA determines that the drug is:
        - Contraindicated for the treatment of the Condition for which the drug was prescribed; or
        - Experimental for any reason.
27. For Injury caused by, contributed to or resulting from the Covered Person being intoxicated by use of alcohol, illegal drug or use of legal medicines that are not taken in the dosage or for the purposed as prescribed by the Covered Person's Physician;
28. Injuries sustained as a result of intentional/unintentional self-inflicted Injury or any attempt at intentional/unintentional self-inflicted Injury;
29. Services for the treatment of any Injury or Illness incurred while committing or attempting to commit a felony; or while taking part in an insurrection or riot; or fighting, except in self-defense;
30. Injury or Sickness for which Benefits are paid or payable under any workers' compensation or occupation disease law or act, or similar legislation;
31. War or any act of war, declared or undeclared; or while in the armed forces of any country;
32. Obesity treatment: Services and associated expenses for the treatment of obesity 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;

33. General fitness, exercise programs, health club memberships and weight loss 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 Doctor's prescription;
34. Acne;
35. Acupuncture and acupressure, aroma therapy, hypnosis, rolfing, Hyperhidrosis, Psychosurgery, biofeedback;
36. Diagnosis and treatment of sleep disorders including but not limited to apnea monitoring, sleep studies;
37. Elective Surgery or Treatment;
38. Vaccines and immunizations (except as specifically provided in the Policy); and
39. Modifications made to dwellings, property, or automobiles such as ramps, elevators, stair lifts, swimming pools, spas, air conditioners or air-filtering systems, equipment that may increase the value of the residence, or car hand controls, whether or not their installation is for purposes of providing therapy or easy access, or are portable to other locations.

CLAIM PROCEDURES

In the event of either an Injury or a Sickness:

1. Contact your Student Health Services, if available. They will provide primary care and, if necessary, refer you to a Provider located nearby for treatment at reduced cost.
2. Submit to Consolidated Health Plans, at the address shown below, an itemized bill. Written Proof of Loss must be submitted by You or Your health care provider within ninety (90) days of treatment, or as soon as reasonably possible.

Please Send claims to:
Consolidated Health Plans (CHP)
2077 Roosevelt Avenue
Springfield, MA 01104
www.chpstudent.com
Electronic Payor ID: 87843

There is no utilization review performed on this Policy.

CLAIMS APPEAL PROCESS

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

Claims Administrator:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
www.chpstudent.com
(413) 733-4540 or Toll Free (800) 633-7867
Group Number: S212414

Servicing Broker:
Parker Waller Insurance, LLC
401 Cedar Street
Greenville, AL 36037
(334) 382-4604 or Toll Free (877) 272-4532

This plan is underwritten by and offered by:
Nationwide Life Insurance Company
Columbus, OH
Policy Number: 302-071-0112

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

VALUE ADDED SERVICES

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

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.